Response to Request for Information for the Nevada Medicaid Managed Care Expansion

Prepared for the Nevada Division of Health Care Financing and Policy

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Cover Letter

State of Nevada
Department of Health and Human Services
Division of Health Care Financing and Policy
StatewideMCO@dhcfp.nv.gov

Re: RFI for Nevada Medicaid Managed Care Expansion

3M Health Information Systems (hereafter referred to as “3M” or “3M HIS”), a wholly owned subsidiary of 3M Company, is pleased to submit this response to the Nevada Division of Health Care Financing and Policy (DHCFP) Request for Information (RFI) regarding the Nevada Medicaid Managed Care Expansion.

Herein, 3M HIS shares our innovative approaches to network adequacy, maternal health, value-based payment design, and coverage of social determinants of health.

Should you have any questions as it relates to our response, please use the contact information below.

Thank you for the opportunity to respond to this Request for Information.

Sincerely,

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Executive Summary

Since 1983,[1] 3M HIS has been driven by a mission to build viable data compilation resources and capabilities, empowering the healthcare industry to understand how to adapt and apply their data most effectively to design and execute strategies and programs that serve as the catalyst for change in the total cost of care, health equity, and member outcomes.

3M Health Information Systems is the world leader at innovating the language of healthcare payment. With an unmatched, 40-year history in payment modernization, care delivery transformation, and population health improvement, 3M methodologies and products are being used by over 30 State Medicaid Agencies to support payment innovation, managed care rate setting, and managed care accountability metrics for performance, beneficiary safety, and quality outcomes measures. Our risk-adjusted patient classification methodologies assist government entities, payers, providers, and collaboratives to set strategic direction, establish quality benchmarks, and drive poor quality and waste out of their systems. In working with Medicaid agencies, 3M HIS has supported the development and improvement of Medicaid value-based programs with both payment innovation and quality oversight projects.

[1] With the 3M methodology, MS-DRGs, 3M transformed the Medicare cost reimbursement model from a percentage of bill charges model to a prospective payment model, where flat fees were paid per admission based on the patient's diagnoses and procedures.

Section 1: Provider Networks

A. *What types of strategies and requirements should the Division consider for its procurement and contracts with managed care plans to address the challenges facing rural and frontier areas of the state with respect to provider availability and access?*

Network access standards play an essential role in ensuring beneficiaries' access to timely and appropriate care.

Operationalizing timely access to ***necessary*** care for primary and specialist care services requires standardized evaluation of both network adequacy and quality that permit evaluation over time. 3M suggests a path to develop a person specific evaluation of ***effective*** network adequacy moving beyond traditional attestations of provider network enrollment indicative of a nominal network. The proposed standardized evaluation of Effective Network Adequacy (ENA) may be further applied to various eligibility categories and sub-populations of intertest (e.g., by plan, geography, dual eligibility status, TANF, HCBS waiver group, race/ethnicity, etc.) and is specifically designed to evaluate access overtime.

We propose consideration of six key steps in establishing, monitoring, and improving Effective Network Adequacy: Data Aggregation and Analysis, Measure Development, Non-Claims Data Source Incorporation, Monitoring, Reporting, and Improvement.

A. Data Aggregation and Trending

We recommend that data aggregation be flexible, permitting alternative analyses by plan, region, cohort, and specialty program assignment. The initial aggregation for assessment is within a full plan footprint. However, aggregation within plan may mask areas of network inadequacy that may consist of micro-regions or beneficiary cohorts. Therefore, measures need to be further developed from bottom up, at the level of the beneficiary.

Flexibility in aggregation requires developing two simultaneous classifications that may be used analyzing the mix of services to beneficiaries and tracking service delivery over time. The first is a person-centric description of the beneficiary that may be used as a clinical classifier to set a standard of patient need. Chronic conditions require greater access to care and services. Acute conditions require timely access to specialist services including facility-based care. Thus, person-based expectations of care requirements dependent upon clinical profile, is an essential building block when determining if a network is providing adequate services on a timely basis to those that need them. Moreover, with extension of managed care enrollment to persons with disabilities and LTSS participants, we believe that a person-based classification is capable of differentiation across the most clinically complex beneficiaries for physical and mental health and, ideally, account for limitations of functional status.

The second element for consideration is classification of the services being delivered. Encounters with primary care providers are fairly straightforward to determine. However, access to specialty services requires greater attention to the nature of services being provided.

Specialist services are often more costly and of lower availability making evaluation of access standards of greater importance.

Taken together, a beneficiary is classified in accordance with their clinical and functional profile (we recommend incorporation of functional assessments routinely gathered from MDS, OASIS, LTSS eligibility determination assessments, for example) with services provided to that beneficiary classified independently. The mix of services (independent of reimbursement for services) is reviewed for adequacy at the beneficiary level. Aggregation of services is taken over beneficiaries within a designated cohort and compared to the expected need for that cohort defined by the person level classification. In this way the "bottom up" picture of beneficiary need is compared to the services being delivered to measure ***effective*** access.

Since measures are operationalized at the person level, aggregation is available at whichever level of detail is of interest. Trending services and person need over time is a simple extension requiring only consistent classification of person clinical/functional profile and service definition. In this way the typical trending issues associated with price, volume and service mix changes over time are reduced to requiring consistent classification of disease and service types over time.

B. Effective Network Adequacy Access Measure Development and Vetting

Following the general outline provided above, matching person classification to service utilization within the measures permits specific beneficiary dependent metrics.
Some services are indicative of network inadequacy or low-quality care:

i) Primary care delivered through the E.D.
ii) Elevated rates of admission for enrollees with acute exacerbations of chronic conditions; and
iii) Return admissions or ED encounters following hospitalization.

We also suggest measures around bounds of routine services that are often subject to physician discretion and practice pattern variation (e.g., Choosing Wisely). For these services we may establish upper and lower bounds of utilization.

These are more general measures associated with network performance and are well established requiring little additional vetting or development.

However, the association of person specific classification with discrete service identification permits the development of more granular service measures. For example, enrollees identified with chronic cardiac conditions should have referrals and visits for cardiac specialist services. This can be coupled with beneficiary chronic illness deterioration rates and access to subsequent specialist procedures within timelines measured by procedure and referral dates. These measures move beyond generic and, while not requiring full development, would require parametrization and vetting to gain acceptance.

The development of detailed access measures integrates with development of internal monitoring and ultimately tracking of success in evolving access of services to beneficiaries within cohorts and regions identified as having access issues.

