Nevada Hospital Assessment Program Bulletin: 23-001

Date: August 17, 2023
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Subject: Requirements for Nevada Private Hospital Assessment & Payment Program

PURPOSE: This bulletin outlines the requirements for the Nevada Private Hospital Assessment & Payment Program as established under NRS 422.3794.

I. Background

To establish a provider assessment on all private hospitals in the state of Nevada, NRS 422.3794 requires the Division of Health Care Financing and Policy (the Division) to poll or survey all hospitals (public and private) by licensure type and, if at least 67 percent of the operators in that operator group vote in the affirmative, the Division may impose an assessment.

Medicaid provider taxes or assessments must follow federal law, guidance, and regulations if the revenue is used to fund the state share of new Medicaid payments or rate increases. See section 42 CFR 433.68. This includes signing an attestation form, if necessary, regarding federal compliance as requested by the Division to receive the new Medicaid payments.

II. Nevada Hospital Assessment Program

For purposes of the Nevada Hospital Assessment Program, all private hospitals will be required to pay the assessment. Public hospitals will be exempt from the assessment. To be eligible for any Medicaid payments associated with the Nevada Hospital Assessment Program, a private hospital must follow all policies or procedures deemed necessary by the State to ensure compliance with federal provider assessment requirements. Otherwise, the State may deny or hold Medicaid payments including those associated with the Nevada Hospital Assessment Program until federal compliance can be verified by the Division.

As of January 1, 2024, **all private hospitals** in the State of Nevada **must** pay the assessment regardless of whether the private hospital voted in support of the assessment or whether the private hospital participates in one of the Nevada Hospital Assessment Payment Programs described in this bulletin. If the assessment is not applied to all private hospitals in the State, Nevada Medicaid will be ineligible to draw down federal Medicaid funding to finance the new payment programs for private hospitals. Federal law requires that state provider taxes or assessments used to finance Medicaid payments be "broad based" (i.e., applied to all providers of a class in a state). 42 CFR 433.68.

Therefore, for purposes of this new assessment program, **all private hospitals** in Nevada will be subject the assessment if the poll or survey results in the necessary 67 percent threshold to implement the assessment as required under state law. NRS 422.3794. As further described below, any private hospital that does not pay its assessment will be subject to certain penalty fees and interest and any other penalties or actions that are necessary to recover owed payments to the

State of Nevada which will be outlined in future regulations for the Nevada Private Hospital Assessment and Payment Program.

A. Assessment Basis and Rate

The assessment basis is the total Inpatient Net Patient Revenue (NPR) less Medicare NPR and Outpatient Net Patient Revenue (NPR) less Medicare NPR. Assessment rates as of August 2, 2023, are 4.397% for Inpatient and 6.000% for Outpatient.

B. Data Source for Assessment

Hospital Medicare cost reports will provide the required data. Hospital cost report data as reported in the RAND database through May of each year will be used for the coming year's model. These data have been used to calculate initial assessment amounts for each facility, with the calculations performed by DHCFP's Special Revenue Unit (SRU) with support from the state's contracted vendor, Mercer.

C. Assessment Recalculation

After year one of the assessment (i.e., CY 2024), the Division will recalculate the assessment every two years, pending any CMS-required changes as necessary to maintain receipt of federal funds. This means, after year one, the assessment amount applicable to each hospital will remain constant for at least every two years to limit administrative burden and allow for a reasonable amount of budget predictability for the State and participating hospitals. Recalculation of the assessment and estimated payment amounts every two years will not require the Division to re-poll hospitals as long as the payment programs and the general uses of the assessment revenue as outlined in the original survey remain consistent.

D. Assessment Collection

Regular assessment amounts will be collected from facilities on a quarterly basis. The Division's Supplemental Reimbursement Unit (SRU) will notify all private facilities of their assessment amounts at the beginning of each quarter along with the due dates and will also collect the assessment payments directly from each hospital. Payments may be made to the state by check or via EFT.

