Joe Lombardo
Governor

Richard Whitley
Director

Nevada Medicaid Opportunities to Address Health Workforce Shortages

Division of Health Care Financing and Policy

Stacie Weeks, Administrator

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Department of Health and Human Services

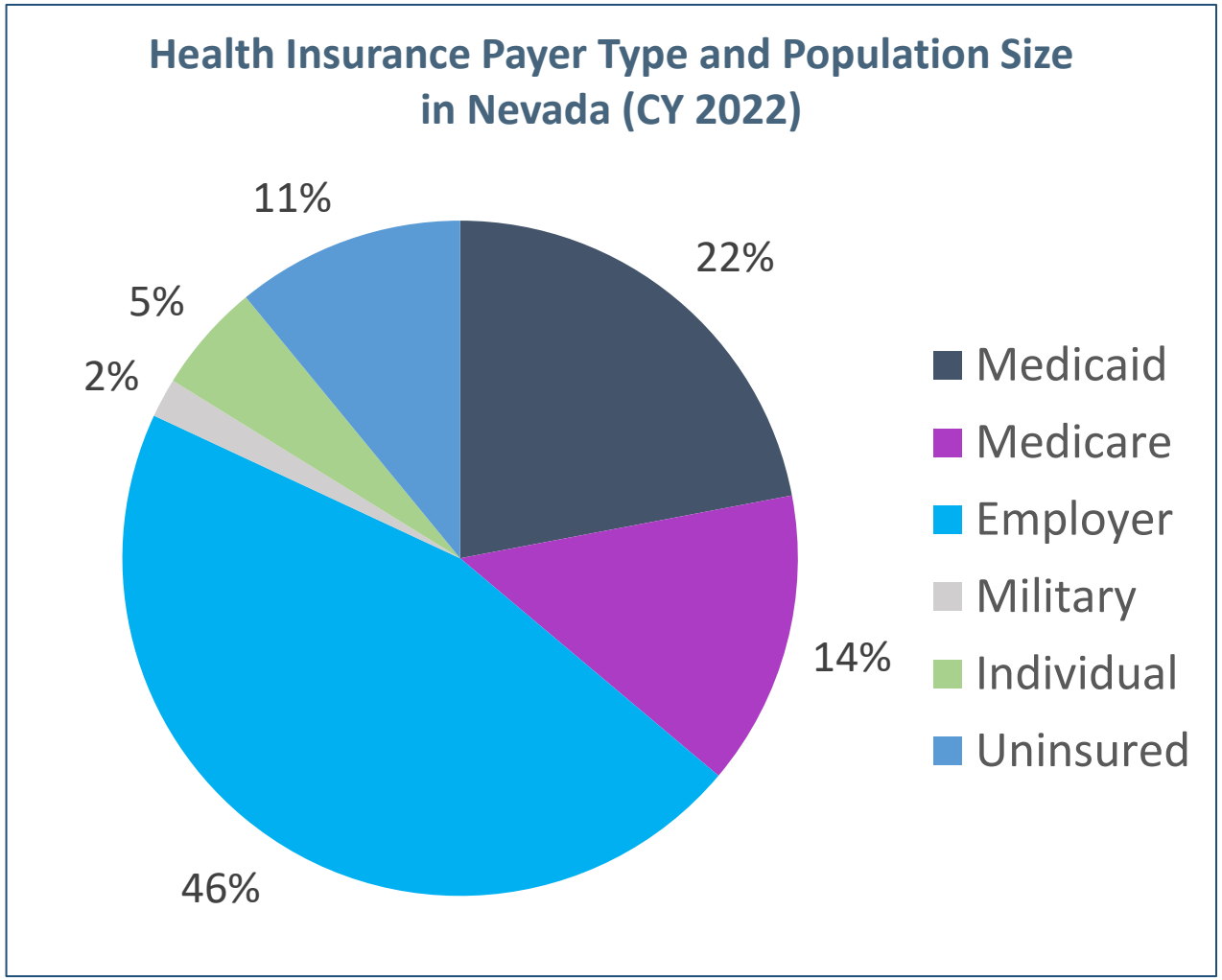
Helping people. It's who we are and what we do.

Agenda

- Nevada Medicaid Overview
- Medicaid Financing
- Provider Reimbursement
- Getting Better Value for Taxpayer Dollars
- Considerations for PPC

Nevada Medicaid

- **Taxpayer-funded** insurance program
- Covers about **1 in 4 Nevadans**; nearly half are children and families.
- Covers **1 in 2 births** in Nevada.
- Payer of last resort and **makes up about a quarter** of Nevada's payer market revenue
- Medicaid is largest source of **federal funds** for health care in the State
- Medicaid creates policy and quality standards for services; payment models can **drive performance**



Source: Data compiled from KFF Health Insurance Status by Payer, 2022.

Medicare vs. Medicaid

Medicare

- Managed by federal government only; Centers for Medicare & Medicaid (CMS)
- Funded by federal government and consumer premiums
- Covers 65 and older; younger who have certain disabilities
- Does not typically pay for long-term care