C. Internal Effective Network Adequacy Access Monitoring Roadmap

The project outline is to create a series of measures that may be aggregated over beneficiary cohorts to provide drill down capabilities within standard dashboards. As discussed in the description of trending, service and beneficiary classifications should be maintained over time permitting variation in the match of beneficiary need to service access to be viewed consistently over time. This is a highly recommended element for a project that is being established to create change in access to care for complex beneficiaries over time.

Goals established within the measure development process will be monitored both internally by the agency and reported back to managed care entities to update their performance compliance.

D. Gather External Data Sources

While not fully described in the measure development overview, an extension of the measure development process we recommend would be to begin introducing patient reported outcome measures (PROM) to quality evaluation. This would form an initial phase of discussion with the longer-term goal of providing beneficiaries voice within the evaluation framework for network adequacy and quality. Standardization of PROM design and collection is a non-trivial level of effort and is therefore considered out of scope for the initial design phase.

Standard claims data, with available functional status assessment data, from DHCFP and CMS (Medicare) claims repositories is the expected primary source of data. This is not expected to be considered an “external” data source and is defined explicitly for completeness. We suggest avoiding layering additional reporting burdens upon managed care plans and providers.

E. Effective Network Adequacy Access Monitoring Standardization

As described in preceding responses an integrated metric dashboard is an expected output of the integrated classification design. These measures can thus serve as highly specific network access adequacy measures to meet the diverse and complex access needs for plan beneficiaries.

F. Effective Network Adequacy Access Reports

De-identified reports at various levels of aggregation should be created as outputs of the network evaluation with dashboard capability for the agency to self-create new reports at timely intervals. These reports can be de-identified versions of reports shared with managed care entities that are created as part of the public performance monitoring and tracking objectives.

B. Beyond utilizing state directed payments for rural health clinics and federally qualified health centers as outlined in state law, are there other requirements that the Division should consider for ensuring that rural providers receive sufficient payment rates from managed care plans for delivering covered services to Medicaid recipients? For example, are there any strategies for ensuring rural providers have a more level playing field when negotiating with managed care plans?

To best level the playing field for rural providers, the State, MCOs, and rural providers need to understand the health status and severity of illness of the served rural population and then ensure that payment policies reflect the level of care needed to meet the needs of the population. For the state, clear information about the rural population's health and disease/need burden empowers the state to justify appropriate payment allocation. The **3M™ Clinical Risk Group** (3M CRG) software is a population classification methodology that describes the health status and burden of illness of individuals in an identified population. 3M CRGs use inpatient and ambulatory diagnosis and procedure codes, pharmaceutical data, and functional health status to assign each patient to a single, severity-adjusted group. The optional 3M Functional Status Groups (FSG) methodology supplements 3M CRGs when individuals have limitations in performing the activities of daily living. 3M CRGs can provide a comparative and detailed population-based understanding of disease severity, which can not only empower a rural provider to design care coordination strategies and best practices to control costs, maintain quality, and improve outcomes, but can enable the state to compare apples to apples, when looking at rural versus urban care. The CRG methodology is updated annually to reflect changes in the standard diagnosis and procedure code sets as well as 3M enhancements to the 3M CRG clinical logic. Differentials in need burden by geography can then advise the state and plan in sub capitation rural provider relationships, differential rural care coordination arrangements or differential percent of base rate negotiations with rural providers. The state can make specific population outcomes the goal of managed care contracts by linking quality and access to successful plan bids. Establishing the outcomes and access required by plans will incentivize plans to negotiate fairly with providers of rural health to achieve those goals and to provide services where they currently do not exist.

C. The Division is considering adding a new requirement that managed care plans develop and invest in a Medicaid Provider Workforce Development Strategy & Plan to improve provider workforce capacity in Nevada for Medicaid recipients. What types of requirements and/or incentives should the Division consider as part of this new Workforce Development Strategy & Plan? How can the Division ensure this Plan will be effective in increasing workforce capacity in Nevada for Medicaid?

The purpose of a workforce development strategy is to ensure adequate provision of healthcare services to meet Medicaid beneficiary, and potentially local community, needs. Requirements should therefore be set in the context of defining those needs which can be specifically derived from beneficiary burden of illness and establishing targets for patient outcomes. The mix of Medicaid beneficiaries and their associated needs are subject to change over time. Similarly, the mix of services required to meet those needs are subject to change.

Take for example the increased role of telemedicine in providing services in lieu of face to face services in rural areas. To measure efficacy of "The Plan," the Division can set targets on what constitutes the anticipated level of service, and the expected impact upon beneficiary outcomes.

It would not be out of keeping for a plan that does not meet the required performance levels for services and outcomes, to contribute to wider innovations aimed at innovating alternative (equivalent) service delivery and/or financial incentives to attract key workers within regions to achieve performance goals.

D. Are there best practices or strategies in developing provider requirements and network adequacy standards in managed care that have been effective in other states with respect to meeting the unique health care needs of rural and frontier communities?

In response (A.) we outline a novel approach for a person-specific but population-administered Effective Network Adequacy measure at the plan level. This same approach allows for geographically subdividing the measure to ensure that rural, frontier (or urban isolated) populations are tracked distinctly. Using this approach along with the 3M methodology to inform providers, MCO(s), and the state on where successes and opportunities are in the system can be effective. 3M methodologies do not require added provider input beyond data that providers are already sharing for claim adjudication. Utilizing the same data, we minimize provider burden, lessening the pressure for all providers, but specifically those that are already struggling for specialized resources in smaller communities.

Because our methodologies are clinical in nature, they ease communication with providers and allow for clinical support for a targeted set of outcomes that are risk-adjusted and show actionable data. In this way, resources can be effectively and efficiently deployed. 3M methodologies are also not prescriptive or restrictive in how they can be improved. Further, our outcome measures highlight where there is a need and show clinically who is in need. As such, frontier and rural providers can tailor methods to their populations/patients needs, which may be different from what methods urban providers deploy. A program that is set up to look at a whole person illness burden and incentivizes outcomes will work in rural, frontier, and urban settings.

E. Nevada Medicaid seeks to identify and remove any unnecessary barriers to care for recipients in the Managed Care Program through the next procurement. Are there certain arrangements between providers and managed care plans that directly or indirectly limit access to covered services and care for Medicaid recipients? If so, please identify and explain. Please also explain any value to these arrangements that should be prioritized by the Division over the State's duty to ensure sufficient access to care for recipients.