E. Assessment-Related Penalties

Per NRS 422.3795, "The Division shall adopt regulations that establish administrative penalties for failure to timely pay an assessment imposed pursuant to NRS 422.3794. Any money collected from such a penalty must be deposited in the Account."

The state will apply a late payment penalty per day for up to a maximum of 10 days for nonpayment of an assessment. In addition, there will be a charge of 1.5% interest on any unpaid amount per month or fraction of a month. The Division's SRU, in collaboration with Division's Fiscal Unit, will track penalties/interest.

Through future rulemaking for this program, the Division may include other penalties or corrective actions to be taken by the State if a private hospital refuses to make a good faith effort to pay its quarterly assessments, including pausing other Medicaid payments for services rendered or, if necessary, in extreme cases, terminating a hospital's enrollment as a Medicaid provider or ceasing the Division's operation of the Nevada Private Hospital Assessment and Payment Program altogether, if necessary to avoid federal fines or significant financial risk to the State General Fund Budget and the State's Medicaid program. All actions taken in response to hospital noncompliance with the assessment will include proper notice by the Division and appeal rights for the provider.

F. Required Balance in the State's Assessment Fund

The State will retain a balance of 3.0% of the quarterly assessment amount, less the state's portion of the assessment for administration.

G. Assessment and Hospital Closures

A private hospital that closes during a quarter is liable for its relative proportion of the assessment amount for the period of the quarter in which it operated. For instance, if a private hospital closed one month into a quarter, it is still liable for one-third of the anticipated quarterly assessment. After the quarter in which a private hospital closes, that private hospital is no longer liable for any assessments.

H. Assessment and New Private Hospitals

The state will begin to assess new private hospitals starting in the fiscal year that begins after the new private hospital begins operation. If the new private hospital does not have 12 months of revenue data with which to calculate an assessment amount, whatever data is available for that hospital will be annualized. The private hospital will be required to pay an assessment based on that annualized amount.

I. Assessment and Hospital Change of Ownership

The liability for an assessment is the responsibility of the ownership party or parties of the private hospital on the first day of the quarterly assessment. However, that liability can be assumed by the new owner or owners. Documentation of the disposition of the liability must be provided to the HSD if the new owner is assuming the tax liability as part of the change of ownership or the party owning the hospital on the first day of the tax collection quarter will be responsible for the payment.

J. Assessment Funds Allowable Uses

NRS 422.37495 says that assessment funds can be used to administer the provisions of NRS 422.3791 to 422.3795, inclusive. Up to 15 percent of the assessment proceeds can be used for the state's program administrative expenses and to fund behavioral health care services.

K. Assessment Funds Carryover Balance

Per NRS 422.37495: "Any money remaining in the Account at the end of a fiscal year does not revert to the State General Fund, and the balance of the Account must be carried forward to the next fiscal year."

III. Fee-For-Service Upper Payment Limit (UPL) Payments

A. UPL Payment Structure

The Division will pay separate inpatient (IP) UPL and outpatient (OP) UPL FFS payments to private hospitals using the assessment revenue and eligible federal Medicaid funds. The Division will use the most recently completed UPL demonstration calculations for the payment period. This will be updated annually. For the initial IP and OP UPL payments, the UPL calculations will be based on most currently available data in the state's SFY24 UPL demonstrations.

There is no application process necessary to participate. However, any private hospital that does not pay its assessment invoice in a timely manner or comply with any necessary documentation for state and federal compliance purposes may be denied or delayed payment by the Division until compliance is met by the private hospital.

Furthermore, if a private Critical Access Hospital (CAH) chooses to receive a cost-settled Medicaid reimbursement rate under state law for outpatient (OP) services and the Division is appropriated the necessary state funding from the

legislature to support such payments for private CAHs in future years, the private hospital will become ineligible under federal law to participate in the OP UPL Payment program made available under this assessment program. The private CAH will still be required, however, to pay the quarterly assessments described in this bulletin or will be subject to penalties and other actions by the State as described in this bulletin to ensure the State remains compliant with federal tax laws and avoids financial risk to the State Budget and Medicaid program.