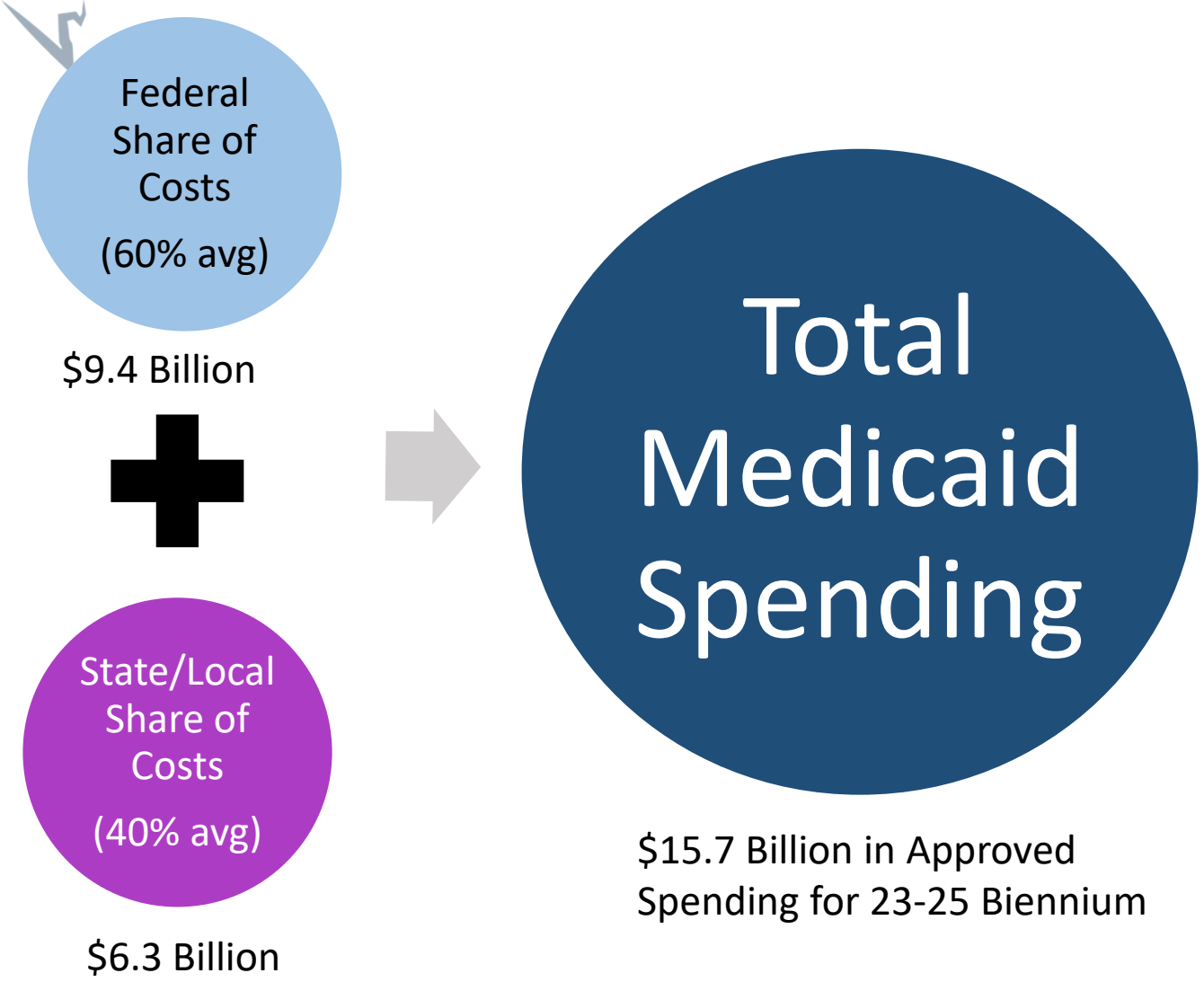
Medicaid

- Managed jointly by state and CMS
- Funded by state and federal government; at no cost to consumer
- Covers low income regardless of age; people with disabilities
- Does pay for long-term care services and more
- Payer of last resort

Dual Eligible –eligible for both programs; people with disabilities who cannot work and people 65+

