October 16, 2023

Nevada Department of Administration
Purchasing Division
515 E Musser St Ste 300
Carson City, NV 89701

To Whom it May Concern,

Anthem Blue Cross Blue Shield (Anthem) shares their excitement with the Nevada Division of Health Care Financing and Policy (the Division) in their efforts to expand the State's Medicaid Managed Care Program statewide and inform the procurement for this program.

Anthem has served as a trusted partner for the health of Nevadans for nearly half a century, including 14 years as a Medicaid managed care entity. As an organization with a rich history of serving Nevadans, Anthem welcomes the opportunity to provide our perspective and recommendations through this collaborative public engagement process. Throughout our response, we have paired our local knowledge with best Medicaid practices gleaned through our parent company, Elevance Health, Inc., and its affiliate health plans who collectively serve nearly 12 million Medicaid members across 27 markets, including the District of Columbia.

We appreciate the opportunity to share our thoughts and look forward to continuing the dialogue about ensuring access to care for Medicaid recipients enrolled in the Medicaid Managed Care Program across all of Nevada.

Sincerely,

Lisa A. Bogard

Lisa Bogard, President & CEO Medicaid Health Plan,
Nevada Medicaid, Anthem Blue Cross and Blue Shield

CC: Stacie Weeks, Administrator, Division of Health Care Financing and Policy

Section 1. Provider Networks

1.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?

Response:

Accessing health care facilities, especially specialty care, can be a challenge for residents of Rural and frontier communities in Nevada. Additionally, limited access to reliable internet and technology in some Rural areas can hinder the adoption of telehealth services, which would otherwise help bridge the gap in health care access. To address these challenges and others, we recommend the Division of Health Care Financing and Policy (DHCFP) consider managed care plans that are experienced and prepared to design Provider Networks that address the health care needs of residents in areas with low population density and limited access.

During the procurement process, we recommend that the Division require managed care plans to submit a comprehensive and strategic approach focusing on health care Provider availability and access, which also addresses the State's changing demographics and health care trends. At a minimum, plans may consider a strategy for developing a broad Network containing all or most of the available Providers in these areas and alternative care delivery models, including paramedicine, mobile health care, and telemedicine.

The State and managed care plans should specify the following details, at a minimum, for the most effective evaluation:

- Specific minimum Provider-to-Member ratios to make sure of an adequate Network in Rural and frontier areas and the actions that will be taken to assess and enforce compliance with Network adequacy requirements regularly. These adequacy requirements should be consistent with the actual Provider capacity of these areas – that is, be attainable, not aspirational.
- Plans, including in-person and virtual care solutions, to address care for the State’s most vulnerable populations, such as beneficiaries with specialized health care needs or behavioral health (BH) or substance use disorder (SUD) diagnoses, children (newborns and infants), and pregnant and postpartum women.
- Description of partnerships with Critical Access Hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Certified Community Behavioral Health Centers (CCBHCs) and their strategy to build trust and strong partnerships with organizations within Rural communities, such as long-term care Providers, faith-based centers, community-based organizations, libraries, and businesses that residents frequently interact with.
- Narrative describing initiatives used in similar states to reduce barriers to care such as investments in Community Health Workers (CHWs), Peer Supports, and doulas; pathways to education and the encouragement and incentivization of health care workforce development; history of work with school nurses and school-based health centers; examples of investments in workforce development initiatives; and strategies to collaborate with the State on broadband investments and initiatives.
- Tailored transportation options for long-distance commutes to health care facilities for residents without access to private vehicles.

By implementing these requirements, the State of Nevada can determine the best managed care partners for ongoing collaboration that can help achieve improved outcomes in its Rural and frontier regions.

1.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?

Response:

Anthem is committed to advancing Rural health equity by working collaboratively with the Division and Rural Providers to develop solutions for Rural Providers. Building on our significant experience serving Members in Rural areas, we recognize the need for creative, localized solutions. We are committed to supporting Rural Providers in serving Members where they live and addressing Rural health challenges, such as concerns with access to care and the volume of Members for alternative payment methods (APM) and Value-Based Purchasing (VBP) arrangements.

We know that payment and delivery systems must be customized to address the Rural landscape to be effective. We are working to bring tailored solutions by developing contracts with Rural Providers designed specifically for their practice and areas of specialty. Further, contrary to the perception that Rural Providers will be paid less than their urban counterparts through managed care than they are with fee-for-service (FFS), Rural Providers will be on the same State fee schedule and compensated equally. The following represent our recommendations to support Rural Providers.

