ADOPTED TEMPORARY REGULATION OF THE

DIVISION OF HEALTH CARE FINANCING AND POLICY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

LCB FILE NO. T003-23A

The following document is an emergency regulation submitted

by the agency on 03/01/2023

Joe Lombardo
Governor

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

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Agency:

Division of Health Care Financing and Policy

Classification [ ] Proposed [ ] Adopted by Agency [ ] Temporary [X] Emergency [ ] Permanent [ ]

The Division of Health Care Financing and Policy adopted the proposed temporary regulation amendment(s) to NAC 422 at a public hearing held on January 20, 2023.

Authority citation other than 233B:
NRS 422.390

Notice Date: December 13, 2022

Hearing Date: January 20, 2023

Date of Adoption by Agency: January 20, 2023

NAC 422.105 Intergovernmental transfers of money from certain counties to Division; discharge of duty to provide medical treatment for indigent inpatients in certain circumstances; money remitted to State Controller to be credited toward transfer to Division. (NRS 422.390)

1. In a county whose population is 100,000 or more within which a public hospital is located, the State or political subdivision responsible for the public hospital shall transfer to the Division an amount equal to:

(a) Seventy percent of the total amount of disproportionate share payments distributed to all hospitals pursuant to this chapter and NRS 422.380 to 422.390, inclusive, for the current fiscal year, less $1,050,000; or

(b) Sixty-eight and fifty-four one hundredths percent of the total amount of disproportionate share payments distributed to all hospitals pursuant to this chapter and NRS 422.380 to 422.390, inclusive, for the current fiscal year,

➥ whichever is less;~~.~~ Or,

(c) If the Division deems necessary, reduce the total computable disproportionate share supplement payments to the equivalent of the total credits applied for the non-federal share pursuant to NRS 428.285 divided by the federal medical assistance percentage for the current year.

2. In a county whose population is 100,000 or more within which a private hospital which receives a disproportionate share payment pursuant to paragraph (c) of subsection 1 of NAC 422.115 is located, the county shall transfer to the Division 1.95 percent of the total amount of disproportionate share payments distributed to all hospitals pursuant to this chapter and NRS 422.380 to 422.390, inclusive, for the current fiscal year, but not more than $1,500,000. Or,

(a) If the Division deems necessary, reduce the total computable disproportionate share supplement payments to the equivalent of the total credits applied for the non-federal share pursuant to NRS 428.285 divided by the federal medical assistance percentage for the current year.

3. If a county transfers to the Division the amount required pursuant to subsection 2, the county is discharged of the duty and is released from liability for providing medical treatment for indigent inpatients who are treated in the hospital in the county that receives a payment pursuant to paragraph (c) of subsection 1 of NAC 422.115.

4. The amount remitted by the board of county commissioners of a county to the State Controller pursuant to subsection 3 of NRS 428.285 will be credited toward any amount which the State or political subdivision of this State, as applicable, is required to transfer to the Division pursuant to subsection 1 or 2 of this section.

(Added to NAC by Div. of Health Care Fin. & Policy by R033-10, eff. 6-30-2010; A by R086-13, 12-22-2014)

2. Except as otherwise provided in subsection 3, for fiscal years 2023 and 2024 the Division will initially distribute for:

(a) Pool A, which consists of all public hospitals in counties whose population is 700,000 or more, total annual disproportionate share payments in the amount of 29.16 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(b) Pool B, which consists of all private hospitals in counties whose population is 700,000 or more, total annual disproportionate share payments in the amount of 9.95 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(c) Pool C, which consists of all private hospitals in counties whose population is 100,000 or more but less than 700,000, total annual disproportionate share payments in the amount of 34.51 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(d) Pool D, which consists of all public hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of 6.83 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year; and

(e) Pool E, which consists of all private hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of 19.55 percent of the total computable disproportionate share supplemental payments for the fiscal year.

~~2.~~ 3A hospital may not receive a disproportionate share payment unless the hospital meets all the requirements:

(a) Established by federal and state statutes and regulations; and

(b) As prescribed in the State Plan for Medicaid.

~~3~~4. A hospital is not entitled to receive a disproportionate share payment that is greater than the amount of its uncompensated care costs.