Financing Medicaid in Nevada

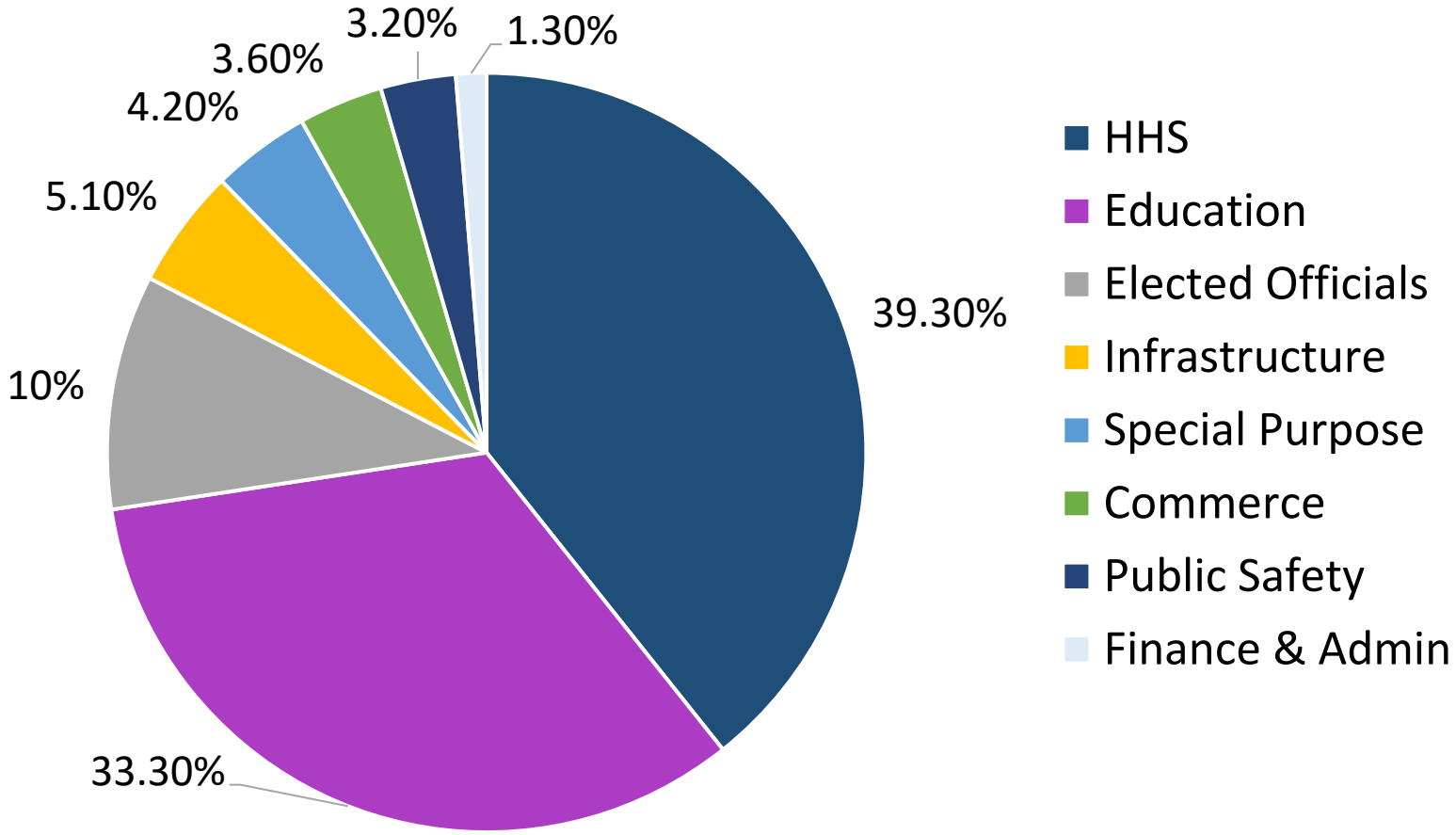
Financing & Nevada Medicaid



- About **3 percent** of Nevada Medicaid annual expenditures are spent on **state administrative expenses** to operate the program.
- The rest of the expenditures **(97 percent)** goes to **provider reimbursement** for rendering covered services to recipients.

23-25 State Expenditures by Function

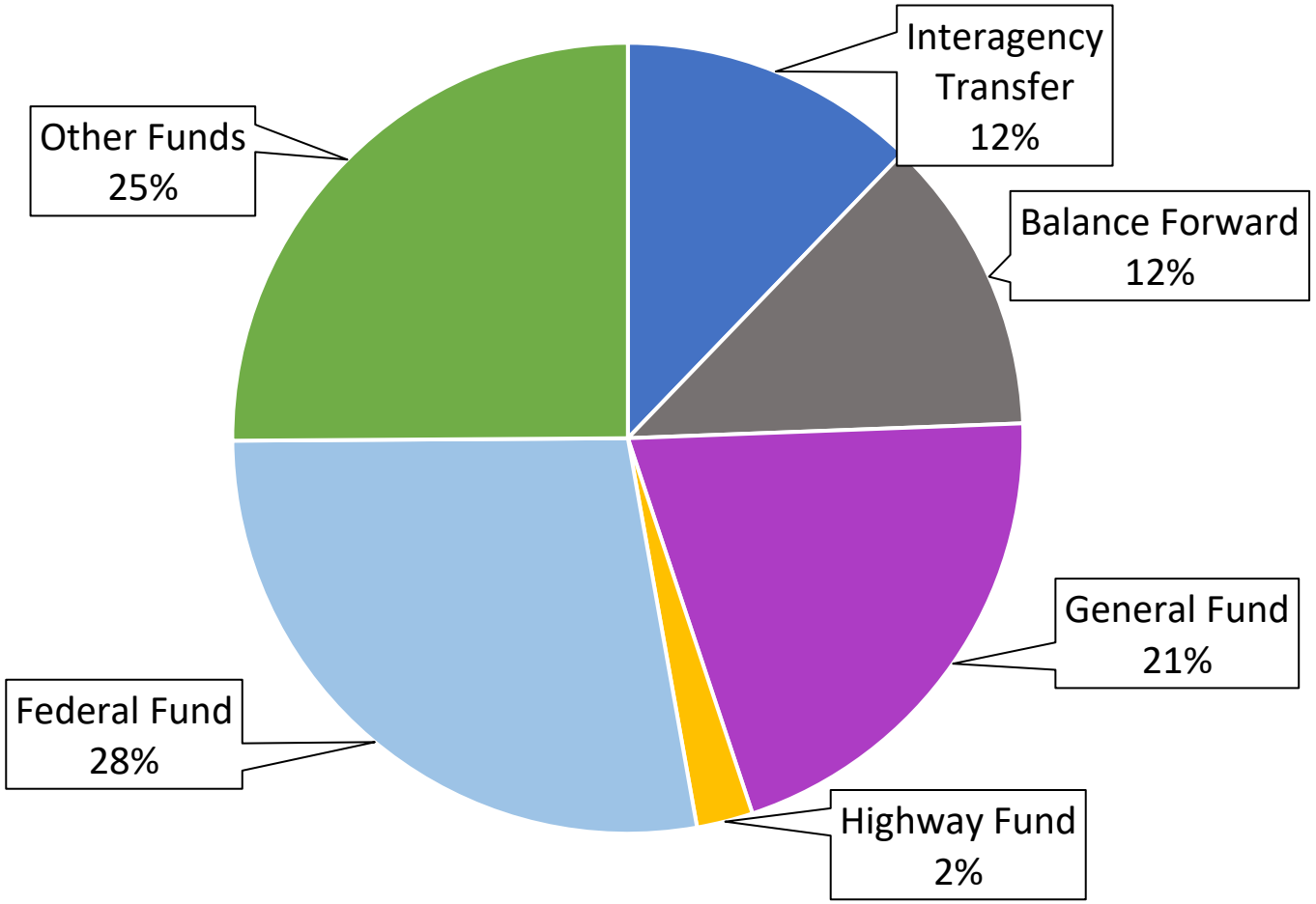
- $53.4 Billion in Approved Spending for 23-25
- $21 Billion in HHS
- 75% of HHS Spending is Medicaid Funds (State/Federal)
- $17.8 Billion in Education



Guinn Policy Center, Nevada's Legislatively Approved Budget, 2023-2025

23-25 Revenue Sources for State Expenditures

- Medicaid primary funding sources – General Fund and Federal Funds
- Sales and Use Taxes make up the largest share (33.2 percent) of the State General Fund revenue forecast for the current biennium, followed by Gaming and Business Taxes



Guinn Policy Center, Nevada's Legislatively Approved Budget, 2023-2025

Budget Planning for 2025 Legislative Session

- To increase spending to our approved base spending levels, Division must **request additional state funding (budget authority)** from Legislature.
- This occurs **every two years** during the biennial Legislative Session; Division is planning for Governor's Budget Proposal for **2025 Session**.
- Information pertaining to the development of budget proposals and the Governor's final budget package is **confidential** until released prior to session.