Our Recommendations

We recommend that Rural Providers have the opportunity to participate in APM or VBP programs and receive the education and support they need to make this transition gradually and methodically. These programs will help minimize barriers and give Providers more flexibility and freedom to improve outcomes. They must also be refined to address the specific needs and concerns that Rural Providers may face such as adequate volume of Members, challenges with technology or information technology (IT) infrastructure, or underfunding. We recommend the following strategies:

- ***Modify Rate Structures for Smaller Numbers***. Design rate structures for smaller numbers of Members that focus on outcomes, which may include follow-up and preventive care quality measures. The minimum requirements for payment in the VBP arrangement should be adjusted to reflect an obtainable average performance for Rural Providers to level the playing field and address disparities these Providers may face.
- ***Require Tailored VBP Options***. Anthem recommends DHCFP require managed care plans to offer a VBP option or options that are tailored to Rural and frontier Providers.
- ***Increase Telehealth Service Availability***. DHCFP should also consider partnering with managed care plans and Rural Providers to increase the availability and adoption of telehealth services. This approach will help make sure that Rural Providers have the opportunity to earn additional funding for quality performance. We also recommend the Division consider working with the University of Nevada, Reno School of Medicine's Project ECHO Rural telehealth program to enhance telehealth capacity in Rural communities.

1.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?

Response:

With all 17 of Nevada's counties under one or more federal Health Professional Shortage Area (HPSA) designations, Anthem believes it is critical to address workforce shortages. We fully support the DHCFP decision to require managed care plans to implement strategies to address Provider workforce challenges. We recommend that DHCFP works with Managed Care Organizations (MCOs) to evaluate the shortages of specific Provider types in each area to address workforce availability and capacity most effectively. We understand shortages are particularly critical for primary care, BH, and OB-GYN Providers. In addition, we recommend that DHCFP consider health plans that can provide the following:

- Allocation of a percentage of community reinvestment dollars to support workforce development.
- Partnerships with colleges, universities, and technical programs to provide incentives for and place graduates in the communities where they are most needed.
- Student loan forgiveness for Providers to serve in Rural communities and fund positions within Rural Provider settings.
- Strategies to diversify the level of degree needed and scope of practice depending on the service and area of service.
- Telehealth options to connect Members and Providers to additional clinical expertise and community of practice opportunities.
- Strong relationships with local and community-based organizations, especially Rural health entities, to work together to solve local concerns.
- Ability to support non-clinical service Providers, such as CHWs, Peer Navigators, and Peer Support.

DHCFP can make certain of the efficacy of these efforts by evaluating plans for long-term sustainability. MCOs should work with the State to establish metrics to evaluate workforce plan effectiveness. Such metrics might include a review of Network access standards, enhanced Provider satisfaction surveys, a review of Member outcomes, and diversity and inclusion indicators.

1.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?

Response:

Incorporating a Rural and Frontier Strategy

Where Members live can significantly influence their health, particularly Rural areas where Members may face significant challenges in accessing health care. Across the 27 markets where Anthem and affiliates serve Medicaid Members, we bring experience in best practices and strategies to meet the unique health care needs of Rural and frontier communities. Understanding the Rural makeup of Nevada, the nuances of the Provider community, and the medical and socioeconomic issues facing Members are all vital components to serving Members via a fully integrated delivery system. Through this experience, we bring a combination of innovative clinical partnerships, virtual health solutions, and dedicated recruitment efforts.

Recommendations

Anthem recommends that DHCFP develops Provider requirements and Network adequacy standards in alignment with Centers for Medicare and Medicaid Services (CMS) standards in Rural areas. This includes one to two virtual health options for every Provider type priority in each of the 17 counties to address Members' care needs, especially for urgent care, maternal support, and BH. A comprehensive and multi-faceted telehealth approach must focus on access in Rural and underserved geographical areas. We believe that the utilization of these virtual health options is critical to help close the gap in Member access. This prescriptive requirement will allow Members to receive virtual health options, a critical component of a Rural health strategy.

While telehealth is critical to expanding access to care in Rural areas, Anthem understands it is an enhancement to in-person care, not a replacement. Considering the challenges that Rural Members face through limited broadband availability, we also recommend that DHCFP works with health plans and telecommunication Providers to address these issues. In addition to virtual health options, we also recommend additional strategies to educate and incentivize Providers to expand capacity through the use of physician extenders, such as nurse practitioners and physician assistants.

1.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.

Response:

Anthem believes providing health care in a variety of care delivery models is critical to our mission to improve the health of humanity. We consistently strive to find solutions to reduce or remove barriers to care and services. For example, our Networks do not contain any limited Networks or delegated specialties. Any Provider, regardless of third-party affiliation, can apply to join our Network. As such, our approach makes sure Members have a variety of methods to access care when and where they need it.