3M notes that the broad adoption of quality process measures may pose an indirect barrier to access by devoting plan attention on processes rather than outcomes and promulgating a disease versus person centered view of performance. 3M recommends use of quality measures

that are broadly encompassing of entire eligibility categories and are person based, rather than disease based, which then creates plan incentives to focus improvement efforts across all beneficiaries. Process measures can be helpful in establishing new patterns for providers and may create comfort for providers to participate, but they should at least be used in conjunction with outcome measures that are tied closer to population health and system performance. 3M has a suite of potentially preventable events that are clinically based outcome measures. These events highlight access issues both in terms of site of service availability and when preventative or chronic care management services are not being accessed:

- **3M™ Potentially Preventable Readmissions (PPR) (Utilized by NY, MS, TX, FL, WI, OH):** This methodology identifies clinically related return hospitalizations and return emergency room visits that may result from deficiencies in the process of care and treatment or lack of post discharge follow-up. PPRs can be an indicator of hospital quality and examining high rates of these readmissions can provide insight into where inadequate care coordination is resulting in inefficiencies and poor healthcare outcomes.
- **3M™ Population-focused Preventables (PFPs) (Utilized by NY, TX, FL, CT):** This methodology encompasses a core set of population-based, quality of care outcome measures for identifying quality-related potentially preventable healthcare events including potentially preventable admissions, emergency department visits, and ancillary services. **3M™ Potentially Preventable Inpatient Admissions (PPAs)** are hospital admissions that could potentially have been dealt with in the outpatient setting **3M™ Potentially Preventable Emergency Department Visits (PPV)** are emergency department visits for conditions that could otherwise be treated by a care provider in a non-emergency setting. **3M™ Potentially Preventable Ancillary Services (PPSs)** helps identify high-cost ancillary services while generating actionable insights that can lower costs and decrease the use of low-value healthcare services.

Section II: Behavioral Health Care

A. Are there strategies that the Division should use to expand the use of telehealth modalities to address behavioral health care needs in rural areas of the state?

No response.

B. Are there best practices from other states that could be used to increase the availability of behavioral health services in the home and community setting in rural and remote areas of the State?

No response.

C. Should the Division consider implementing certain incentives or provider payment models within its Managed Care Program to increase the availability and utilization of behavioral health services in rural communities with an emphasis on improving access to these services in the home for children?

The Division should consider using 3M Clinical Risk Groups (CRG) to risk-adjust base rates and pay for care management based on the whole person and their resource needs. In this way, diagnosing and treating behavioral health conditions will be adjusted for and compensated for, incentivizing a view of all the member's needs.

Behavioral health needs can also create different needs for intervention in medical chronic conditions. CRG assignments take these interactions into account. This means more accurate payments as well as better information for those performing care management. If the Division is paying for complete person management while adjusting payment for quality and disease progression, then providers will be incentivized to manage all of their assigned members for whatever is needed including alternatives like telehealth or school-based services for mental health and physical wellbeing.

If a full sub-capitation model placing plans at risk for total expense using a CRG whole person model is out of scope, then a reduced model can be envisaged. Sub-populations routinely in need of behavioral health services can be identified and risk stratified using the granularity of the CRG risk model to assign unique clinically differentiated, mutually exclusive, categories. Each risk category may be assigned to the beneficiary with an associated combination of outcomes targets (e.g., fewer admissions or ED events) and service expectations (e.g., service encounters for mental health at regular intervals). Metrics may be summed from the individual to a plan performance total, adjusted for the targets defined at the risk category level, and used to provide payment adjustment incentives. Note that the information used to create payment adjustment incentives provides detailed performance comparison across plans for enrollees

within the risk cohorts. These data provide insights into plan performance and gaps in care that may require further agency intervention.

Section III: Maternal & Child Health

A. Are there other tools and strategies that the Division should consider using as part of the new Contract Period to further its efforts to improve maternal and child health through the Managed Care Program, including efforts specifically focused on access in rural and frontier areas of the State?

3M offers solutions to empower Medicaid agencies to understand and impact maternal and child adverse and safety events, complications, and excess potentially preventable utilization rates, identify trends, and develop programs to improve outcomes, safety, quality, and efficiency.

3M is at the forefront, working to address maternal health challenges in the United States. According to the Centers for Disease Control and Prevention (CDC), there are more than 50,000 severe maternal morbidity events per year, and the number is continually increasing. Complications during childbirth mean a poor experience for the mother, a possible adverse impact on the infant, and future risk to both. Births with complications are also more expensive than deliveries without complications, even before factoring in any potential mid-or long-term issues. Understanding maternal complications (including SMM) is foundational for maternal quality improvement programs.

3M's approach, **3M™ Severe Maternal Morbidity (3M SMM)**, is an integrated solution that helps an organization identify and trend risk-adjusted maternal outcomes. The CDC examines 21 complications that they consider severe impactable maternal morbidity events. These complications include blood transfusions, embolism, shock, sepsis, renal failure, hysterectomy, and more. Administrators can use 3M methodologies, as described below, to recognize complication criteria, as well as adverse events for consideration. 3M also tracks potentially avoidable, clinically related, post-delivery admissions to the hospital or emergency room within 30 days of delivery. Using this broader brush on maternal adverse events gives a fuller picture of potentially avoidable quality defects among deliveries to identify variation and create policies that make change. 3M SMM empowers analysis of all facility or network care pathways for a wide array of harmful events that could have potentially been avoided. 3M SMM incorporates four 3M methodologies:

- **3M™ Potentially Preventable Admissions (PPA)** and **3M™ Potentially Preventable Emergency Department Visits (PPVs)**. (**Antepartum Care)** Provides insight into lack of access to high quality outpatient care or care coordination. **PPAs** are hospital admissions that could potentially have been dealt with in the outpatient setting. **PPVs** are emergency department visits for conditions that could otherwise be treated by a care provider in a non-emergency setting.
- **3M™ Potentially Preventable Complications (PPC)**. (**Delivery)** This methodology provides insight into all delivery-related preventable complications, including SMM indicators. This methodology identifies conditions not present on admission and determines whether the conditions were potentially preventable given patient

characteristics, reason for admission, clinical procedures, and interrelationships between underlying medical conditions.

- **3M™ Potentially Preventable Readmissions (PPR).** (**Postpartum Care**) This methodology identifies clinically related return hospitalizations and return emergency room visits that may result from deficiencies in the process of care and treatment or lack of post discharge follow-up. PPRs can be an indicator of hospital quality. Examining high rates of these readmissions can provide insight into where inadequate care coordination is resulting in inefficiencies and poor healthcare outcomes.

