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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.

Suzanne Bierman, JD, MPH
Administrator

April 15, 2020

Nevada Medicaid Request for Public Engagement Regarding Feedback Provided to Date on the CY 2022 Managed Care Request for Proposal Suggestions from the Community to Date

The Division of Health Care Financing and Policy (DHCFP) has held six public workshops (1 in Reno, 2 in Carson, and 3 in Las Vegas) to obtain feedback from stakeholders related to suggested revisions for the next managed care contract. At these workshops, it was asked if the DHCFP would share suggestions received as they were received. Currently, the DHCFP has received letters from Nevada Hospital Association, Nevada Psychiatric Association, Clark County Children's Mental Health Consortium, the Nevada Academy of Pediatric Dentistry, and private citizens. Frequent suggestions are as follows:

1. Medicaid Fee-For-Service (FFS) rates should be the payment floor for Managed Care Organization (MCO) reimbursement.
2. Non-contracted hospitals should be paid the Medicaid FFS rate schedule.
3. Critical Access Hospitals reimbursement should follow Medicare guidelines.
4. Claims processing and payment guidelines shall be established by the DHCFP and not the MCO.
5. Timely filing requirements should be subject to certain exemptions.
6. Industry standards should be required for billing, remittance, payment and claims reviews.
7. Authorization criteria should be standards across the Quality Improvement Organization (QIO)-like vendor and all MCOs.
8. The MCO annual Medical Loss Ratio should be posted on the DHCFP website annually.
9. The CMS approved capitated rates should be posted annually on the DHCFP website.
10. Reports and dashboards should be posted to the DHCFP website and available for public consumption.
11. An intensive in-home benefit should be added as a Medicaid covered service.
12. MCOs should provide all behavioral health services inclusive of residential treatment programs.
13. MCOs that subcontract behavioral health services should have to subcontract to more than one organization to allow for additional provider choice.
14. The Division of Child and Family Services Mobile Crisis Response Team should be contracted to complete assessments for all MCOs as a safety net provider.
15. MCOs should submit access plans to address network sufficiency issues. This access plan should include a description of collaborative efforts with the local behavioral health and social service authorities.
16. MCOs must maintain an up-to-date user-friendly, online, searchable provider directory that includes language spoken, website addresses, office hours, provider types, areas of expertise, practice limitations, age restrictions, disability accessibility, and whether the provider is accepting new members.
17. The MCO develops written member outreach and education materials, which are publicly available for no charge.
18. The MCO convenes quality improvement teams quarterly that are comprised of MCO staff, youth, families, child welfare staff, and other community stakeholders and groups to focus on network adequacy, clinical quality, cultural disparities, and access to appropriate care for children and youth.
19. Keep the dental waiver, Prepaid Ambulatory Health Plan, as a carve out from Managed Care Organizations to ensure dentistry is not diluted and obscured by the medical services provided under the managed care model.
20. Require MCOs to demonstrate compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) by providing an enhanced attestation form they must submit at the time of Request for Proposal (RFP) proposal.

21. Ensure the contract is specific to MHPAEA regulations as outlined in 42 CFR 438.905 and 438.910.
22. Analyze the impact on providers of Targeted Case Management (TCM) services by adding the Residential Treatment Center (RTC) benefit back under managed care. Does this negatively impact their budget?
23. The DHCFP should increase the dispensing fee for 340 B Pharmacies. The 340 B Pharmacies must invoice the state for drug costs, which is much lower than commercial costs. This would allow the DHCFP access to low 340 B drug prices, while providing a financial incentive to 340 B providers, meanwhile the overall costs would still result in cost savings.
24. Allow 340 B pharmacies to call the pharmacy benefit manager to override prior authorizations.
25. Analyze the financial impact to providers if you remove the voluntary Seriously Emotionally Disturbed (SED) disenrollment from the managed care population.
26. Define criteria for case management services provided by the MCOs. Require the MCOs to utilize a standard disease stratification tool across all programs.
27. Allow Medicaid MCOs to reimburse primary care practices using evidence-based approaches to risk stratification to identify and provide case management services to their patients.
28. Increase the accuracy of the member demographic data or create alternate pay for performance standards so that providers are not responsible for members that they cannot locate.
29. Work with Primary Care Providers (PCP) to determine better ways to define network adequacy because a one provider for every 1500 members is not sufficient to address patient access to care.
30. Secret shopper parameters should include the Third Next Available Appointment standard.
31. Primary care is not urgent care and better definitions should be incorporated to better define the models that the DHCFP is looking for and who is available to provide them.
32. The DHCFP should pay primary care practitioners for care coordination efforts that will be necessary to close the referral loop that was discussed within the public workshops.
33. The DHCFP should not require the MCOs to operate walk-in clinics as this model is not a primary care model of care. The DHCFP should support models of care that promote primary care practices.
34. The DHCFP should schedule future workshops in partnership with the Division of Public and Behavioral Health to address strategies for improving behavioral health care and outline plans on how the DHCFP request for proposal can assist with those efforts.

The DHCFP is scheduling follow up calls and public workshops. The DHCFP will begin to work with a vendor to assist in the RFP revision process in April 2020. Please check the DHCFP's public notices page for upcoming public workshops and stakeholder meetings. In the interim, the DHCFP, is still accepting written feedback until 5:00 pm June 30, 2020, via MCORFPfeedback2021@dhcfp.nv.gov . There will be no acknowledgement by the DHCFP of receipt of the comments. Acceptance of comments places no obligations of any kind upon the DHCFP. Furthermore, when submitting comments and feedback to this notice, commenters should clearly identify themselves and their affiliation, the item their comments are referring to, and applicable program policy and/or requirements to which they are responding. The DHCFP may publish the feedback received to the public at large via the DHCFP internet website.

Providing comments in response to this letter will not prohibit interested parties from responding to any future procurements.

Sincerely,

Cody L. Phinney
Cody L. Phinney (Apr 16, 2020)

Cody L. Phinney, MPH
Deputy Administrator

Cc: Health Plan of Nevada, Inc
Silver Summit Healthplan, Inc
Amerigroup Nevada, LLC
Liberty Dental of Nevada, Inc
January and February Public Workshop Attendees

Letter to Public 3-11-20

Final Audit Report 2020-04-16

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