Barriers can arise during transitions from one MCO to another. Continuity of care does not merely mean honoring the services the Member is receiving at the time of transition. It means identification and delivery of care that is holistic, continually assessed for appropriateness, adjusted as necessary, and monitored for outcomes.

It is critical that MCOs implement processes to seamlessly support continuity of care during Member and Provider transitions, providing efficient Member transition while assuring that continuity of care and services comply with all applicable state and federal requirements. We know that any type of transition can potentially be stressful for Members, so we work with Members every step of the way to make sure they have the information and supports in place to prevent disruption in care. Our clinical team coordinates benefits and services across managed care plans to verify that all gaps in care and services are identified and resolved, regardless of which plan pays. This includes coordination of shared case planning and regular care conferences to coordinate services for each Member as needed. Further, we work closely with the Member's new or previous MCO, program administrator, Providers (in- or out-of-Network), and external care coordinators to facilitate a smooth transfer of medical records, prior authorization information, care plans, treatment plans, and other pertinent information.

Anthem does not have any arrangements in place that would limit access to Covered Services, but we recommend the Division include requirements for systems and processes for facilitating seamless Member transitions from FFS to managed care, one MCO to another MCO, from program (funding source) to program (funding source), or from one Provider to another.

Recommendations

Our specific recommendations for removing any barriers to care through the transition period of the next procurement include the following requirements for MCOs:

- Contiguous, out-of-state Provider arrangements.
- Health information exchange (HIE) incentives for Provider adoption.
- Processes to assure continuity of care, such as working with Providers, open and transparent conversations with Members, etc.

These recommendations can create significant value for Members, including, but not limited to, stable access to care, maintaining trusted and established Provider relationships, and decreased Emergency Department utilization.

Section 2. Behavioral Health Care

2.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?

Response:

We recommend a few strategies the Division could consider to effectively expand the use of telehealth modalities to address the BH care needs in Rural areas of the State. These strategies include innovative Health Equity initiatives, working with local community agencies and entities such as schools, libraries, and grocers, removing barriers to care, and evaluating and using data-driven best practices. Moreover, telehealth should be used to enhance, not supplant, Provider capacity and capabilities.

Behavioral Health Access Initiatives

To increase BH access and services, particularly in Rural areas of the State, managed care plans should demonstrate a broad and agile Network of specialty Providers with options to access technology. Members in Rural areas often have the same health needs, both behavioral and physical, as those in urban areas; however, they experience barriers to health care that individuals in urban centers would not necessarily face. By expanding policies for place of services and reimbursement models for specialty Providers, telehealth networks can reflect the needs of the Members they serve and connect Members to quality Providers who are prepared to partner with Rural communities. Members with positive Provider experiences are more likely to remain engaged in their health care and are less likely to experience preventable negative outcomes.

Working with Community Agencies & Removing Barriers to Care

Many Members who live in Rural communities do not have access to high-speed, home-based internet or Wi-Fi services. This can be a barrier to accessing telehealth services. Fortunately, the Nevada government is investigating how to increase access to broadband for Rural communities. Anthem supports these initiatives. Other telehealth access locations can include on-site care at schools, retail stores, disability and aging organizations, and faith-based centers. It is essential that Rural Members have access to locations where they can participate in telehealth. The Division may also consider expanding reimbursement for telehealth to include asynchronous and remote Member monitoring.

It can be difficult to get nationally based Providers to commit to telehealth in Nevada due to current regulations. However, there are opportunities wherein credentialing can be streamlined to allow more nationally based Providers to practice in the State. Collaboration with these entities, allowing them to become Nevada-credentialed and -licensed Providers, will allow more national telehealth Providers to support Nevadans by increasing access to care.

Licensure compacts can decrease the time-consuming process for practitioners seeking to practice telehealth in multiple states. Anthem recommends the State initiate drafting language to allow provisional licensure pre-compact or a compact waiver. The average wait time for a license for physicians seeking to practice interstate in the medical licensure compact is 19 days compared to 60 days or as long as four months for an individual state license. With a licensure compact for practitioners, Nevada would have greater availability and flexibility, as licensed nurses and clinicians can practice in other compact states without having to obtain an additional state license. Multi-state licensing compacts continue to gain traction as telehealth practices expand around the country.

Anthem recognizes that screening, early intervention, continuity of care, and whole-person Care Management are key components of effective BH Care Management. We believe that with an even greater emphasis on integrating physical and BH services through access to telehealth, MCOs deliver better health outcomes. By using a collaborative approach, promoting value-based programs, this holistic care will lead to Network engagement, Network capacity expansion, and access to whole-person care.