Understanding trends where policies can impact change are easiest when viewed as rates per 10,000 births. Expected values can be calculated using risk-adjusted cohorts. When comparing the actual occurrences to the expected value, based on the risk of the mothers and severity of the deliveries, variation can point to where action should be taken. Some complications may be unavoidable, but where there is an excessive number of complications, there is opportunity for improvement. For example, a hospital with a rate of 104 PPCs may look better than another hospital with 123 PPCs, but what if the second hospital is providing services to mothers that have higher risk factors and underlying chronic illnesses? The expected value for the first hospital may be only 85 complications and so they are actually struggling, while the second, with a complicated patient panel, has an expected rate of 140 and is therefore doing better than expected. Bringing the expected values, which incorporate risk adjustment into the discussion, provides much more clearly and fairly depicts the true performance of each hospital. Further, adding in post-delivery hospital and emergency room visits to the analysis doubles the number of complications per 10,000 deliveries, allowing for more views of variation and opportunity for action. Variance in poor outcomes and root cause analysis can be leveraged to be aware of those mothers that are likely to experience negative outcomes post discharge and any needed follow-up can be arranged prior to discharge. This is particularly useful if needed services are not available near the mother's home. The same is true of mothers that are more likely to experience issues prior to delivery.

For a holistic view of all antepartum, delivery, and postpartum services, 3M recommends **3M™ Patient-focused Episodes (PFE)**, which creates a maternal episode for risk-adjusted cohorts and allows for benchmarking to compare costs and outcomes. 3M PFEs is a categorical, clinical model that defines episodes of care to reflect a patient's total burden of illness, not merely the presence of a single bundle of care. 3M PFEs simultaneously quantify the patient's acute and post-acute resource needs, considering both the immediate need for care and baseline health status. The methodology was designed for payment, utilization analysis, and clinical insight. PFEs also support provider profiling based on risk-adjusted clinical outcomes and compute actual costs and expected resource utilization.

Further, when these outcomes are combined with 3M Clinical Risk Groups, a mother can be examined for chronic illness and the needs that will remain post-partum. This means the mothers who will be discharged to a frontier or rural environment, or those that may struggle prior to delivery without certain specialties can be planned for in advance. Prescriptions

needed appointments or telehealth arrangements can be made prior to discharge. Infants can also receive a CRG and those can include coded SDOH factors as well. This means that infant health can be tracked in terms of delivery complications and the mother of the child or by the child themselves or both. Similar to a mother's needs, an infant's CRG can help determine needed services and specialties before an infant is sent home to a frontier or rural setting. Arrangements for any specialty care can be made so conditions are monitored and those managing the infant's condition will receive a full risk profile of the infant.

B. Are there certain provider payment models (e.g., pay-for-performance, pregnancy health homes, etc.) that the Division should consider that have shown promise in other states with respect to improving maternal and child health outcomes in Medicaid populations?

3M recommends adopting a payment model that rewards providers for quality care, rather than fee for service. In the maternity and child outcomes setting, like others, improved health care outcomes are achievable with payment when patients are risk-adjusted, and providers are compensated accordingly.

By creating financial incentives to encourage and reward innovation in the delivery of services, as opposed to the Medicaid agency dictating the process of care or mandating adherence to state-imposed clinical processes, Medicaid agencies have experienced collaborative improvement in the quality of care. Potentially preventable events (PPEs) are not going to be reduced to zero. Rather, PPEs are risk-adjusted outcome measures that can be expressed in rates and show where providers are performing better or worse than their peers. Between the clinical reasoning that removes extra visits or admissions and streamlines what needs to be viewed, providers feel fairly compared.

In general, PPE-based payment reforms determine the difference between the actual and the expected volume of potentially preventable events and adjust payments based on the magnitude of the difference in actual and expected volume. The determination of expected volume must be risk adjusted for the case mix of the patients being treated by a provider or health plan. PPAs and PPVs are population measures and are risk adjusted using 3M™ Clinical Risk Groups (CRGs). PPRs and PPCs are hospital performance measures and are risk adjusted using 3M™ All Patient Refined DRGs (APR DRG). CRGs and APR DRGs are categorical systems that are comprised of exhaustive and mutually exclusive risk categories, under which each patient is assigned to only one risk category. This categorical structure allows the actual PPE rate in each risk class for a provider or health plan to be compared to the PPE rate in a reference population such as a national database. CRGs and APR DRGs are not only used to risk adjust PPE rates but can also be used to directly set per case and per capita payments.

Specifically, in a maternity performance program, 3M Potentially Preventable Complications (PPC) and 3M Potentially Preventable Readmissions (PPR) and return visits to the emergency department (PPR ED) can be effective and efficient measures of quality and performance during a pregnancy. A PPC is a complication that occurs during the inpatient delivery stay. A PPR is a clinically related readmission following the delivery. A PPR-ED, though not as acute as a

readmission is a clinically related visit to the ED indicating a complication. An infant program could also use outcome measures to determine gaps in care. While infant check-ins can be tracked, 3M Potentially Preventable Admissions (PPA) and 3M Potentially Preventable ED Visits (PPV) can show where other primary care or specialty care is not being accessed or is ineffective. When combined with a CRG that shows the full illness burden of the child, network inefficiencies can be surfaced.

Below are examples of state programs that have seen success at reducing preventable events and improving healthcare outcomes.

Texas Health and Human Services
Since 2012, Texas Health and Human Services has utilized 3M APR DRG for in-patient payment. Recently, the agency has also committed to implementing 3M Enhanced Ambulatory Patient Groups (EAPG) as the payment methodology for outpatient hospital and ambulatory surgical center care.

The agency has also comprehensively adopted 3M's Quality of Care measure framework to promote quality of care, patient safety, closure of gaps in care, reduction in low value care, and reduction in potentially avoidable costs. Please see the link to the Texas Healthcare Learning Collaborative[2] to see 3M's set of performance quality measures in action. The solutions extend to approximately 5.5 million members in managed care contracts, including adults, people with disabilities, children, state foster care participants, and maternity populations. Texas collaborates closely with 3M not only on measures, but also on public reporting/dashboarding and incentive design. This collaboration between Texas Health and Human Services and 3M has achieved stakeholder transparency and has enabled Texas Medicaid to save more than $50M in quality related savings per year. Programming that enables this cost savings includes their Pay-for-Quality (P4Q) Program[3], health plan capitation withhold programs, hospital quality-based payment programs, and value-based default enrollment steerage utilizing 3M measures.[4]

Florida Agency for Healthcare Administration (AHCA)
Florida AHCA, with approximately 4.9 million enrolled Medicaid members, has been a 3M active client since 2006 for reporting and 2013 for payment. AHCA currently uses 3M APR DRG and 3M EAPG respectively for in-patient and out-patient payment.