State Department Planning Proposals

2024

Governor Budget Proposals & Bill Released

Early 2025

Budget Bill Amended/Passed by State Legislature

Feb-June 2025

Final Version Signed by Governor

Mid-2025

Provider Reimbursement Rates

Medicaid Delivery Systems

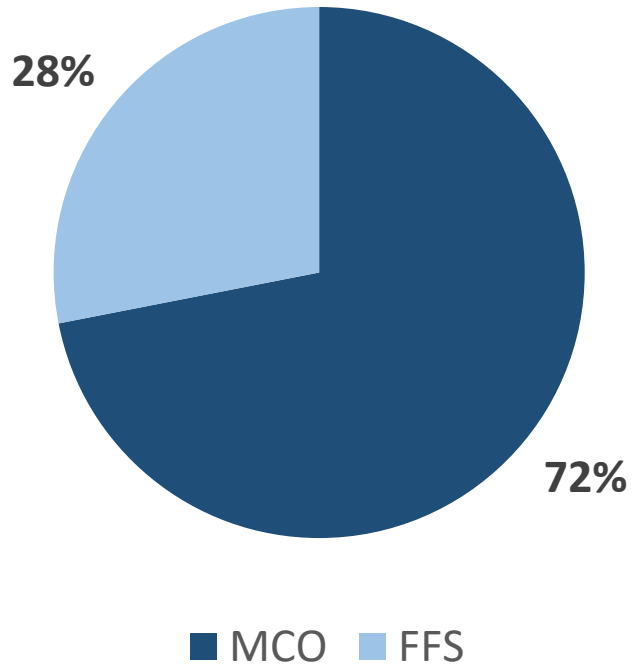
Fee for Service (FFS)

- State sets rates & pays providers directly per service
- Rewards volume only
- Risk to state budget; no utilization management
- Rural & waiver recipients; aged, blind, and disabled

Managed Care Organization (MCO) System

- State contracts with managed care organizations (MCOs) to manage cost, utilization, quality of care
- MCOs develop provider networks and pay providers
- MCOs negotiate rates with providers

NV Medicaid Recipient by Delivery System

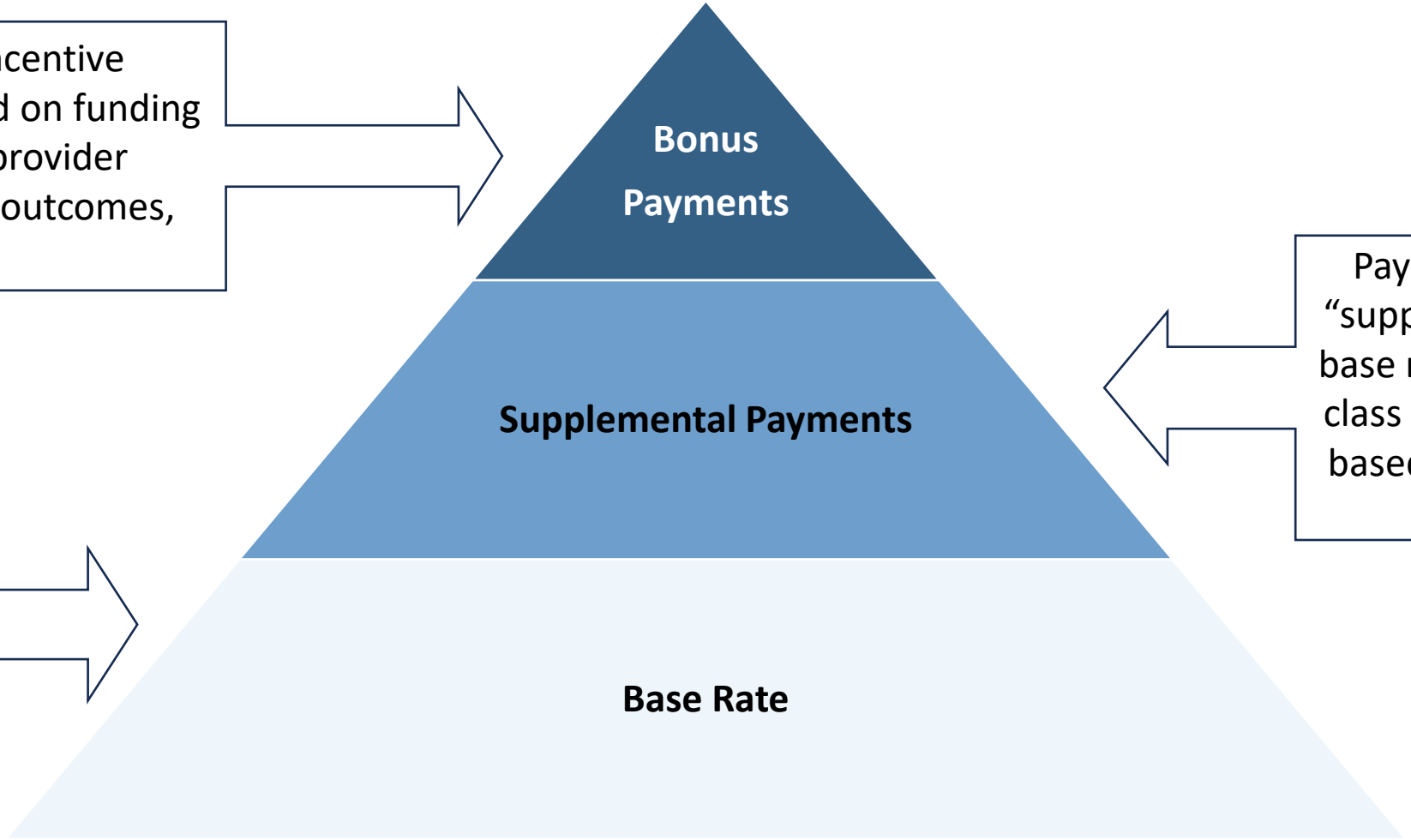


Nevada is **implementing value-based payment design** in managed care to reward providers for lowering costs and improving outcomes.

