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Richard Whitley
Director
Health and Human Services

Nevada Medicaid 101 & Rate Reviews

July 19, 2018

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Agenda Item IV (SeniorVetSpecial)
Meeting Date: 07-19-18

Objectives

- Increase knowledge of Medicaid Services
- Increase knowledge of Medicaid Service Delivery Models
- Discuss Services for Aged and Disabled Individuals
- Discuss Reimbursement Processes
- Discuss changes introduced by Assembly Bill (AB) 108
- Discuss challenges and risks encountered in reviewing rates

Who is Eligible for Medicaid

Mandatory Individuals	Optional Individuals
Children	Women with breast or cervical cancer under 200% of the FPL
Pregnant Women	Disabled children who require medical facility care, but can appropriately be cared for at home – Katie Beckett eligibility group
Parent/Caretaker	Health Insurance for Work Advancement (HIWA) is for individuals 16 to 64 who are disabled. It allows them to retain essential Medicaid benefits while working and earning income.
SSI Recipients (Blind or Disabled)	Home and Community Based Waivers
Certain Qualified Medicare Beneficiaries (QMB)	Childless Adults

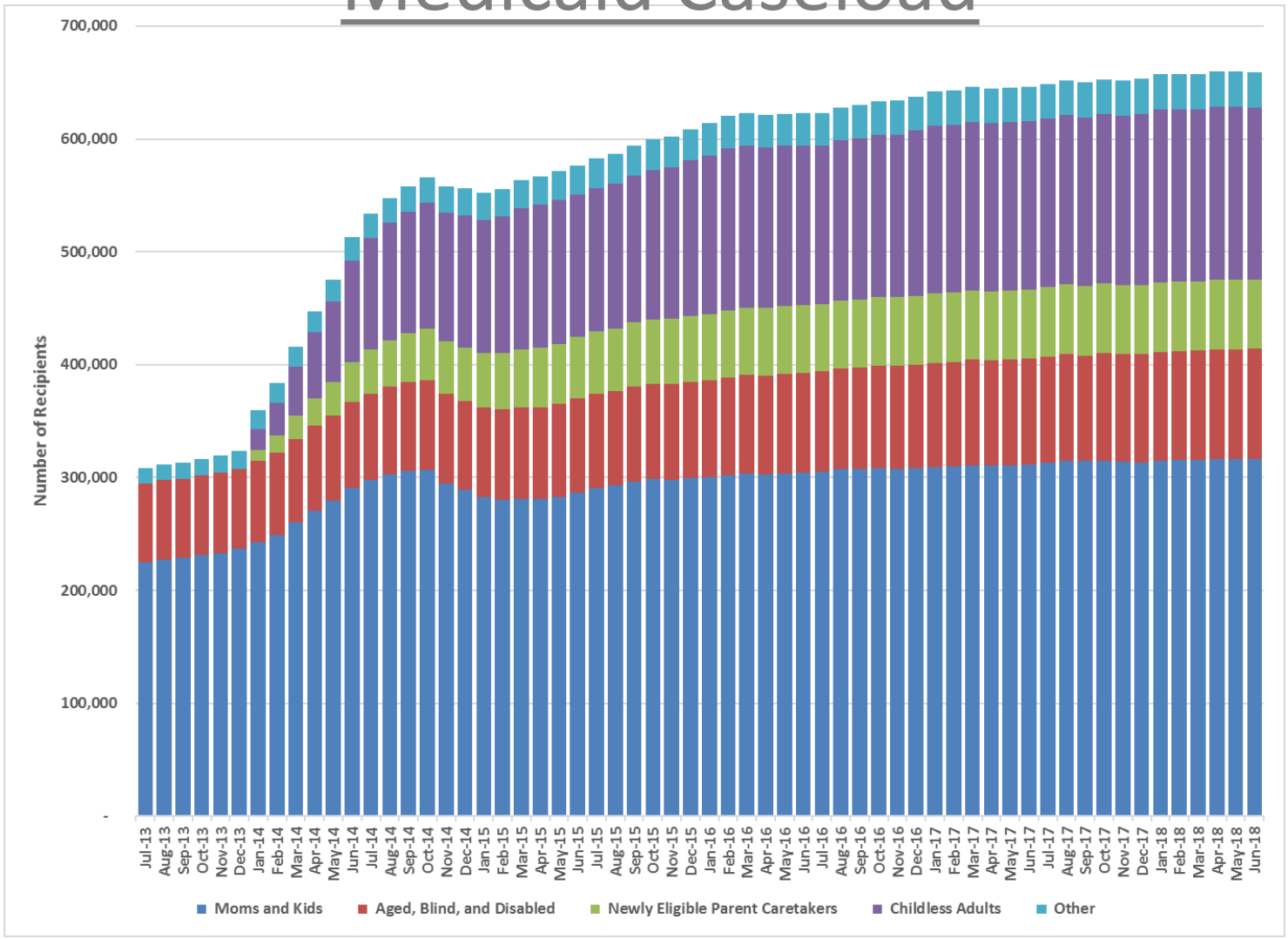
Medicaid Statistics

Total Medicaid Population:	659,298
Expanded Population:	214,489
Aged, Blind & Disabled:	97,376

SFY Medical Expenditures:

$3,752,718,613

Medicaid Caseload



DHCFP Health Programs

The Division of Health Care Financing and Policy administers two major health coverage programs which provide health care to Nevadan's.

Medicaid provides health care to low-income families, as well as aged blind and disabled individuals. Nevada expanded our program to include low-income childless adults January 1, 2014 as part of the Patient Protection and Affordable Care Act (ACA).

Total Medicaid Recipients: **659,298**

Nevada Check Up provides health coverages to low-income, uninsured children who are not eligible for Medicaid. Services are provided as fee-for-service and through managed care organizations.

NV Checkup Recipients: 27,813

General Rules of Medicaid

- Services must be Medically Necessary
- Comparability of Services
- Free Choice of Provider
- Statewide Coverage
- Utilization Control
- Proper & Efficient Administration
- Payment for Services Furnished outside the State of Nevada
- Assurance of Transportation (MTM)