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[2] Texas Healthcare Learning Collaborative, *available at* https://thlcportal.com/home, last visited 6/29/2023.
[3] Pay-for-Quality (P4Q) Programs | Texas Health and Human Services, *available at* https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-programs, list visited 6/29/2023.
[4] *See* Value-Based Enrollment Incentive Program Report - 2021 | Texas Health and Human Services, *available at* https://www.hhs.texas.gov/reports/2021/01/value-based-enrollment-incentive-program-report-2021, last visited 6/29/2023; *see also* Texas Department of State Health Services, https://www.dshs.texas.gov/thcic/hospitals/Potentially-Preventable-Complications-Reports/; and *Reports on statewide all-payer PPC incidence* - Texas Health and Human Services Commission www.thlcportal.com - *Interactive webpage on PPC performance by hospital, by service delivery plan, and by managed care plan, with data for multiple years.*

AHCA has licensed 3M potentially preventable events software to analyze claims and encounter data and has produced performance reports on the contracted insurers in the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program, with an eye to understanding how to reduce unnecessary hospital utilization and improve quality. . . Florida Managed care plans were most recently asked to commit to specific PPE improvements in their contracts with the state program.[5] The chart below indicates the average target reductions across all health plans for potentially preventable admissions, readmissions, and emergency department visits over the next five years. The chart also provides the percentage of potentially preventables in each category, calculated in fiscal year 2017/2018.[6]

	Year 1	Year 2	Year 3	Year 4	Year 5
PPA (23% of hospital admissions are potentially preventable in Florida)	8.21%	2.92%	2.97%	3.11%	3.25%
PPR (7% of hospital readmissions are potentially preventable in Florida)	5.70%	3.15%	3.27%	3.22%	3.40%
PPV (62% of ED visits are potentially preventable in Florida)	3.86%	2.77%	2.86%	3.05%	3.30%
Potentially Preventable Event Type	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
PPA - Potentially Preventable Admissions*	8.21%	2.92%	2.97%	3.11%	3.25%
PPR - Potentially Preventable Readmissions**	5.70%	3.15%	3.27%	3.22%	3.40%
PPV - Potentially Preventable Visits***	3.86%	2.77%	2.86%	3.05%	3.30%

* 23% of hospital admissions are potentially preventable in Florida

** 7% of hospital readmissions are potentially preventable in Florida

*** 62% of ED visits are potentially preventable in Florida

Table 1: Target reductions in Florida's determined rates of potentially preventable events.

[5] *See*, Winter 2019 analysis of PPEs for Florida Medicaid enrollees: FL Medicaid Quality quarterly report Winter 2019; and Florida Medicaid: Potentially Preventable Events Dashboard Series, Workbook: PPE Dashboard – External (myflorida.com); *see also* Florida Agency for Health Care Administration. Analysis of Potentially Preventable Healthcare Events of Florida Medicaid Enrollees: July 2015 to June 2016. Tallahassee, FL: AHCA, Winter 2017; and Florida Agency for Healthcare Administration. Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees. Tallahassee, FL: AHCA, Spring 2017.

[6] State of Florida, Agency for Health Care Administration, Comprehensive Quality Strategy 2020 Update (DRAFT) *available at* Comprehensive_Quality_Strategy_Report.pdf (myflorida.com) (ahca.myflorida.com/content/download/8651/file/Comprehensive_Quality_Strategy_Report.pdf) last visited 7/3/2023.

New York Medicaid

As part of New York's Delivery System Reform Incentive Payment (DSRIP) program, provider systems were incentivized to reduce Potentially Preventable Admissions, Readmissions, and ED Visits.[7] In addition to the incentive program, New York relied on 3M to identify providers and specific population segments where potentially preventable event rates were higher than expected, based upon statewide norms.[8]

3M potentially preventable events software was also approved for use by Managed Care Organizations in New York for quality in value-based care arrangements.

Ohio Department of Medicaid

Ohio Medicaid uses 3M PPRs to publish their Hospital and Managed care organization report cards to modernize payments specific PPR performance reporting to improve quality and efficiency of care delivery across the state. The agency examines performance with a view toward the ratio of actual to expected potentially preventable readmissions. Rewards or penalties may be imposed based upon performance over time.[9]

Connecticut Department of Social Services

Connecticut Medicaid moved from an inpatient hospital reimbursement system based on interim per diem rates and cost settlement to a prospective payment system based upon 3M APR DRGs. This well-established program began with the following goals:

1. Administrative simplification by following the same reimbursement policies and procedures as Medicare.
2. Greater accuracy in matching reimbursement amounts to relative cost and complexity.
3. Easier ability to partner with payers to develop innovative payment strategies that reward improved quality, as opposed to increased quantity of care; and
4. Increased transparency in payment methodology.

At the time of implementation, Connecticut had the highest level of Medicaid costs per enrollee.[10] Today, Connecticut's reimbursement cost is moderate compared to other state Medicaid agencies.

Utilizing 3M CRGs and 3M PPEs, the Connecticut Department of Social Services also implemented a PCMH+ Shared Savings program for participating entities in CY2017.

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[7] NYS DOH CMS independent evaluator report-University at Albany, State University of New York, page 22.
[8] New York State, Department of Health, NYS Department of Health Announces Release of DSRIP Waiver Extension for Public Comment, *available at* https://www.health.ny.gov/press/releases/2019/2019-09-17_dsrip.htm, last visited 6/29/2023.
[9] Ohio Administrative Code, Rule 5160-2-14, Potentially preventable readmissions.
[10] Kaiser State Health Facts, 2009 data, cited by State of Connecticut, Department of Social Services, Office of the Commissioner, *Fiscal Analysis DRG Reimbursement Methodology*, June 30, 2015.

The goals of the program include:

1. improve health outcomes,
2. improve the care experience of Medicaid members, and
3. reduce the growth of health care costs.