Charts and tables created by the Department of Health and Human Services, Division of Health Care Financing and Policy

Types of Provider Rate Increases

Bonus or incentive payments based on funding levels and provider performance, outcomes, etc.



Payments that "supplement" the base rate paid to a class of providers; based on funding levels.

Typical fee schedule or rate per service based on funding levels or provider cost reports.

Overview of Quadrennial Rate Review (QRR)

This is a review required by State law that occurs **ever four years** for certain provider types.

The results of this review and report are **"advisory"** and do not result in automatic rate increases.

DHCFP must still **seek approval to request state funding** through the Governor's Budget at the Legislature (which meets every two years) to finance major rate increases.

DHCFP is exploring **increasing rates in second year** of a biennium if there is a sizeable surplus in its budget and it aligns with improving access to areas identified as gaps in complying with the new federal Access Rule.

QRR Results

Results are often mixed depending on the provider type.

- For some services/provider types, our rates are on par or higher than the 5 states we compare to; for other services/provider types, our rates are lower than other states. There is often variation (some higher, some lower) within the same fee schedules. Broad generalizations are difficult to make.
- The same can be said for the costs of providing services. Some providers report costs that far exceed the current rates, while others report that their costs are lower than current rates. Again, there is often variability within the same provider type/fee schedule.
- For certain services/provider types, the Division has not received any data on provider costs.

QRR is informative but limited to the data available to the Division.

Aligning Rates Gaps with Access Gaps

- Ranking of greatest need for reimbursement rate increases when compared to access to care challenges:
  1. PT-22 Dentist*
  2. PT-76 Audiologist
  3. PT-17-215 Substance Abuse Agency Model (SAAM)
  4. PT-24 Advanced Practice Registered Nurse (APRN)*
  5. PT-20 Physician M.D., Osteopath, D.O.*
     - Primary Care
     - Pediatrics
     - Psychiatrists
     - OB/GYN
  6. PT-77 Physician Assistant

Note this list is not all encompassing as there are other provider types that consistently show gaps in access and reimbursement, including but not limited, anesthesiologists, PT/SP/OT, radiologists, urologist, nephrology, clinical psychologists, behavioral outpatient providers, etc.

*Received rate increase last session

The Big Picture

- Average Nevada v. Medicare Rates
  - All Services – 96% of Medicare
  - NV is 7th in the nation for Medicaid reimbursement that are higher as compared to Medicare
  - Highest is in Delaware (at 118% of Medicare)
  - Lowest is Rhode Island (at 37% of Medicare)
- Cost differential (Health care costs are higher in Nevada)
- Commercial rate differential

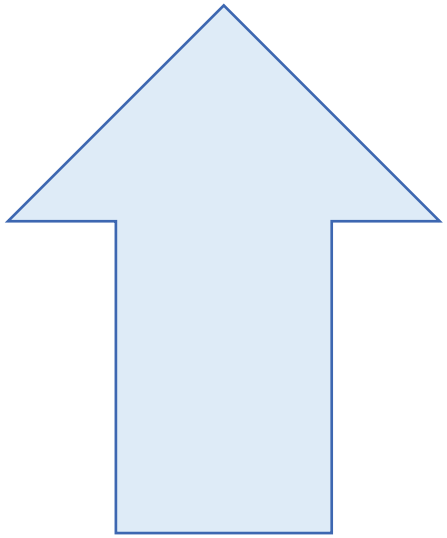
- Last in the Western region and 48th overall, is ranked 39th in health care and reproductive outcomes
- 49th in coverage, access and affordability
- 51st, or last, in health care quality and prevention

KFF, available at: Medicaid-to-Medicare Fee Index | KFF

Increasing Medicaid Provider Reimbursement

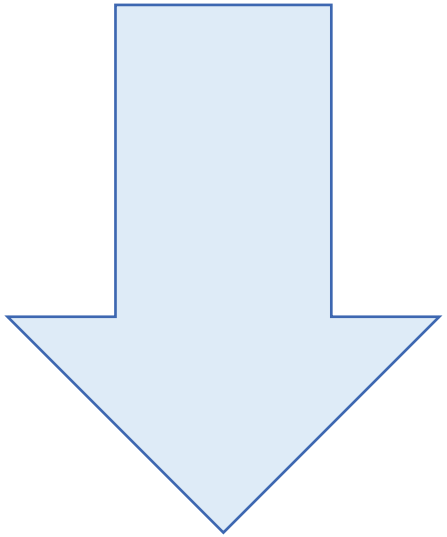
State must increase amount of State General Fund dollars spent on Medicaid medical expenditures to draw down Federal matching funds in order to increase provider rates.

Requires legislative action and Governor's signature (every two years).