- Early Periodic Screening and Diagnostic Treatment (EPSDT)
  - *States are required to provide **all** medically necessary services to individuals under the age of 21. This includes services that would otherwise be optional services but not part of the Nevada Medicaid State Plan.*

10 Essential Health Benefit Categories

Nevada's Mandatory & Optional Services

Mandatory Services:

- Physician Services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under the age of 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Nursing facility (NF) services for individuals 21 or over
- Transportation

Covered Optional Services *(not all inclusive)*:

- Prescription drugs
- Medical care or remedial care furnished by licensed practitioners (Limited)
- Diagnostic, screening, and preventive services
- Dental services (only EPSDT), dentures
- Therapy (physical, occupational, speech, audiology)
- Prosthetic devices, eyeglasses
- Primary care case management
- ICF/MR services
- Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for individuals under age 21
- Nursing Facility services for individuals under 21
- Home health care services
- Personal care, Private Duty Nursing & Hospice Services
- Targeted case management (limited)

Service Delivery Models

Medicaid procures services in the private health care market through purchasing services on a fee-for-service (FFS) basis or through paying premiums to one or more contracted managed care organizations (MCO).

Title XIX (Medicaid) MCO in Nevada

- *In urban Clark and Washoe counties except for the Medicaid Assistance for Aged, Blind and Disabled or Institutional Categories*
- *Disenrollment may occur for individuals that are severely emotionally disturbed (SED), in Child Protective Services (CPS) or severely mentally ill (SMI).*
- *Tribal Members may also opt out*

MCOs:

- *Anthem*
- *Health Plan of Nevada (HPN)*
- *Silver Summit*

What is Fee-For-Service (FFS)?

- Individuals can receive medically necessary services from any provider enrolled with Nevada Medicaid
- Referrals from a primary care physician are **not** required to see a specialist
- Individuals must coordinate and manage their own care unless they are enrolled in a waiver program.
- DXC (formerly HPE) is the State's fiscal agent. They are responsible for administering the FFS Medicaid program on the State's behalf.

What is Managed Care?