As part of the program, 3M PPA and PPV measures are used alongside other traditional HEDIS and AHRQ quality measures. In the most recent 2021 WAVE quality results report by Mercer, PPAs were reduced by 0.19% and PPVs by 21.45% (comparing CY 2019 and CY 2020). As a result, CT paid out $2.01 m in the shared savings pool to PEs who achieved their quality goals for this WAVE.[11]

Maryland State Regulatory Authority

The state of Maryland has used its regulatory authority (Health Services Cost Review Commission) to enter into a multiyear, all-payer, population health model to reduce total cost of care. This is a unique model, focused upon hospital-based contracts for population health management of services, that generates a minimum savings for CMS of $330 million in 5 years, with additional savings for all other payers while maintaining quality of care. Within the first two years of the program, hospital-acquired conditions in the state declined by 15.26%, with estimated cost savings of $110.9 million over that period. [12]

In structuring this unique payment model, HSCRC built its model, audited by CMMI and CMS actuaries, around APR DRGs, EAPGs, and PPCs. These methodologies were selected due in large part to their acceptability to the hospital steering committees and the dependable, long term, relationship between 3M and the state, enabling them to rely on 3M being there for the duration of the multiyear deal and beyond.[13]

Mississippi Division of Medicaid

Mississippi Medicaid managed care, with an enrollment of approximately 700,000 lives, currently utilizes 3M quality measures in both their health plan capitation withhold program and hospital quality-based payment program. Agency leadership has indicated a 12.6 % reduction in risk adjusted rates of potentially preventable hospital inpatient readmissions from 2019 to 2022, and a 4.6% reduction in potentially preventable returns to emergency departments. The reductions were the result of collaborative efforts among Mississippi Medicaid, health plans, hospitals, and 3M.

[11] Connecticut Department of Social Services. Connecticut State Innovation Model Operational Plan Award Year 4. Hartford, CT: DSS, 2019 *available at* SIM_Operational_Plan_AY4_Narrative_AY4_20190110_Final-Revised.pdf (ct.gov) (https://portal.ct.gov/-/media/OHS/SIM/Test-Grant-Documents/NGA-2019/SIM_Operational_Plan_AY4_20190110_Final-Revised.pdf?la=en), last visited July 3, 2023.
[12] Calikoglu S, Murray R, Feeney D. Hospital pay-for-performance programs in Maryland produced strong results, including reduced hospital-acquired conditions. Health Aff (Millwood). 2012;31(12):2649-2658
[13] Maryland All-Payer Model | CMS Innovation Center

Section IV: Market & Network Stability

1. Service Area

A. Should Nevada Medicaid continue to treat the State as one service area under the Managed Care Contracts or establish multiple regional- or county-based service areas? Please explain.

There are pros and cons for either approach. The principal benefit(s) of multiple defined service areas is a reduction in noise for providers and beneficiaries (one plan to deal with), and a presumed reduction in administrative complexity. Competition between plans is driven at the time of the bidding and selection phase and, hopefully, results in cost effective bid submissions from winning bidders that, as a result of their winning bid, own the service delivery area and will invest in programs to better beneficiary health through deeper engagement within the service delivery area.

The principal benefit of broadening the service area to statewide is that there is no area let behind (operate within the state and plans must operate within every region) with competition to attract beneficiaries present throughout the lifetime of the contract cycle not just for the duration of the bid phase. The benefit to plans is the reduction of administrative load with more beneficiaries enrolled. Conversely the plan may face high administrative costs through presence in all regions that may not be covered with sparse enrollment in some regions. Knowing which path is optimal is unclear. In either approach some elements are clear and can be introduced within the Managed Care Contracting framework:

i) Reduce administrative unknowns and ambiguity – for example establish expected payment rates for providers as a baseline from FFS. Plans may opt to contract with high volume providers for alternative rates but would otherwise follow a standard structure.
ii) Set service standards and outcome goals for all regions. Plans should not be able to cherry pick beneficiaries by their characteristics or avoid participating within sub-regions within whatever geographic entity is ultimately defined. Setting standards and goals for plans enables actions that may require financial offsets to support those sub-regions and beneficiaries “left behind.”
iii) Facilitate ongoing provider and plan interaction to achieve the service standards and outcomes. Routine reporting is an essential component of this process.

Ultimately the goal of managed care is to leverage the expertise and innovation in plans to improve the health care delivered to all Medicaid beneficiaries within the state. Establishing what that means is more important than the division of responsibility across plans to achieve it.

B. Please describe any other best practices used in other states that the Division should consider when establishing its service area(s) for managed care plans that have balanced the goal of ensuring recipient choice and market competition (price control) with market stability and sufficient provider reimbursement.

No response.

2. Algorithm for Assignment

A. Are there other innovative strategies that the Division could use in its Medicaid programs with respect to the assignment algorithm that promotes market stability while allowing for a "healthy" level of competition amongst plans?

Assignment algorithms provide a powerful incentive through which Medicaid agencies can help direct beneficiaries towards preferred outcomes. There exists both a duty of care to the beneficiary for which a plan selection is being made, and a requirement of fairness to the plan that new enrollees are assigned in a non-arbitrary manner. We therefore recommend that auto assignment algorithms are developed around known outcomes quality targets for plans providing services in a local geographic area.

The definition of local geographic area and targeted quality outcomes is a product of agency design. However, assignment to plans within local geographies based upon relative performance on outcomes metrics:

i) Provides beneficiaries with assignment intended to provide higher quality of care for the enrollee.

ii) Serves as an incentive for plans to improve their quality of care and, if performance is regularly updated throughout a contract period, provides an ongoing incentive to improve health outcomes.

iii) When targets are crafted within regions improvement "raises all boats" - performance in highly concentrated areas does not weight performance in other regions (e.g., rural areas with access issues);

The overhead required to manage an auto assignment algorithm can be minimized when using performance metrics based upon readily available claims data.

Section V: Value-Based Payment Design

A. Beyond the current bonus payment, what other incentives or strategies should the Division consider using in its upcoming procurement and contracts to further promote the expansion of value-based payment design with providers in Nevada Medicaid?

3M HIS supports Medicaid program administrators with policy development and program design, utilizing 3M's risk-adjusted patient classification methodologies outlined in the table below. Each of these methodologies has a unique approach to drive improved value, reimbursement optimization, and population health analytics, thereby improving health equity, costs, utilization, and quality outcomes that enable risk adjusted analytics and clinical classification, including whole person, condition, and service level risk. 3M proposes the following incentive and strategies to promote the expansion of value-based payment design with providers in Nevada Medicaid.

