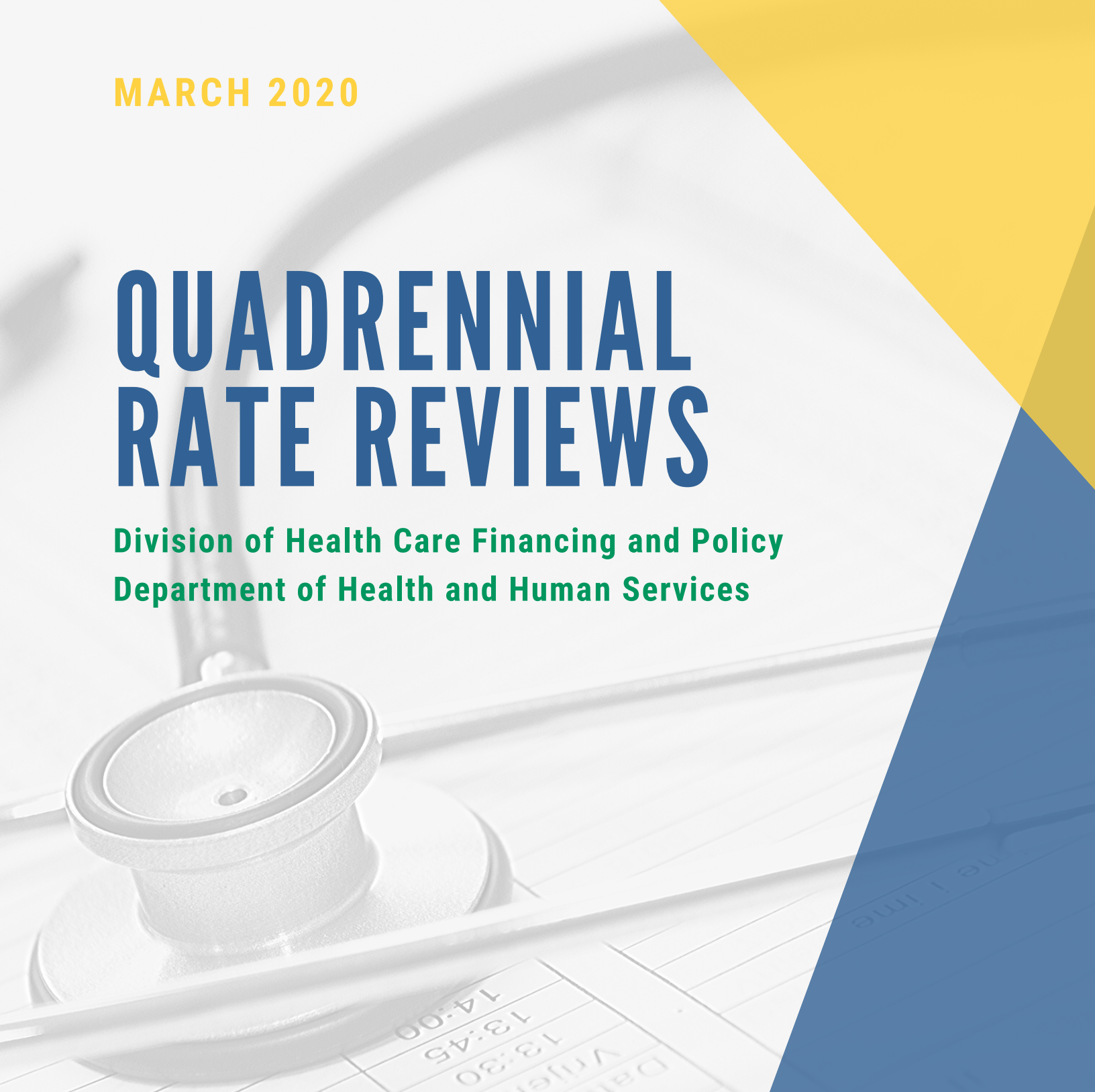
MARCH 2020

QUADRENNIAL RATE REVIEWS

Division of Health Care Financing and Policy
Department of Health and Human Services