A health care organization that:

- Helps people navigate the health care system
  - Provide care coordination
  - Provide patient education
  - Provide preventative care
  - Connect individuals with primary care and specialty providers
  - Ensure the right service is provided at the right time in the right setting
- Maintains a network of health care providers for their membership

Managed Care Services

- Managed Care covers most of the services that are in the CMS approved Medicaid State Plan, such as:
  - Physician/Hospital Services
  - Pharmacy
  - Behavioral Health Services
  - Personal Care Services
  - Home Health
  - Therapy Services

- MCOs have the flexibility to offer additional services based on need and the plan selected

Services Not Covered by Managed Care

- Hospice
- Adult Day Health Care
- Non-Emergency Transportation
- Targeted Case Management (TCM)
- Home and Community-Based Waiver Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Orthodontia
- Nursing Facility stays more than 45 days
- Residential Treatment Center stays more than 30 days

Rate Review Processes

- **Formula Based Rates**
  Rates are set using the relevant Medicare Fee Schedules and formulas with data provided by the Centers for Medicare & Medicaid Services (CMS). These formulas incorporate factors like adjustments for malpractice risk and geographic locations.

- **Provider-specific Negotiated Rates**
  Rates are set through negotiations with specific providers, typically to cover a percentage of billed charges or a specific flat rate that covers an acceptable portion of the providers costs.
  - *This is typically done for out of state providers*

Rate Review Processes (Cont'd)

- **Contracted Actuarial Vendor Rates**

  Providers submit cost reports to an actuarial vendor that analyzes the data and recommends rates based on the data reviewed.

  - *This typically applies to facility based providers (i.e. Hospitals)*

- **Medicaid State Plan**

  All current rate methodologies are documented in the Nevada Medicaid State Plan, Attachments 4.19-A and 4.19-B

Assembly Bill 108

- Introduced during the 2017 Legislative Session to address continuing concerns raised by Nevada health care providers regarding Medicaid reimbursement amounts.

- Requires the Division to review all of the Medicaid rates every 4 years.
  - *Medicaid currently has approximately 250,000 codes/rates*
  - *Medicaid currently reviews the rates on a rolling 4 year calendar*

Reimbursement Findings

If the reviews find that the rate of reimbursement for a service or item does not accurately reflect the actual cost of providing the service or item, this bill requires the Division to calculate a rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommend that rate to the Director of Health and Human Services for possible inclusion in the Medicaid State Plan

Challenges

Appropriating the funding to meet the rising costs for Medicaid.

Medicare Upper Payment Limit (UPL) and Federal Funding:

- The Code of Federal Regulations (CFR) 42, part 447 defines procedures concerning payments made by State Medicaid agencies.
- Restricts the amount of money a State Medicaid program may pay for Medicaid fee-for-service costs based on Medicare's reimbursement for similar services.
- If the UPL is exceeded, the State would be out of compliance with Federal Regulations and therefore be ineligible for Federal Funds.
  - *The federal share typically covers 65% of Medicaid fee-for-service costs*
  - *Losing the federal match would significantly impact the ability of the Nevada Medicaid program to reimburse for services*

Rate Examples – Aged, Blind or Disabled (21+)

Outpatient Office Visit – 15 minutes

Nevada :	**$71.58**
Oregon:	$51.25
Idaho:	$69.04
Wyoming:	$65.97
Colorado:	$64.00
New Mexico:	$50.52
Arizona:	$51.58
Utah:	$64.75
Montana:	$76.35
Average Rate:	**$61.68**

Nevada is 16% above the average of these adjoining states and ranks #2 in this comparison

Rate Examples – Aged, Blind or Disabled (21+)

Outpatient Office Visit – 25 minutes

Nevada :	**$105.48**
Oregon:	$75.68
Idaho:	$101.85
Wyoming:	$93.62
Colorado:	$94.44
New Mexico:	$79.45
Arizona:	$75.90
Utah:	$95.39
Montana:	$112.26
Average Rate:	**$91.07**

Nevada is 15.8% above the average of these adjoining states and ranks #2 in this comparison