State Taxes (Rate or Economic Impacts)

Provider Taxes (New)

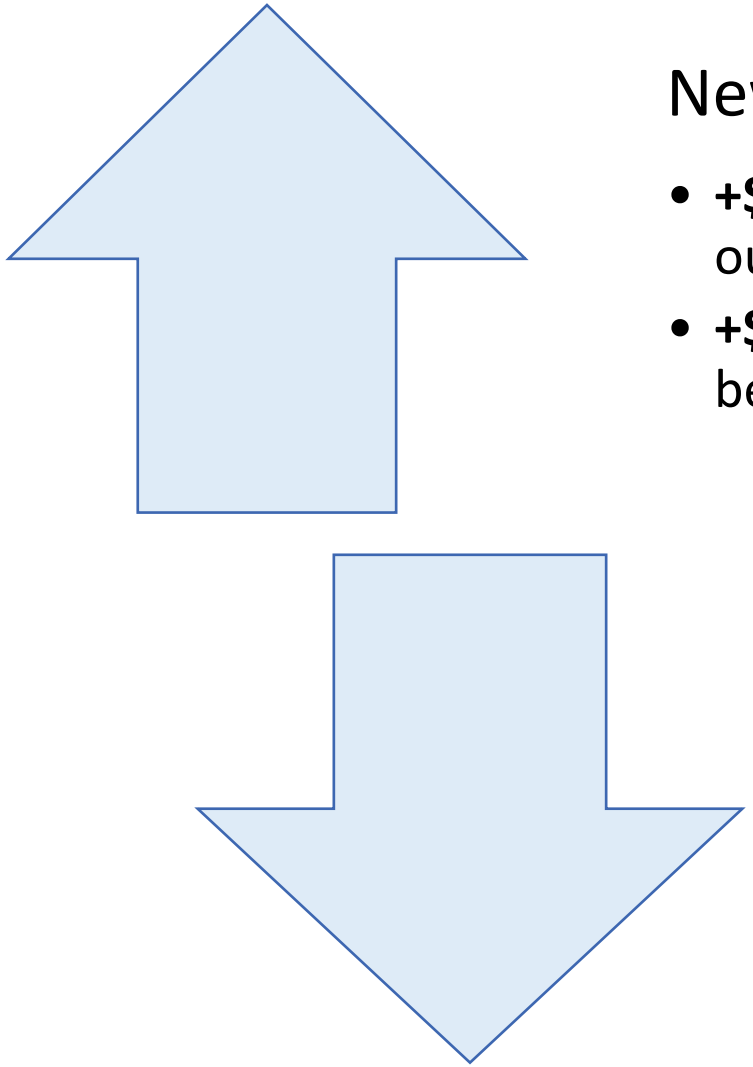


Spending on Other State Functions

Total Cost of Care (Value-Based Payment)

Spending on certain Medicaid Services, Populations, Provider

Recent Examples



New private hospital tax established

- **+$600 million** each fiscal year for inpatient and outpatient services
- **+$45 million** each fiscal year for community behavioral health

Hospital Payment Quality Collaborative (w/State and Managed Care Plans)

New provider rate increases

- **+$200 million** in biennium in new investments for provider reimbursement rates

Private Hospital Provider Tax

- To establish a provider assessment on a medical facility type in the state of Nevada, NRS 422.3794 requires the Division of Health Care Financing and Policy 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.
- With the implementation of the **new provider tax in Jan. 2024**, Nevada Medicaid hospital inpatient and outpatient rates have improved.
  - FFS reimbursement in total now matches average **Medicare rates** which is limit under federal law.
  - MCO reimbursement in total now matches the **average commercial rate** which is the limit under federal law
- Provider taxes lead to **winners and losers**, amongst providers. Not all provider taxes are as successful as hospital tax.
- **Federal requirements** must be met to leverage Medicaid funds.

Investment in Services that Drive Value

Community Health & Clinic Services

- Primary Care Services
- Outpatient Behavioral Health Care
- In-Home Services & Therapies (including Telehealth) that Reduce Institutionalization and/or Hospitalization
- School Health Services
- Community Health Centers
- Community Health Workers
- Peer Supports
- Medication Management Services
- Among Others