~~4~~5. The Division will calculate the total computable disproportionate share supplemental payments by

(a) ~~d~~Dividing the amount allocated to this State pursuant to 42 U.S.C. § 1396r-4(f) by the federal medical assistance percentage for the current year determined pursuant to 42 U.S.C. § 1396d(b); *or, if the Division deems necessary,*~~:~~

(b) Reducing the total computable disproportionate share supplemental payments calculated pursuant to subsection 5(a) to an amount whereby the sum of resulting intergovernmental transfers required by NRS 428.285 are equivalent to the total credits applied in NRS 428.285.

(Added to NAC by Div. of Health Care Fin. & Policy by R033-10, eff. 6-30-2010; A by R086-13, 12-22-2014)

422.115 NAC Designation of pools of hospitals and distribution of disproportionate share payments to each pool; requirements; limitations; calculation of total computable payments. (NRS 422.390)

1. Except as otherwise provided in ***subsections 2 and 3*** [~~subsection 2~~], the Division will initially distribute for:

(a) Pool A, which consists of all public hospitals in counties whose population is 700,000 or more, total annual disproportionate share payments in the amount of 87.97 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(b) Pool B, which consists of all private hospitals in counties whose population is 700,000 or more, total annual disproportionate share payments in the amount of 1.69 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(c) Pool C, which consists of all private hospitals in counties whose population is 100,000 or more but less than 700,000, total annual disproportionate share payments in the amount of 5.86 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(d) Pool D, which consists of all public hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of 1.34 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year; and

(e) Pool E, which consists of all private hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of 3.14 percent of the total computable disproportionate share supplemental payments for the fiscal year.

2. Except as otherwise provided in subsection 3, for fiscal years 2023 and 2024 the Division will initially distribute for:

(a) Pool A, which consists of all public hospitals in counties whose population is 700,000 or more, total annual disproportionate share payments in the amount of 32.46 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(b) Pool B, which consists of all private hospitals in counties whose population is 700,000 or more, total annual disproportionate share payments in the amount of 9.49 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(c) Pool C, which consists of all private hospitals in counties whose population is 100,000 or more but less than 700,000, total annual disproportionate share payments in the amount of 32.90 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year;

(d) Pool D, which consists of all public hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of 5.90 percent of the total computable disproportionate share hospital supplemental payments for the fiscal year; and

(e) Pool E, which consists of all private hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of 19.25 percent of the total computable disproportionate share supplemental payments for the fiscal year.

3[~~2~~]. A hospital may not receive a disproportionate share payment unless the hospital meets all the requirements:

(a) Established by federal and state statutes and regulations; and

(b) As prescribed in the State Plan for Medicaid.

4[~~3~~]. A hospital is not entitled to receive a disproportionate share payment that is greater than the amount of its uncompensated care costs.

5[4]. ***Except as otherwise provided in subsection 6, the*** [~~The~~] Division will calculate the total computable disproportionate share supplemental payments by dividing the amount allocated to this State pursuant to 42 U.S.C. § 1396r-4(f) by the federal medical assistance percentage for the current year determined pursuant to 42 U.S.C. § 1396d(b).

6. If the Division determines there is a justification to reduce the total computable disproportionate share supplemental payments calculated pursuant to subsection 5, it may reduce the total computable disproportionate share supplemental payments to an amount that is not less than the amount calculated where the credits pursuant to subsection 4 of NAC 422.105 are equal to the sum of the intergovernmental transfers required pursuant to the calculations in subsections 1 and 2 of NAC 422.105.

(Added to NAC by Div. of Health Care Fin. & Policy by R033-10, eff. 6-30-2010; A by R086-13, 12-22-2014)

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Administrator

INFORMATIONAL STATEMENT

Temporary Changes to Nevada Administrative Code (NAC) Chapter 422.105 and 422.115

The Division of Health Care Financing and Policy (DHCFP) hereby submits this informational statement as required in accordance with Nevada Revised Statutes (NRS) 233B.066.