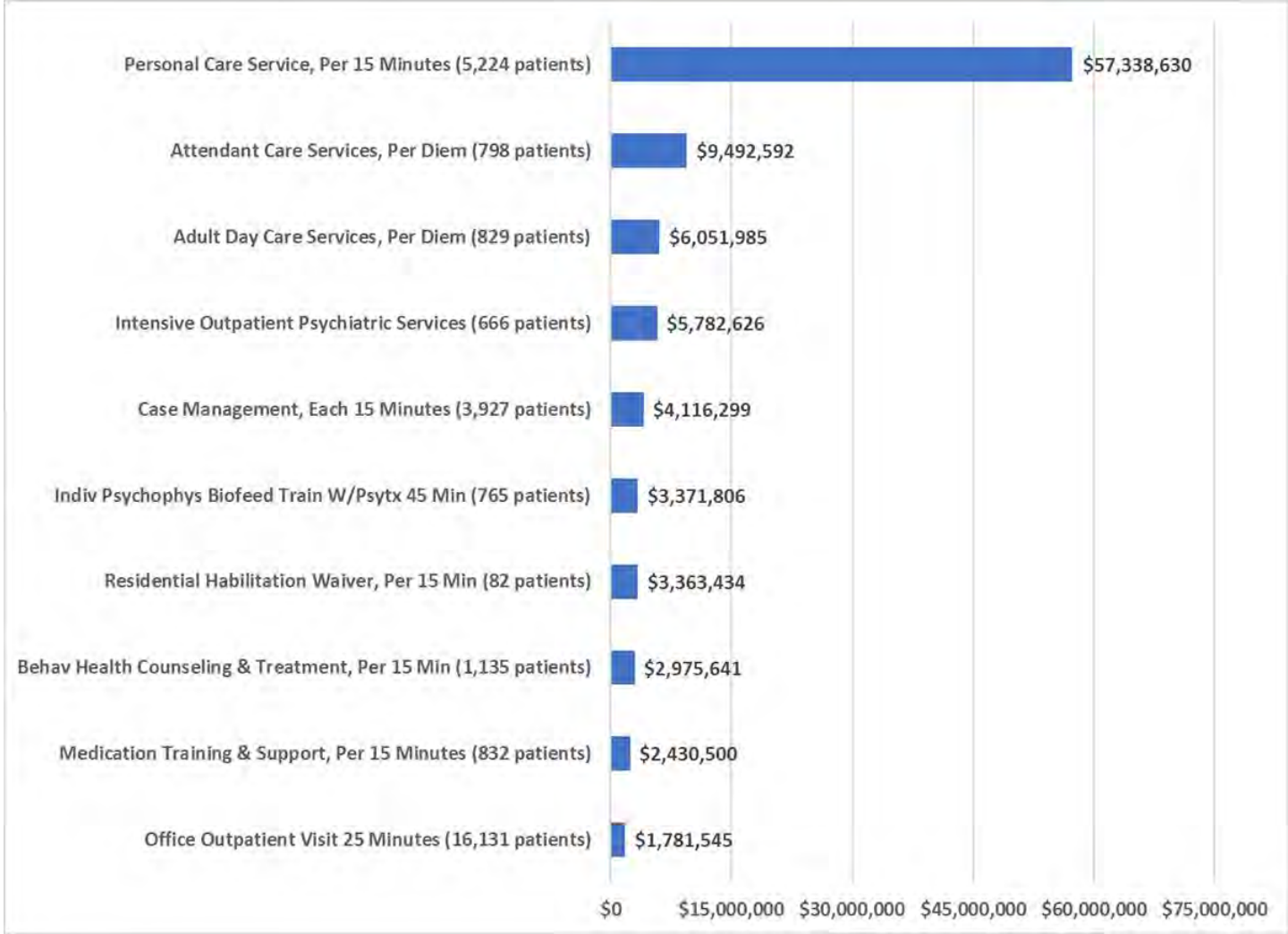
Rate Examples – Aged, Blind or Disabled (21+)

Emergency Room Visit (High Severity)