B. UPL Payment Reconciliation

There will be no reconciliation of UPL payments to actual experience.

C. UPL Payment Effective Date

The effective date is January 1, 2024. The state may consider payment for earlier periods pending the feasibility of that option.

D. Federal Approval

Federal approval for these UPL payments will occur via approval of State Plan Amendments (SPAs). The SPAs must be submitted to CMS by no later than the last day of the quarter of the intended start date. For example, if January 1, 2024 is the target start date, the SPA must be submitted to CMS by March 31, 2024. If October 1, 2023 is the target start date, the SPA must be submitted to CMS by December 31, 2023. Public notice was conducted by the State in the first quarter of 2023.

E. UPL Payment Logistics

Medicaid payments associated with the private hospital assessment program will be paid on a quarterly basis following the collection of assessment funds. The Division is responsible for making these payments directly to providers.

F. UPL Payments and DSH

The new private hospital UPL payments will count as hospital revenue and thus future DSH payments will be impacted.

G. UPL Payments and Weighting

Payments under the proposed OP UPL program are determined by the aggregate OP UPL available to Nevada private hospitals and the FFS paid claim counts for each private hospital. Private hospitals will receive proportional amounts of the aggregate OP UPL based on their relative claim counts. However, as part of the State's efforts to ensure access to care in rural areas, the Division will weight claims for private CAHs and Sole Community Hospitals (SCHs) more than all other private hospitals. The Division is targeting a claims weight for CAHs and SCHs such that the State can reasonably avoid financial risk to these hospitals with the new assessment by improving payments to these private hospital types and therefore access to care in rural communities.

The current modeling of the OP UPL payments is based on the SFY23 UPL demonstration. The actual OP UPL payments in SFY24 will be based on the forthcoming SFY24 OP UPL demonstration. As such, the actual claims weights for each actual upcoming payment might be different than the initial modeling, but still consistent with the State's targets. Additionally, it is possible that the weights will change from year to year as OP UPL demonstrations are updated.

IV. Managed Care State Directed Payments (SDPs)

A. SDP Structure

The Division will request permission from CMS to establish a new, separate SDP for private hospitals. This SDP will be made to facilities by managed care organizations (MCOs) and will be based off current Medicaid-service utilization. SDP calculations will be made separately for inpatient and outpatient services, and so there will be two separate payments. Any eligible private hospitals will be included; there is no application process to participate

B. Allowed SDP Populations

The Division will only include services for Title XIX populations as eligible for these payments.

C. Federal Approval

Federal approval of an SDP is required before any payments connected to that SDP can be made. The state's targeted start date for the SDP is January 1, 2024, but that will depend on CMS approval of the SDP.

D. SDP Payment Logistics

Payments will be made quarterly by MCOs in a timely manner. The methodology currently envisions calculating estimated payments which will be then reconciled based on actual managed care utilization. This would equate to four payments, with a reconciliation to follow. Final payment methodology for 2024 will be the result of CMS review and approval. Subsequent payment methodologies may be impacted by publication of the CMS final rule.

E. SDP Limits

CMS has limits on the size of SDP amounts. These limits can vary by class of facility. For this SDP, the limit for acute hospitals and Critical Access Hospitals will be 100% of the average commercial rate (ACR). For all other classes of facilities, the limit will be 100% of Medicare. These limits were selected by the Division in a manner that maximizes available federal funding to participating private hospitals.

F. SDP and MCO Premium Taxes

The Division will provide sufficient revenues to the MCOs to enable them to pay the SDP. This increase in revenues is subject to the current 3.5% MCO premium tax. The state can use up to 15 percent of the assessment total that it retains to provide the state share of these increased payments to MCOs. In the initial two years of the program, the Division estimates that the cost of the premium tax to the Division will be at least $10 million, annually.

The new SDP payments will count as hospital revenue and thus future DSH payments will be impacted.