BDR 32-1004
AB 445

EXECUTIVE AGENCY

FISCAL NOTE

AGENCY'S ESTIMATES

Date Prepared: April 11, 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 (Cost-based rates) (Expense)			$3,150,286	$8,419,136
Vendor support (auditing) (Expense)			$1,585,724	$3,171,448
System Costs (MMIS) (Expense)			$7,840	
Personnel Services (Expense)		$59,177	$81,628	$163,256
In-State Travel (Expense)		$14,536	$18,715	$37,430
Operating (Expense)		$12,983	$18,485	$36,970
Equipment/Furniture (Expense)		$17,178		
Information Services (Expense)		$19,368	$713	$1,426
Total	0	$123,242	$4,863,391	$11,829,666

Explanation (Use Additional Sheets of Attachments, if required)

The Division reviewed this BDR and determined it would have a fiscal impact. Under the bill, some providers who render behavioral health services may qualify for tax abatement. A provider establishing or expanding certain types of services provided to children in Nevada could apply for tax abatement through the Department of Taxation. After one year of operations under the tax abatement, the provider may request a cost-based rate from Medicaid.

To estimate costs, the Division used available data to identify the difference between current reimbursement rates and provider costs. This data was used to estimate the percentage of services that would be rendered by a provider with a cost-based rate. The number of services was multiplied by the identified difference between current rates and cost to estimate expenditures.

A start date of 7/1/24 is used in this analysis as providers would not be able to apply for tax abatement until 7/1/23. The Division anticipates needing one additional staff position to support the scope of the work required by the bill; vendor support would also be needed to audit provider cost reports for accuracy and completeness to set cost-based rates. System costs are also anticipated to map provider-specific rates to the providers who qualify for cost-based rates.

The bill also allows companies to make donations to the Account to Improve Mental Health Services for Children, which would then be used to fund supplemental or enhanced payments to providers who render behavioral health services to children. The Division’s understanding of these payments is that funding would come solely from the Account above, with no additional cost incurred by the State.

Name Stacie Weeks

Title Administrator

GOVERNOR'S OFFICE OF FINANCE COMMENTS

Date Tuesday, April 04, 2023

The agency's response appears reasonable.

Name Amy Stephenson

Title Director

FN 12438

Fiscal Impact Analysis

Division of Health Care Financing and Policy
Cost-Based Rates for Behavioral Health Services for Children
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	$0	$0	$0	$0
FY25	$3,150,286	$2,013,984	$1,135,326	$976
Total	$3,150,286	$2,013,984	$1,135,326	$976

Percent of services rendered by provider with cost-based rate	
PT 14	20%
PT 63	50%
PT 86	30%
PT 13	30%

Description of Budget Concept

This fiscal note estimates the impact of allowing certain providers to qualify for cost-based rates for behavioral health services provided to children. AB 445 would permit providers of these services (either new entities or those expanding operations) to qualify for tax abatement benefits under certain conditions. After 1 year of operations, the provider would be able to request a cost-based rate be paid by Nevada Medicaid.

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/service:
SFY22 (07/01/2021 - 06/30/2022) Incurred with Runoff, Net Allowed Amount, *Provider Types (PTs) 13, 14, 63, and 86; services rendered by providers in Nevada to individuals under the age of 21.*

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) To identify the gap between current reimbursement rates and provider costs, the Division used several sources of data. For PT 14, survey data from the Quadrennial Rate Reviews was used to determine provider costs. As surveys were last issued in 2019, the median of the provider responses for each service was inflated forward using CPI data. The percent change for each code was determined and averaged to estimate the overall percent increase needed in PT 14 rates to meet costs. For PTs 13 and 63, the Division receives cost information from some in-state providers during enrollments and rate appeals. Each provider's cost data was compared to their negotiated rate (CPI was also applied to reported costs to trend to the current year). The average percent change between all providers was used as an estimate as to how much higher PT 13/63 rates would need to be to meet cost. For PT 86, the Division has neither QRR data or cost reports; the average percent increase between PTs 13, 14, and 63 was used to estimate the percent increase needed for PT 86.

4) The Division does not expect all providers in each PT to seek a cost-based rate, as it would entail establishing new facilities or expanding operations to serve additional children or provide additional services. However, the Division frequently hears concerns from providers enrolled under these PTs indicating reimbursement rates prevent additional services from being provided; as such, it is reasonable to assume some existing providers would expand services or new providers would offer services in Nevada. The Division used the percentages listed in the table above to estimate the existing percentage of services that would be impacted/new utilization that would be added as a result of this BDR. The percentages above were applied to current spending under each provider type; that total was then multiplied by the percent increase needed to the rates for each respective PT to estimate the costs of this BDR>

5) Although this bill would become effective 7/1/23, providers would need to have had a tax abatement arrangement in place for one year prior to applying to DHCFP for a cost-based rate. As such, a start date of 7/1/24 is used in this analysis. The Division assumed a 9-month ramp up of costs to allow for time for applications for cost-based rates to be submitted and analyzed. The ramp up period should also capture the time it would take for providers to work with the Department of Taxation prior to being approved for tax abatement as described in the bill.

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

7) 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).