Get upstream to identify and treat health issues earlier

Improves access to cost-effective, appropriate care

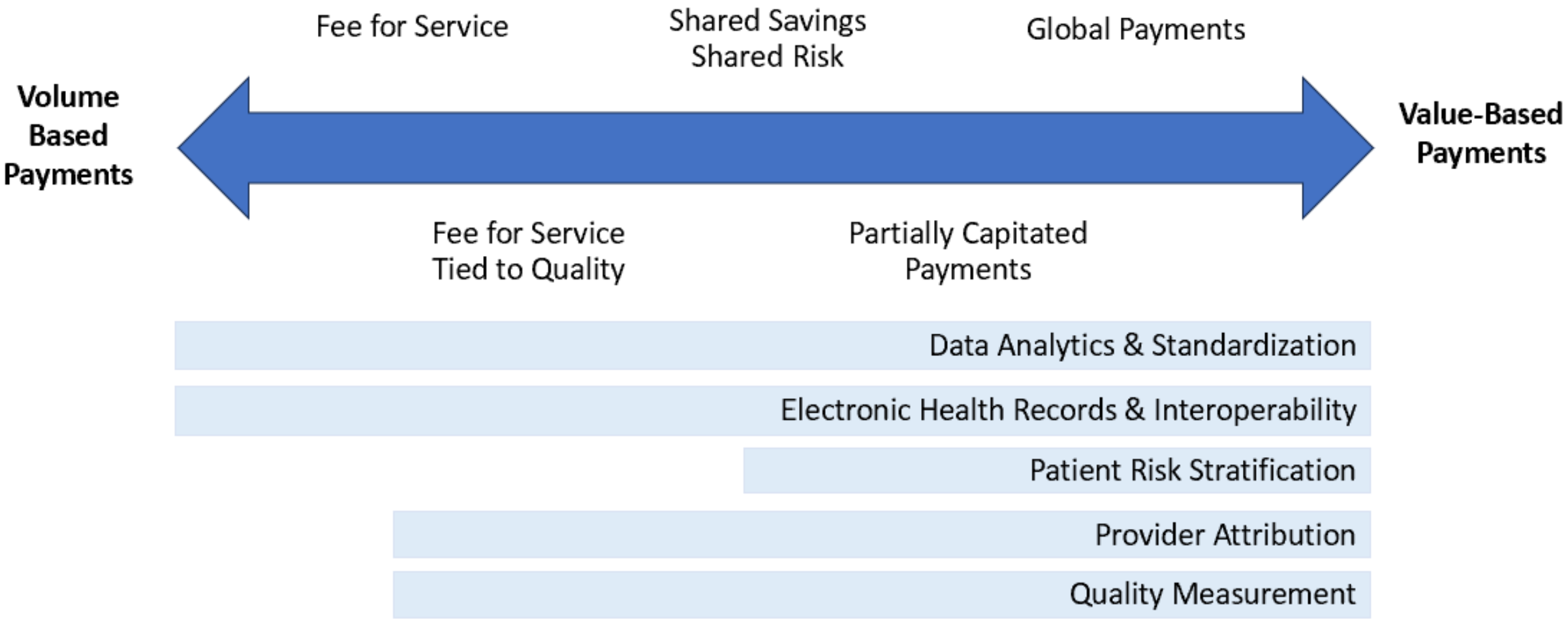
Improves health outcomes for population

Reduces need for unnecessary high-cost ER/hospital visits

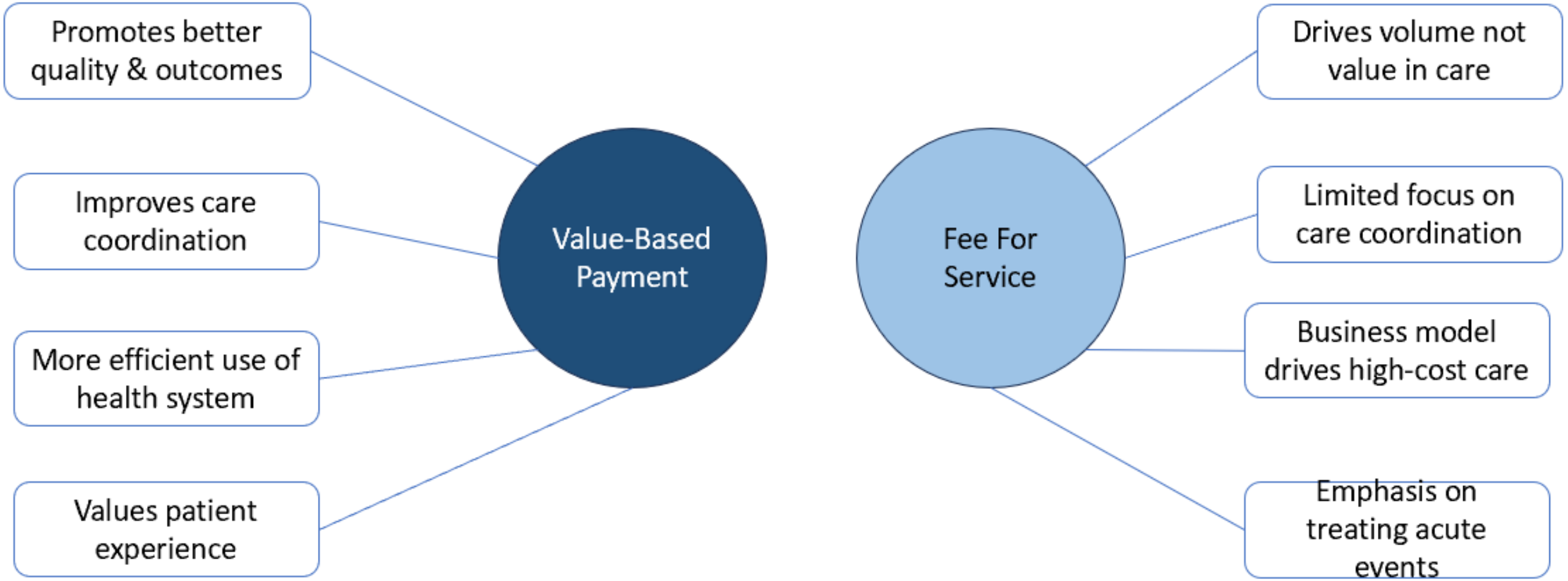
Saves Medicaid spending per member, over time

$1 invested in primary care = $13 savings

Provider Payments that Drive Value



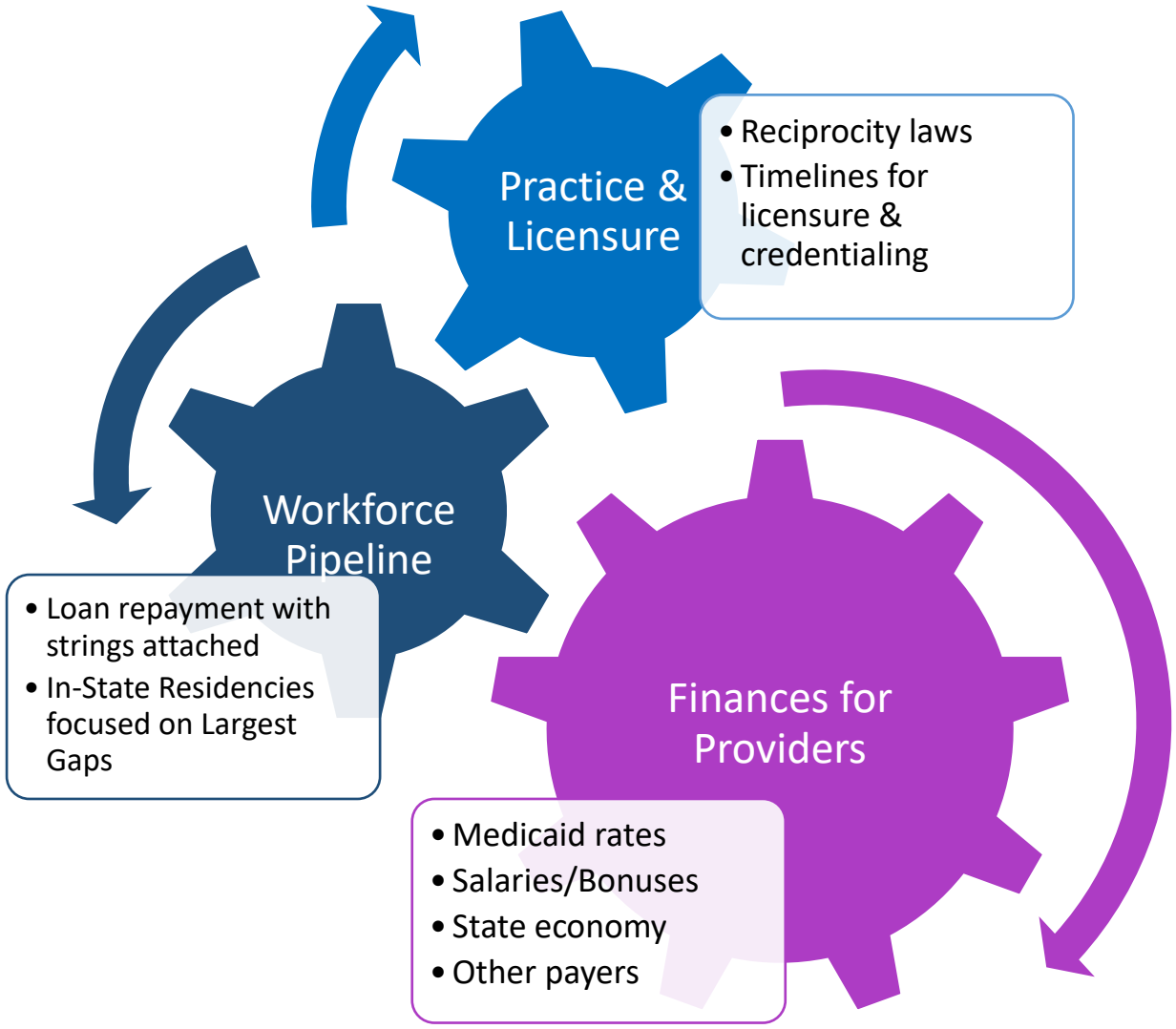
Why Value Based Care?