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

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Executive Summary

The Division of Health Care Financing and Policy (DHCFP) has conducted rate reviews per the requirements of Assembly Bill 108 (AB 108) from the 2017 Legislative Session, which requires a comparison of providers' costs to Medicaid reimbursement rates. The provider types (PT) reviewed in this report include:

PT 17-166 Family Planning Clinics
PT 17-171 Methadone Clinics
PT 17-174 Public Health Clinics
PT 17-182 Indian Health, Non-Tribal Clinics
PT 17-183 Comprehensive Outpatient Rehabilitation Facilities
PT 17-195 Community Health Clinics
PT 17-198 HIV Clinics
PT 22 Dentist/Oral and Maxillofacial Surgery
PT 23 Hearing Aid Dispenser and Related Supplies
PT 27 Radiology and Noninvasive Diagnostic Centers
PT 32 Ambulance, Air or Ground – Cost-based Public
PT 32 Ambulance, Air or Ground – Private and Other Public
PT 43 Laboratory, Pathology/Clinical
PT 72 Nurse Anesthetist
PT 74 Nurse Midwife
PT 76 Audiologist

Surveys were used to determine providers' costs. Despite multiple outreach efforts, participation in the provider cost surveys was suboptimal, with zero responding providers for most provider types. Survey responses were received only for **PT 22 Dentist/Oral and Maxillofacial Surgery** and **PT 43 Laboratory, Pathology/Clinical** providers, and for **PT 32, Ambulance, Air or Ground – Cost-based Public** providers that are already paid through a cost-based reimbursement methodology. Of the providers in PT 22 and PT 43 that responded to the cost survey, their reported costs were significantly higher than current Nevada Medicaid rates.

Per the requirements of AB 108, the DHCFP recommends increasing rates for **PT22 Dentist/Oral and Maxillofacial Surgery** and **PT 43 Laboratory, Pathology/Clinical.** For **PT22 Dentist/Oral and Maxillofacial Surgery**, the estimated fiscal impact of reimbursement at the median of providers' reported costs is approximately $269 million for the 2022-2023 biennium, with a non-federal share of $79 million. The estimated fiscal impact of reimbursement at providers' reported costs for **PT43 Laboratory, Pathology/Clinical** is $2.8 million for the 2022-2023 biennium, with a non-federal share of $0.7 million. These recommendations have been provided to the Director of the Department of Health and Human Services for review and possible inclusion in the State Plan for Medicaid.

Purpose

Nevada Medicaid and Nevada Check Up currently provide health care coverage to approximately 671,000 Nevadans. These recipients access health care through either a fee-for-service or managed care service delivery system. Health care providers frequently voice concerns about Nevada Medicaid's reimbursement rates being too low to cover their costs of providing services to Medicaid and Check Up recipients. If these providers stop serving Medicaid and Check Up recipients, these recipients may have difficulty obtaining treatment needed to maintain their health.

In an effort to gather data to quantify the gap between Medicaid rates and provider costs, Assembly Bill 108 (AB 108) was passed and signed into law during the 2017 Legislative Session. This bill requires the Division of Health Care Financing and Policy (DHCFP) to review each Medicaid reimbursement rate every four years. These quadrennial rate reviews determine if current Medicaid reimbursement rates accurately reflect the actual cost of providing services or items needed by Medicaid and Check Up recipients. If the DHCFP finds that a reimbursement rate does not accurately reflect the actual cost of providing the service or item, this bill requires the DHCFP to calculate the rate of reimbursement that accurately reflects the actual cost of providing the service and recommend that rate to the Director for possible inclusion in the State Plan for Medicaid.

Background

As of January 2019, there are over 290,000 active rates for Nevada Medicaid, covering 64 provider types (PT). A provider type indicates who is providing a service. Provider types may include individuals, facilities, or other organizational structures. Most provider types and specialties have their own rate methodologies, and therefore, must be analyzed separately. The DHCFP developed a quadrennial rate review schedule by provider type. In developing the schedule, the DHCFP prioritized provider types that had not recently received rate increases or reviews.