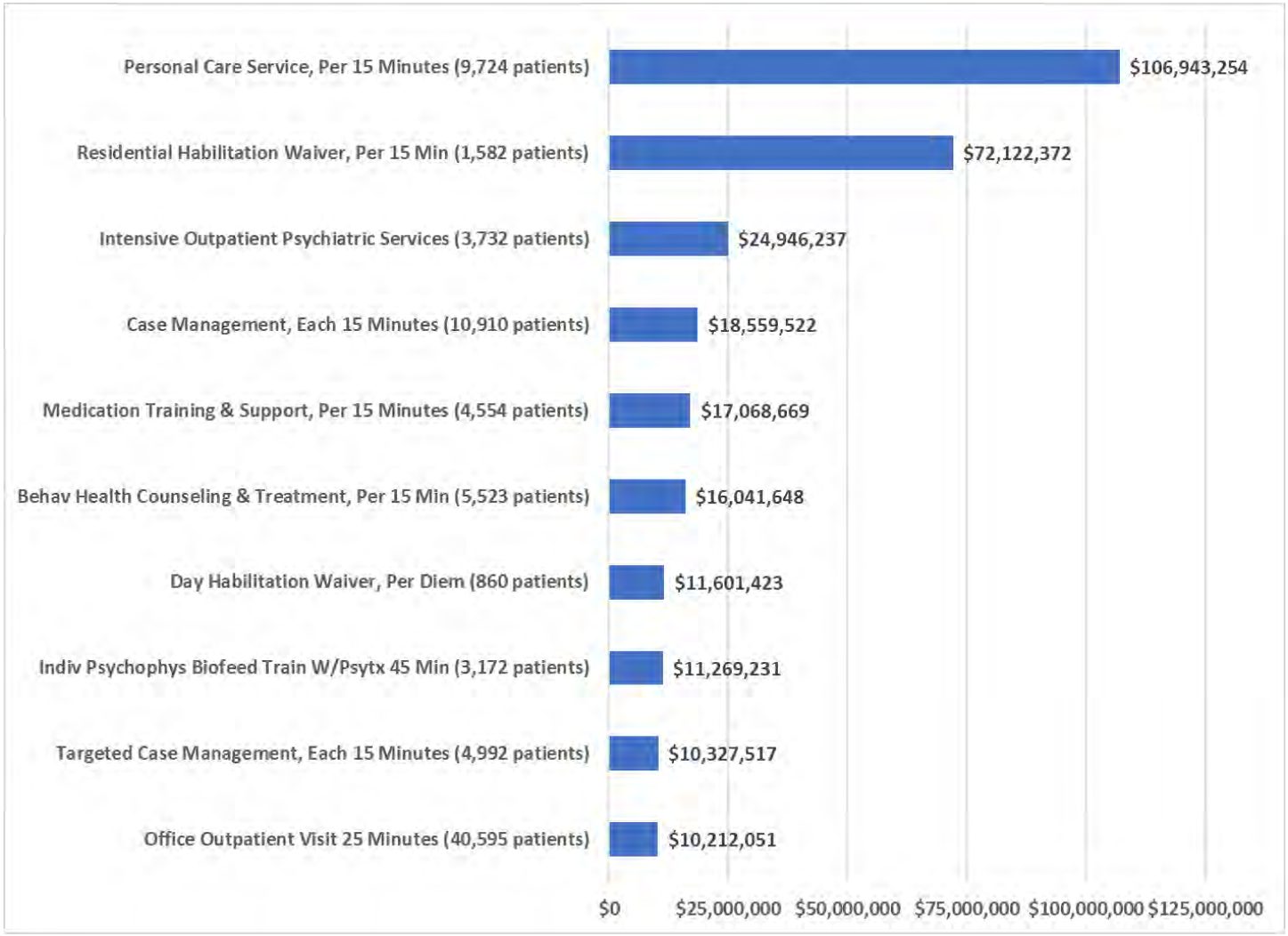
Nevada :	**$167.66**
Oregon:	$121.54
Idaho:	$150.31
Wyoming:	$173.61
Colorado:	$139.99
New Mexico:	$150.71
Arizona:	$136.91
Utah:	$133.17
Montana:	$184.48
Average Rate:	**$148.84**

Nevada is 12.6% above the average of these adjoining states and ranks #3 in this comparison

Top 10 Procedures by Cost – 65 Years & Older



Top 10 Procedures by Cost – ABD 21 Years & Older



Questions and Contacts

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