Considerations for PPC

Influences on State Provider Workforce

- Improving access to care requires a multi-pronged strategy
- Increasing Medicaid rates alone cannot solve the issues facing access to care
- The need to attract providers cannot come at the cost of quality in the system
- GME/IME strategies should be expanded with Medicaid where possible
- Loan repayment for providers willing to live and work in a region for at least several years
- Removal of administrative burdens to billing (Centralized Credentialing & Streamlining Prior Authorizations)



Considerations for Medicaid Rates & Investments

Nothing is free and must be paid for by State tax dollars

Health care spending is growing nationally; taxpayers can't afford to keep up

State general funds are limited, and there are other important costs to the State, like education, transportation, etc.

Limited State funds must be prioritized and get best deal for taxpayer dollar

You pay for what you get, and spending of limited State funds on Medicaid reimbursement should be built to drive:

- Better outcomes and quality for Medicaid recipients
- Result in a more cost-effective use of the health care system

Accountable care and value-based payment models have resulted in better outcomes and more cost-effective care in other states

Questions?

Contact Information

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Administrator, DHCFP

Acronyms

- DHCFP – Nevada Division of Health Care Financing and Policy
- FFS – Fee For Service
- MCO – Managed Care Organization
- QRR – Quadrennial Rate Review

Appendix

Quadrennial Rate Review Overview

- NRS 422.2704 states:
- ***Review of and recommendations concerning rates of reimbursement.*** *On or before January 1, 2018, and every 4 years thereafter, the Division shall:*
- *1. Review the rate of reimbursement for each service or item provided under the State Plan for Medicaid to determine whether the rate of reimbursement accurately reflects the actual cost of providing the service or item; and*
- *2. If the Division determines that the rate of reimbursement for a service or item does not accurately reflect the actual cost of providing the service or item, calculate the rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommend that rate to the Director for possible inclusion in the State Plan for Medicaid.*
- The Quadrennial Rate Review (QRR) is a comparison of Fee-for-Service (FFS) reimbursement rates to provider's reported costs, current Medicare reimbursement rates, and other state's FFS reimbursement rates. The report is a valuable tool used to provide rate increase recommendations to the Director of the Nevada Department of Health and Human Services.

QRR Survey Process

- NRS 422.2704 states that the Division must compare costs for "each service or item" covered by Medicaid. As such, the Division must analyze cost information on a CPT/HCPCS/Revenue code level to ensure compliance with the statute.
- The Division utilizes the fee schedules for each respective provider type to generate surveys.
  - Providers are asked to list the cost of providing each service or item that they provide to Medicaid recipients. Providers do not need to include data for every code on the fee schedule.
  - Providers are given about 60 days to participate; responses are returned via email.
  - The Division maintains a dedicated QRR mailbox for any questions the providers may have during the survey period.

QRR Data Analysis

- Upon the close of the survey period, the Division begins analyzing provider responses.
  - Responses are aggregated for each provider type; the median costs are determined for each CPT/HCPCS/Revenue code.
  - The median cost is compared to the current Nevada Medicaid rate.
  - Additionally, the Division researches what Medicare pays for the service and compares the NV Medicaid rate to the median rate paid by 5 other states' Medicaid programs.
- A fiscal analysis is completed by determining the difference between the NV Medicaid rate and the scenarios listed below. The difference in reimbursement rate is multiplied by the annual utilization of that service to determine the impact.
  - Provider costs
  - Medicare rate
  - Median of other states' rates
  - 5/10/15% rate increase

QRR Report

- After all fiscal analysis has been completed and reviewed, the results of each survey are compiled into an annual report. The annual report is sent to the DHHS Director's Office and published online.
  - The QRR reports includes information on the QRR process and methodology, data on the number of provider responses received, and data related to the fiscal impact of each scenario.
  - In the upcoming QRR report, we are also adding more granular data showing more detail about the provider responses.
    - The upcoming report will show a breakdown per provider type of the number of codes DHCFP received data on, the number of codes on each fee schedule that would need to increase to align with costs, and the number of codes where provider responses indicated NV Medicaid rates may exceed the cost of providing the service.