This report encompasses the first two quarters of reviews (quarters three and four of calendar year 2018) and includes the following provider types:

PT 17-166 Family Planning Clinics
PT 17-171 Methadone Clinics
PT 17-174 Public Health Clinics
PT 17-182 Indian Health, Non-Tribal Clinics
PT 17-183 Comprehensive Outpatient Rehabilitation Facilities
PT 17-195 Community Health Clinics
PT 17-198 HIV Clinics
PT 22 Dentist/Oral and Maxillofacial Surgery
PT 23 Hearing Aid Dispenser and Related Supplies
PT 27 Radiology and Noninvasive Diagnostic Centers
PT 32 Ambulance, Air or Ground – Cost-based Public
PT 32 Ambulance, Air or Ground – Private and Other Public
PT 43 Laboratory, Pathology/Clinical
PT 72 Nurse Anesthetist
PT 74 Nurse Midwife
PT 76 Audiologist

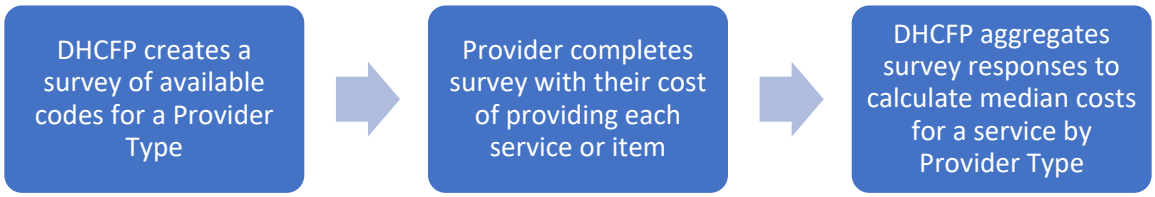
The results of these reviews are summarized below.

Methodology

In order to assess provider costs, providers whose rates are under review are asked to complete a survey related to their costs of providing each service or item that is allowed under their provider type. The DHCFP reached out to providers in multiple ways to encourage their participation in the cost surveys: website postings, web announcements, and social media posts; email/fax outreach from DXC Technology; DHCFP emails/calls to providers; and contact with provider associations and boards.

The cost survey spreadsheets for each provider type list available Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, descriptions, and modifiers. Providers fill in their cost information for each code that they use and submit their completed survey to DHCFP. DHCFP staff then analyze the survey data to determine the median cost of providing each service or item for each provider type. Median costs are used rather than average costs because the median minimizes the impact of outliers with extremely high or low costs reported on the provider surveys. Note that the DHCFP does not have the authority to audit the cost information submitted by providers in their survey responses; the DHCFP simply uses the information provided by providers to estimate the costs of providing services to Medicaid and Nevada Check Up recipients.

Figure 1: Provider Cost Calculation



In order to paint a more complete picture concerning Nevada Medicaid's reimbursement rates, DHCFP staff also analyzed how Nevada Medicaid's rates compare to other states' Medicaid rates and to Medicare's rates. The states used for comparison were Arizona, Colorado, Idaho, Montana, New Mexico, Oregon, Utah, and Wyoming. These states were selected due to their proximity to Nevada as well as similarities in population distribution. In researching other states' Medicaid reimbursement rates, every effort was made to find the rate that most closely aligned with Nevada Medicaid's rate. DHCFP staff researched fee schedules effective during the same timeframe as the survey period and attempted to find the reimbursement rates for matching provider types. In some instances, a compatible provider type did not exist in another state or services were not included in their fee schedules. Staff calculated a median of the other states' Medicaid rates for each service to compare to Nevada's rates.

Once the comparison data was completed, a fiscal analysis for the upcoming 2022-2023 biennium was performed to demonstrate the impact of changing current Nevada Medicaid fee-for-service rates to rates that align with providers' reported costs. Fiscal impact analyses were also completed for the additional scenarios of aligning with Medicare rates or the median of other states' Medicaid rates. No fiscal impact analyses were completed for the provider types that did not provide responses to the provider cost surveys.

Whereas calculation of the fiscal impact of a fee-for-service rate increase is relatively straightforward, calculating a reimbursement rate change on managed care capitation payments is technically complex and challenging. The Centers for Medicare and Medicaid Services (CMS) require Medicaid managed care capitation rates to be actuarially sound and Nevada Medicaid relies on contracted certified actuaries for capitation rate development. Actuarial development of the managed care portion of the fiscal impact estimates is beyond the scope of this project. Instead, the DHCFP used a managed care multiplier to gross up the fee-for-service estimates to reflect the potential changes in capitation rates due to a change in fee-for-service reimbursement rates.