Methodology	Applicability	Notes
3M™ All Patient Refined Diagnosis Related Groups (APR-DRGs)	Inpatient admissions	Includes four severity of illness subclasses and risk of mortality
3M™ Enhanced Ambulatory Patient Groups (EAPGs)	Ambulatory visits	Hospital outpatient, ambulatory surgical center, other clinics
3M™ Clinical Risk Groups (CRG)	Population health and reimbursement	Person health, functional status and population-based reimbursement
3M™ Potentially Preventable Complications (PPC)*	Inpatient hospital care	identify conditions not present on admission a
3M™ Ambulatory Potentially Preventable Complications (AM-PPC)*	Outpatient visit, ambulatory visit	PPC is linked to ambulatory procedure
3M™ Potentially Preventable Readmissions (PPR)*	Inpatient hospital care, population health outcomes	Includes PPRs to the Emergency Department
3M Potentially Preventable Admissions (PPA)*	Population health outcomes	Included as part of 3M™ Population-focused Preventables (PFP)
3M Potentially Preventable Emergency Department Visits (PPVs)*		
3M Potentially Preventable Ancillary Services (PPSs)*		

Table 2: 3M Proprietary Patient Grouping Methodologies

While APR-DRGs and EAPGs can be used to align inpatient and outpatient payments respectively, 3M CRGs will allow a full perspective of the members resource needs based on the whole risk of an individual beneficiary. When setting budgets or examining overall spend and utilization, the full illness burden is important, especially to ensure cost savings are not occurring to the detriment of a member's health. CRGs can also be aggregated to provider, group, or MCO levels, allowing an entire panel to be viewed based on expected resource versus actual resource use. CRG risk scores also include social determinate data if it has been codified, with Z-codes for example. A CRG can also be trended and monitored to analyze and deter disease progression, where such progression can be avoided and proper monitoring and documentation for chronic illnesses.

Once there is a clinically set risk-adjusted expectation for the outcome of an inpatient stay (APR DRG), outpatient stay (EAPG), and overall utilization during the measurement year (CRG), benchmarks can be set and monitored against actual expenditures and utilization. Best practice includes quality monitoring measures. 3M has several quality measures that show outcomes. Different from process measures, 3M's quality measures align to total cost of care and value. They can be used to monitor programs for quality and work well in tandem with any process (HEDIS type) measures that are being used to drive performance metrics.

In our initiatives with Medicaid agencies, we take care to work together to define quality goals that have a direct and quantifiable relationship with cost. We are expert in classification system design and take care to version control logic over multiple years so that data used for risk adjustment and identification of outcomes and health cost is consistent when data inputs (e.g., claim coding information) change. In this way, we can separate performance change (frequency of event) from population change and utilization cost per unit. This clarity is essential when calculating change from a baseline or benchmark over a multi-year initiative.

The table below depicts how Medicaid agencies around the country are utilizing 3M methodologies for payment models and for reporting purposes.

Methodology	Medicaid Programs		Application
	Payment	Reporting	
PPEs			
Potentially Preventable Admissions (PPAs)	4	2	Per Capita Admissions in a Population
Potentially Preventable Emergency Department Visits (PPVs)	4	2	Per Capita ED Visits in a population
Potentially Preventable Readmissions (PPRs)	5	8	Identification of Readmissions following Hospital Discharge
Potentially Preventable Return Emergency Department Visits (PPREDs)	0	1	Identification of ED Visits following Hospital Discharge
Potentially Preventable Complications (PPCs)	3	3	Identification of Complications for inpatients
Risk Adjustment			
All Patient Refined DRGs (APR DRGs)	1	1	Inpatient PPE Risk Adjustment
All Patient Refined DRGs (APR DRGs)	28	3	Per Case Payment
Clinical Risk Groups (CRGs)	0	0	Population PPE Risk Adjustment
Clinical Risk Groups (CRGs)	2	0	Per Capita Payment

Table 3: Medicaid Programs using PPEs, APR DRGs and CRGs for Payment and Reporting

B. Are there certain tools or information that the State could share, develop, or improve upon, to help plans and providers succeed in these arrangements?

3M utilizes reporting to monitor an established program's effectiveness and need for modification over time. 3M consultants are available to provide ad-hoc reporting as needed, as well as design and produce regular reporting for internal and external initiatives. Participant-facing reporting on potentially preventable events will allow for providers and MCOs to monitor their own performance. In addition to participant-level reporting, aggregated reporting would enable Nevada Medicaid to also monitor overall performance. 3M employs risk-adjusted norms to benchmark and create an expected amount of cost, resource use, and quality measures, based upon the severity of illness of the program members. Risk-adjusted norms enable Medicaid agencies to provide clinically credible and actional information to payers and providers.

Annually, 3M reviews existing programs to strategize any policy decisions. While knowledge sharing and questions can be addressed at any time, an annual review ensures that decisions are still effective, and work as designed. When changes are warranted based upon the review, 3M experts can provide recommendations for policy revisions.

C. What considerations should the Division keep in mind for promoting the use of value-based payment design with rural providers?

State and Federal agencies, supporting urban and rural areas, rely on 3M's model of methodology transparency, clinically intuitive design, and robust model stability, which serve as foundations for our four decades of success in changing provider behavior to promote efficiency and better outcomes for patients. 3M has pioneered the concept of inpatient episode payment with MS-DRGs for Medicare patients and APR-DRGs for non-Medicare patients. We have coupled payment reform, which resulted in dramatic improvements in lengths of stay, with a complementary effort in quality and patient safety improvement.

Providing actionable information that is clearly understood by providers to support effective transformation strategies is central to 3M design ethos. Our tools are flexible in design enabling adaptation to unique constructs. One size will not necessarily fit all in a successful program.

Implementation Support: 3M HIS provides a highly qualified team of project managers, clinical and economic experts, requirements analysts, and development personnel to assist our clients in the implementation of our proprietary groupers. At the outset of the project, 3M HIS will assign an implementation manager who will serve as the primary point of contact throughout the implementation of the methodologies. The implementation manager will facilitate meetings and workgroups throughout the various stages of the methodology implementation between Nevada Medicaid, third party vendors (MMIS vendor, program design vendor, etc.), payers, all other necessary stakeholders, and key 3M HIS personnel. Initial implementation activities and planning include:

- Initial discussions regarding platforms, products, and components.
- Develop recommendations for updating the groupers in a timely and accurate manner.

- Developing which grouper versions will be used for implementation.
- The creation of 3M state-specific product component specifications
- Assistance during the MMIS product installation and testing phase of the generic components followed by the state-specific grouper product.
- Coordinate methodology education sessions with payers and providers as needed.
- Ongoing technical assistance once use of the 3M methodology begins.

