BDR 38-971
SB 241

EXECUTIVE AGENCY

FISCAL NOTE

AGENCY'S ESTIMATES

Date Prepared: March 21, 2023

Agency Submitting: Department of Health and Human Services, Health Care Financing and Policy

Items of Revenue or Expense, or Both	Fiscal Year 2022-23	Fiscal Year 2023-24	Fiscal Year 2024-25	Effect on Future Biennia
Medical Services (Swing-Bed) (Expense)		$425,533	$1,004,003	$2,008,006
Medical Services (Outpatient) (Expense)		$2,175,675	$5,070,837	$10,141,674
Total	0	$2,601,208	$6,074,840	$12,149,680

Explanation (Use Additional Sheets of Attachments, if required)

The Division has reviewed this BDR and determined it would have a fiscal impact if passed into state law. Under the BDR, the Division would be required to reimburse all critical access hospital (CAHs) in Nevada for outpatient and swing-bed services using a cost-based rate methodology, similar to how Nevada Medicaid reimburses CAHs today for inpatient services when provided to Medicaid recipients. Today, these services are paid by the Division using a prospective payment system (at a fee schedule rate). The Division projects that paying all CAHs enrolled in Medicaid at cost for these services would result in a fiscal impact of $8,676,048 for the FY24-25 biennium ($2,282,597 in State General Funds). The Division assumes the increase in Medicaid reimbursement for swing beds will substantially increase utilization of these services (90% increase) because of the low reimbursement rates paid by Nevada Medicaid for these services and the associated low usage of these services by CAHs today. The Division intends to work with CAHs to establish a methodology for the new cost-based rate methodology that reduces administrative burden on both providers and the state given that these types of payment methodologies can create burden. Separately, it should be noted there is the potential for the increased reimbursement to CAHs for these services may impact the amount received CAHs through the state's Medicaid supplemental payment programs that are available to CAHs, specifically the Upper Payment Limit (UPL) program. The UPL program allows Medicaid to “supplement” current payments to certain providers for specific services that are based on a fee schedule up to an amount that is equal to the amount that these providers would have received for these services from Medicare. The Division lacked sufficient time to conduct a full analysis of those impacts for this fiscal analysis.

Name Stacie Weeks

Title Administrator

GOVERNOR'S OFFICE OF FINANCE COMMENTS

Date Tuesday, March 21, 2023

The agency's response appears reasonable.

Name Amy Stephenson

Title Director

Fiscal Impact Analysis

Division of Health Care Financing and Policy
Cost based reimbursement for Critical Access Hospitals
Analysis Summary

Estimated Fiscal Impact FY22-FY23 Biennium

State Fiscal Year	Total Computable	Federal Funds	General Fund	County Funds
FY22	$0	$0	$0	$0
FY23	$0	$0	$0	$0
Total	$0	$0	$0	$0

Estimated Fiscal Impact FY24-FY25 Biennium

State Fiscal Year	Total Computable	Federal Funds	General Fund	County Funds
FY24	$2,175,675	$1,622,219	$545,305	$8,151
FY25	$5,070,837	$3,756,476	$1,294,801	$19,560
Total	$7,246,512	$5,378,695	$1,840,106	$27,711

Description of Budget Concept

This Budget Concept estimates the cost of reimbursing Critical Access Hospitals (CAHs) at cost for the delivery of Outpatient (OP) services.

Methodology

1) Fee-For-Service (FFS) utilization and managed care encounter were captured by running a report out of the MMIS using the following parameters for PT 75 Critical Access Hospitals(CAHs):
SFY22 (07/01/2021 - 06/30/2022) Incurred with Runoff, Net Allowed Amount

2) Patient by Category counts were captured by running a report out of the MMIS to include FFS patients and Managed Care (MCO) patients.

3) Pulled total amount paid by provider for PT 12 by NPI and Provider ID for SFY 22. Then collected the costs from providing services from the respective cost reports for each provider. Applied Consumer Price Index adjustments (to inflate costs to align with the utilization time period) based upon respective cost report end dates and applied to figures pulled from cost reports. Calculated the difference for paying for these costs and what was paid for SFY 22 to calculate estimated difference for cost based reimbursement.

4) Total computable expenditures are grown forward based on the DHHS Office of Analytics caseload projections.

5) FMAP rates were applied to determine the federal share of estimated costs. Note that the COVID-19 enhanced FMAP (+6.2%) for Medicaid is used through March 31, 2023. Enhanced COVID FMAP amounts are tiered down across CY 2023 to align with the 2023 Federal FY Omnibus Appropriations Bill, which allows the following enhanced FMAP amounts: 6.2% (CY23 Q1); 5.0% (CY23 Q2); 2.5% (CY23 Q3); 1.5% (CY23 Q4).

6) This analysis does not account for potential impacts to Supplemental Payment programs, as that impact is currently unknown.

Fiscal Impact Analysis

Division of Health Care Financing and Policy
Cost based reimbursement for Provider Type 44-Swing-Beds
Analysis Summary

% of projected increase in utilization
90%

Estimated Fiscal Impact FY22-FY23 Biennium

State Fiscal Year	Total Computable	Federal Funds	General Fund	County Funds
FY22	$0	$0	$0	$0
FY23	$0	$0	$0	$0
Total	$0	$0	$0	$0

Estimated Fiscal Impact FY24-FY25 Biennium

State Fiscal Year	Total Computable	Federal Funds	General Fund	County Funds
FY24	$425,533	$282,901	$128,358	$14,274
FY25	$1,004,003	$654,572	$314,133	$35,298
Total	$1,429,536	$937,473	$442,491	$49,572

Description of Budget Concept

Estimate the fiscal impact to reimburse Swing-Bed providers at cost of providing service to Medicaid patients to ensure rural patients have continued access to a skilled nursing facility level of care.

Methodology

1) Fee-For-Service (FFS) utilization and managed care encounter were captured by running a report out of the MMIS using the following parameters for this provider type 44, Swing Bed Hospitals:
SFY22 (07/01/2021 - 06/30/2022) Incurred with Runoff, Net Allowed Amount

2) Patient by Category counts were captured by running a report out of the MMIS to include FFS patients and Managed Care (MCO) patients.

3) Extracted the cost of providing swing bed services to Medicaid recipients from Medicare Cost Report Worksheet D-1, Title XIX - Hospital , as the actuary described they would calculate per day cost to obtain per diems for providers delivering swing-bed services to Medicaid recipients. This amount way multiplied by the number of days for MCO and FFS patients respectively. This resulting figured was increased by 90% to account for an increase in utilization. The Division has heard feedback from rural hospitals indicating that many facilities do not utilize swing-bed services due to low reimbursement rates; DHCFP staff expect and increase in utilization tied to enhanced reimbursement.

4) Total computable expenditures are grown forward based on the DHHS Office of Analytics caseload projections.

5) FMAP rates were applied to determine the federal share of estimated costs. Note that the COVID-19 enhanced FMAP (+6.2%) for Medicaid is used through March 31, 2023. Enhanced COVID FMAP amounts are tiered down across CY 2023 to align with the 2023 Federal FY Omnibus Appropriations Bill, which allows the following enhanced FMAP amounts: 6.2% (CY23 Q1); 5.0% (CY23 Q2); 2.5% (CY23 Q3); 1.5% (CY23 Q4).