The combined fee-for-service and managed care fiscal impact estimates were projected forward to the upcoming biennium (state fiscal years 2022 and 2023) using projected growth rates based on caseload projections from the Department of Health and Human Services Office of Analytics. These total computable estimates included both the federal and non-federal share of the projected impact. Federal Medical Assistance Percentage (FMAP) rates were applied to determine the non-federal share of each proposed rate change scenario.

Results

The rate reviews for the third and fourth quarters of 2018 represent the first reviews completed under the AB 108 quadrennial rate review process. Unfortunately, provider response to the rate surveys was much lower than anticipated. Due to the low initial response rate, staff conducted additional outreach efforts to acquire cost data from providers. These efforts included additional web announcements, emails, and contact with provider associations. Despite these efforts, DHCFP received no survey responses for several provider types. When this occurred, staff were unable to draw conclusions related to provider costs and the fiscal impact of increasing the reimbursement rates to align with providers' costs. Response rates by provider type are shown in the table below.

Table 1: Response Rates by Provider Type and Specialty

Provider Type, Specialty	Enrolled Providers	Codes in Fee Schedule	Responses Received	Response Rate
PT 17 Special Clinics, 166 Family Planning Clinics	3	73	0	0%
PT 17 Special Clinics, 171 Methadone	7	4	0	0%
PT 17 Special Clinics, 174 Public Health	6	126	0	0%
PT 17 Special Clinics, 182 Indian Health Programs (Non-Tribal)	1	18	0	0%
PT 17 Special Clinics, 183 Comprehensive Outpatient Rehabilitation	6	37	0	0%
PT 17 Special Clinics, 195 Community Health Clinic	27	86	0	0%
PT 17 Special Clinics, 198 HIV	3	27	0	0%
PT 22 Dentist/Oral and Maxillofacial Surgery	1,079	345	14	1%
PT 23 Hearing Aid Dispenser/Clinical	8	52	0	0%
PT 27 Radiology and Noninvasive Diagnostic	38	2,536	0	0%
PT 32 Ambulance, Air or Ground – Cost-based Public	15	30	3	20%
PT 32 Ambulance, Air or Ground – Private and Other Public	73	30	0	0%
PT 43 Laboratory, Pathology/Clinical	62	1,260	1	2%
PT 72 Nurse Anesthetist	266	116	0	0%
PT 74 Nurse Midwife	55	100	0	0%
PT 76 Audiologist	112	154	0	0%

DHCFP received a total of eighteen cost survey responses across all provider types. The largest number of survey responses came from **PT22 Dentist/Oral and Maxillofacial Surgery** with a total of fourteen responses submitted, yet five of these providers submitted only their usual and customary rates and did not provide cost data. One **PT 43 Laboratory, Pathology/Clinical** provider submitted a cost survey, but that provider only included their costs for a single code (procedure code 80307 Presumptive Drug Screening Chemical Analyzer). Three responses were submitted by **PT 32 Ambulance, Air or Ground – Cost-based Public** providers; these providers are already reimbursed at cost, so no additional analysis was undertaken related to the reimbursement for this provider group.

Table 2 below provides a high-level summary of the fiscal impact of reimbursement at provider costs for **PT 22 Dentist/Oral and Maxillofacial Surgery** and **PT 43 Laboratory, Pathology/Clinical**. The fiscal impact is calculated as the difference between estimated total computable expenditures under reimbursement at provider costs and the base scenario expenditures at current reimbursement rates.

Table 2: 2022-23 Biennium Fiscal Impact Estimates

Provider Type, Specialty	Median of Reported Provider Costs	
	Total Computable	Non-Federal Share
PT 22 Dentist/Oral and Maxillofacial Surgery	$269,202,931	$79,487,535
PT 43 Laboratory, Pathology/Clinical*	$2,815,153	$701,712

* One code only.