Communication Plans: Because 3M methodologies are expressed in a detailed, clinically meaningful manner, they provide actionable information that is sufficient for MCOs and providers to achieve sustainable behavior change. The use of 3M CRGs to differentiate patients based on their overall chronic illness burden or the use of 3M's risk-adjusted PPEs, provides the basis of transparent and clinically precise communication. In addition, 3M provides extensive reading material for MCOs or providers to engage in order to understand the depth of clinical accuracy behind each of 3M's methodologies.

Provider and MCO engagement requires building trust to foster both participation and ultimately success in value-based care engagements. 3M's pillars of methodology transparency, clinically intuitive program design, and robust model stability have served as foundations for our four decades of success in changing provider behavior to promote greater efficiency and better outcomes for patients. Regarding the Maryland total cost of care program, an JAMA article stated, "The one thing that is absolutely critical to what we were able to do is the presence of a lot of data . . . . We had a tremendous amount of information that we shared openly . . . and that doesn't exist in many places."[14] We have found that to build the trust necessary to implement a successful value-based program design, the following key components are necessary:

- Clinically intuitive design – to improve patient care, including coordination of care, the program must be risk adjusted and clearly describe the patients' severity of illness. 3M methodologies meet this component, and we provide extensive online resources for those who want to dig deeper into our methodology design.
- Clarity in what is being controlled – programs where costs are managed, subject to performance incentives and/or penalties must clearly show how those receiving payment can impact outcomes. 3M consultants can support the development of these incentives and show the logical behind the program.
- Review and acceptance – value-based program models require stability over time and design transparency for providers and MCOs. When a program is built on a 3M tool, that program has a foundation of transparency, where 3M is an expert in "version control", a key requirement of Federal contracts, and the creation of supporting documentation such as definitions manuals. Further, 3M's longevity in the healthcare payment transformation endeavor makes us a stable, reliable partner.

[14] Austin S. Kilaru, Christina R. Crider, Joshua Chiang, et al, *Health Care Leader's Perspectives on the Maryland All-Payer Model*, JAMA Health Forum, February 4, 2022.

When a Medicaid agency implements a 3M methodology, part of our implementation support includes arranging and coordinating methodology education sessions with providers and managed care plans, as appropriate. These education sessions are invaluable for a Medicaid agency to achieve buy-in from its stakeholders. Once stakeholders understand the underlying methodology and the levels under their control in a well-designed value-based program, behavior change over time can be achieved.

Section VI: Coverage of Social Determinants of Health

A. Besides housing and meal supports, are there other services the Division should consider adding to its Managed Care Program as optional services in managed care that improve health outcomes and are cost effective as required by federal law?

No response.

B. Are there other innovative strategies in other states that the Division should build into its Managed Care Program to address social determinants of health outside of adding optional benefits?

3M recommends using data analytics to leverage social risk with clinical risk to set policies that target resource allocation to achieve the greatest impact. 3M™ Clinical Risk Groups (CRGs) is a patient grouping methodology that describes the chronic illness burden of a patient. The categorical severity adjustment incorporates all types of claims and diagnosis codes into account, including pharmaceutical data, functional/mental health status, and z codes (social determinants of health) when assigning risk groups, which can help you identify individuals with multiple chronic co-morbid conditions and determine their severity of illness.

The 3M CRG approach is a categorical system that is comprised of mutually exclusive risk categories, under which each patient is assigned only one risk category. CRGs classifies patients into risk-adjusted groups by clinical characteristics, severity, and burden of illness. As such, 3M CRGs provide insight into a patient's health status, clinical risk, and expected utilization, without having to know the individual ICD-10 diagnosis codes to target both individual care management and community outreach more systematically. CRG use cases include:

- **Risk adjustment in quality measurement and payment incentives**. 3M CRGs provide accurate, detailed, information regarding each patient's risk burden, such that providers are able to accurately assess the resources needed to care for the population. The methodology creates a common language between providers and payers in risk-sharing relationships. As such, an increasing number of commercial and Medicaid payers measure the performance of managed care organizations, primary care practices and other entities by using 3M methodologies that are risk-adjusted with 3M CRGs. 3M's Potentially Preventable Admissions, Potentially Preventable Emergency Department Visits, and/or Potentially Preventable Services are methodologies that identify quality of care and delivery system failures for which there is reasonable likelihood that the event could have

been prevented. 3M CRG's adjustment for differences in population health status is essential when determining which events could have potentially been prevented. Further, the CRG risk adjustment for 3M PPEs helps providers decide where to put limited care management resources for greatest impact. Comparing observed volumes to a benchmark (3M has nation-wide norms available) allows providers to know where there is opportunity for improvement potentially preventable services in comparison to people with the same/similar illness burden.

- **Tracking disease progression**. 3M CRGs can be used to determine if a patient's chronic disease is effectively managed over time. Such disease management can be an incentive that is incorporated into a value-based arrangement. Disease progression, as evidenced through changes in CRG, can also be a relevant indicator of gaps in care where a condition may not be receiving effective management. The Health Quality Council of Alberta, for example, used 3M CRGs to measure the progression of diabetes in the provincial population.
- **Understanding pediatric health status**. 3M CRGs are a common measure of health status for children with complex health needs, as evidenced by multiple studies published in peer-reviewed journals.
- **Patient alerts at the point of care**. During an office visit, some clinicians in New York state can see a dashboard that shows a patient's current and previous 3M CRG assignment and recent potentially preventable events. This allows a clinician to address needs when the patient is in front of them.
- **Understanding full illness burden.** CRGs take all types of claims and diagnosis codes into account when developing a person's clinical risk groupings. This means a care manager can see all aspects of an individual's needs, including SDoH if it is available.
- **Highlighting patients that need to be seen.** A CRG can show the current and past illness burden of an individual. Because CRGs are based on visit and diagnosis codes, if a patient is not seen for a chronic illness periodically for management of the condition, the CRG will change and show that deficiency in care. Likewise, the CRG output can highlight where there may be an emerging condition, or one being treated by pharmaceuticals but not managed and coded by a primary care doctor or specialist.

C. Nevada requires managed care plans to invest at least 3 percent of their pre-tax profits on certain community organizations and programs aimed at addressing social determinants of health. Are there any changes to this program that could be made to further address these challenges facing Medicaid recipients in support of improving health outcomes?

No response.

Section VII: Other Innovations

Please describe any other innovations or best practices that the Division should consider for ensuring the success of the State's expansion of its Medicaid Managed Care Program.

No response.