Federal law requires state Medicaid programs to make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. The federal government provides a specific annual allotment of federal funds for each state for their DSH program, which in turn must be matched by state dollars and paid to qualifying hospitals. Historically, Nevada has funded its state share of the costs of this federally required program through two Intergovernmental Transfer (IGT) agreements with Clark and Washoe Counties as outlined in Nevada Administrative Code (NAC) 422.105. These regulatory changes were requested by Clark County to ensure the viability of this federally required program for the county budget and all affected parties. Because Clark County's uncompensated care limit had been reduced by the state's efforts to expand Medicaid, the historical formula resulted in unintended overpayments to the University Medical Center (UMC). This resulted in Clark County having to return those payments to the state to be paid to other hospitals in Clark County under the DSH pool arrangement in state law. Since 2017, DSH audits have resulted in approximately $30 million in redistribution payments for Clark County and University Medical Center (UMC) that had to be repaid to DHHS for distribution to other hospitals under the DSH pool arrangement. The result of the significant size of these repayments for DSH in addition to Clark County's significant financial contribution to the program has made this historical arrangement financially unviable for Clark County.

DHCFP proposed and approved the adoption of temporary regulatory changes to chapter 422 of NAC, which implements provisions relating to the DSH program. NAC 422.115 Section 2 a-e outlines the updated percentages used to calculate and determine the distribution of DSH funds. NAC 422.105 sections 1c and 2a reduces the total computable disproportionate share supplement payments to the equivalent of the total credits applied for the non-federal share pursuant to NRS 428.285 divided by the federal medical assistance percentage for the current year. These regulatory changes will result in a solution that sustains the state's critical DSH program while minimizing the impact of these redistributions for Clark County and UMC.

DHCFP solicited comment of these proposed changes from the public by holding a public workshop on December 16, 2022 and a public hearing on January 20, 2023. The below information includes details related to the public workshop and public hearing including attendance and public response.

A Public Workshop was held December 16, 2022. There was limited public response about this regulation. Comments received generally called for an explanation of how the new DSH distributions by pool were calculated and to show support of the regulation changes. DHCFP did receive a comment regarding the downside to the changes being proposed and the risk to the program. DHCFP responded that the regulatory changes were made with the intent to hold harmless Pools B through E and reduce the recoupment from Pool A. Copies of the proposed regulations, notices of workshop and notices of intent to act upon the regulation were made available at the website of the Division of Health Care Financing & Policy at:

https://dhcfp.nv.gov/Public/AdminSupport/MeetingArchive/Workshops/2022/Workshops_2022/

A copy of this summary of the public response to the proposed regulation may be obtained from the Division of Health Care Financing & Policy, 1100 E. William St., Suite 101, Carson City, Nevada 89701, 775-684-3639, or email to l.aaron@dhcfp.nv.gov.

A public hearing was held on January 20, 2023 and there were 11 individuals who attended. There was no public comment received, either orally or written. Below are the individuals that attended the public hearing who identified themselves.

- Charles Olander, Ferrari Reeder Public Affairs (FRPA)
- Amy Levin, MC, Anthem
- Chris Bosse, Renown
- Mark Rosenberg
- Frederick Gibison, Mercer
- Michelyn Y. Domingo, Anthem
- Samantha Sato, Carrara Nevada
- Dorothy A. Edwards, Washoe Behavioral Health
- Joy Cleveland, Anthem
- Charles Greenberg
- Michael Willden

The Division reached out to the Nevada Hospital Association (NHA) to determine if any of the DSH Hospitals could be deemed to be impacted as a small business. NHA confirmed that no DSH hospitals met the definition of a small business. The Division additionally reviewed prior NAC changes and personally reached out to the two hospitals historically impacted. Both hospitals additionally confirmed that they do not meet the definition of a small business. As there were no hospitals participating in the DSH program that meet the definition of a small business as defined by NRS 233B, the Division concluded there was no impact to small businesses in Nevada.

A summary of affected business's responses may be obtained by submitting a public records request either electronically at https://dhcfp.nv.gov/About/HIPAA/HIPAArecordreq/ or by mailing the request to:

Custodian of Records
Nevada Division of Health Care Financing and Policy
1100 East William Street
Carson City, NV 89701

DHCFP anticipates no adverse economic effects, either direct or indirect, on regulated businesses as the result of the regulation. There will be no direct or indirect cost to regulated or small businesses.

DHCFP believes that there will be no beneficial effects, either direct or indirect on regulated or small businesses as the result of these regulations.

DHCFP does not anticipate any immediate effects, either adverse or beneficial, on regulated or small businesses because of these regulations. DHCFP does not anticipate any long-term effects, either adverse or beneficial, on regulated or small businesses because of these regulations.

There is no fiscal impact to the Division for the enforcement of this regulatory change.