There are several important caveats to the estimates provided in Table 2. First, provider costs may have changed after the submission of their cost surveys. Any post-survey changes in provider costs are not accounted for in the analysis. Second, the estimates shown above include an estimated impact of fee-for-service rate increases on managed care capitation rates. For the purpose of this analysis, a managed care multiplier was used to gross up the fee-for-service expenditure estimates. It is likely that the multiplier imprecisely captures the impact of fee-for-service rate changes on managed care capitation rates. Managed care capitation rates must be actuarially sound and must be calculated by a certified actuary; that actuarial analysis is beyond the scope of this report. Third, these fiscal impact estimates are subject to change dependent on updated caseload and FMAP projections for the upcoming biennium.

Recommendations

Per the requirements of AB 108, DHCFP recommends rate increases for **PT 22 Dentist/Oral and Maxillofacial Surgery** and **PT 43 Laboratory, Pathology/Clinical** to better align Nevada Medicaid rates with the providers' reported costs.

PT 22 Dentist/Oral and Maxillofacial Surgery

Aligning Nevada Medicaid's PT 22 rates with the providers' reported costs represents an average increase of 215 percent per code. The estimated total computable impact is $269 million for the upcoming biennium, with a non-federal share of $79 million. A less costly option may be to align with providers' reported costs for preventative services only; the total computable impact of this option is $54 million for the same time period (non-federal share $16 million). The fiscal impacts for additional scenarios are also presented in Table 3 below. Note that under the scenario that aligns with other states' Medicaid rates, some rates would increase while others would decrease.

Table 3: 2022-23 Biennium Fiscal Impact Estimates for PT 22 Dentist/Oral and Maxillofacial Surgery

Rate Change Scenario	Total Computable	Non-Federal Share	Average Change per Code
Align with Median of Reported Provider Costs	$269,202,931	$79,487,535	215%
Align Preventative Services with Median of Reported Provider Costs	$54,820,072	$16,186,719	247%
Align with Median of Other States' Medicaid Rates	$30,333,282	$8,956,507	64%
Align with Medicare Rates	N/A	N/A	N/A
5% Rate Increase	$9,596,088	$2,833,436	5%
10% Rate Increase	$19,192,176	$5,666,873	10%
15% Rate Increase	$28,788,264	$8,500,309	15%

PT 43 Laboratory, Pathology/Clinical

For PT 43, only one provider responded to the cost survey and the responding provider reported cost for a single code (procedure code 80307 Presumptive Drug Screening Chemical Analyzer). Increasing the Nevada Medicaid rate for this code to align with the provider's costs would result in a 48 percent increase for this code, with a total computable fiscal impact of $2.8 million for the upcoming biennium (non-federal share $0.7 million). The table below provides other rate increase options for consideration. Note that each of these additional scenarios applies changes to multiple rates, not just the single code reported in the provider cost survey. Under the scenario that aligns reimbursement rates with other states' Medicaid rates, some rates would increase while others would decrease.

Table 4: 2022-23 Biennium Fiscal Impact Estimates for PT 43 Laboratory, Pathology/Clinical

Rate Change Scenario	Total Computable	Non-Federal Share	Average Change per Code
Align with Median of Reported Provider Costs*	$2,815,153	$701,712	48%
Align with Median of Other States' Medicaid Rates	$45,260,992	$11,281,864	83%
Align with Medicare Rates	$2,510,385	$625,745	148%
5% Rate Increase	$4,844,903	$1,207,652	5%
10% Rate Increase	$9,689,807	$2,415,305	10%
15% Rate Increase	$14,534,710	$3,622,957	15%

* One code only.

Conclusion

This report has been provided to the Director of the Department of Health and Human Services for review and possible inclusion of the recommended rate adjustments in the State Plan for Medicaid. Reimbursement rate changes require a State Plan Amendment and approval from the Centers for Medicare and Medicaid Services. Although rate changes can be implemented during the current biennium or through the next Legislative Session, it is important to note that managed care organization capitation rates may need to be recalculated and recertified for any rate changes that do not align with the normal capitation rate setting cycle. If the Director recommends a rate change be included in the State Plan, DHCFP would update the fiscal impact analysis to reflect revised caseload projections, updated FMAP percentages, and alignment with the chosen start date.