Fragmentation in care can occur when a Member sees their Primary Care Provider (PCP) and is referred elsewhere for a BH screening. Earlier this year, the Center for Medicaid and CHIP Services (CMCS) changed its policy on Medicaid reimbursement for interprofessional consultation. Now, federal matching funds can be used for interprofessional consultation. With this change, a PCP could confer with a BH specialist about continuing to treat their Members' BH needs and receive advice about referrals and coordination. To leverage this policy change, states must submit Medicaid state plan amendments and waiver requests that include coverage for interprofessional consultation. We encourage the Division to pursue, in partnership with MCOs, reimbursement and policies that adopt these consultations as part of the Medicaid fee schedule.

2.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?

Response:

Anthem supports the Division in seeking opportunities to advance care and leverage best practices from other states to increase the availability of BH services in homes and communities across Rural and remote areas of the State, especially since all of Nevada's 17 counties experience federal HPSA designations. Best practices include innovative programs that promote and expand community partnerships, mobile crisis intervention teams staffed with BH specialists who understand how to support psychological crises, wraparound intensive community-based and in-home outpatient services, and evidence-based practices such as those within Family First Prevention Services Act (FFPSA).

In 2020, Congress passed the National Suicide Hotline Designation Act, creating 988 as the nationwide number for suicide prevention and BH crisis response, with the goal of connecting individuals in BH crises with BH services. The goal of mobile crisis intervention teams is to provide effective and timely care while allowing individuals to remain in their communities, whenever possible. While the State does have a 988 number and an existing framework for mobile crisis intervention, Anthem recommends investing in workforce development to expand mobile crisis capabilities or coordinating with MCOs that will provide that workforce investment.

Wraparound provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious BH or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in wraparound.

CCBHC can work with mobile crisis intervention teams to provide Care Coordination and provide wraparound delivery. By expanding CCBHCs in the State, other service delivery models such as mobile crisis intervention services are also expanded.

Innovative Community Partnerships

Anthem recommends working with select MCOs that have innovative approaches to partnering with Providers and community- or faith-based organizations to bring clinical and non-clinical services to the communities where needs exist most.

Supporting evidence-based therapies and programs that promote innovation and build capacity allow more direct integration of services to deliver a whole-person approach to care. By providing a comprehensive continuum of care delivery, complete Case Management, and integrating services, we can reach Members where they are and deliver direct coordination to promote the provision of services in homes and community settings.

Including programs such as Targeted Case Management (TCM), Parent-Child Interaction Therapy (PCIT), Multisystemic Therapy (MST), Functional Family Therapy (FFT), and other intensive in-home programs promote stable and healthy family dynamics and prevent an out-of-home placement. Our knowledge and experience managing the health care and services for individuals experiencing BH conditions and SUDs give us the ability to recommend blended or bundled reimbursement strategies that can reduce administrative burden from multiple claims submissions, reduce claim errors, and promote timely payment. While we know not all community-based, high-fidelity wraparound services and Provider types are billable or included in MCO management in Nevada, we support incorporating these valuable services into managed care. These services also support step-down and proactive discharge planning and successful transitions back to the home, which may also prevent long-term inpatient or residential stays.

Collaborative and Integrated Care

We support the Division's goal to support BH services and opportunities statewide, with programs specifically designed for Rural areas. We partner with Providers across the delivery system and provide value-based payment models that promote quality, practice transformation, and the delivery of integrated care. We take a proactive approach – for example, through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings and gap in care reporting that help make sure Members are connected to the preventive services they need. Supporting cross-system collaboration, in January 2023, the CMS released guidance to state Medicaid partners to leverage the historically prohibited Medicaid service of interprofessional consultations, which Medicare has been reimbursing since 2019. Timely access to specialty Providers improves the Member outcome for both physical and BH. Guidance asserts that Rural areas face the most significant Provider shortage challenges; more than 60% of non-urban counties do not have a psychiatrist and almost half of non-urban counties do not have a psychologist[1].

MCOs are in a unique position to leverage expertise and provide payment strategies that improve the use of outpatient BH services and strengthen integrated care for children and adults. Collaborative Care Code consultations are a best practice; they are one component of a collaborative care model and are especially important for improving access to specialty care such as child and adolescent psychiatrists. In other states, we have seen the use of behavioral health integration (BHI) codes that allow for consultation between practitioners. We have seen many affiliates incorporate these BHI codes into Medicaid fee schedules, which also allow for alternative payment interactions or value-based payments for the use of such codes. By placing these codes in the Medicaid fee schedule, states can expand the continuum of care delivery, complete 'warm hand-offs' post-screening for services, and assure individuals follow through with BH appointments.

Expanding Additional Services for In Lieu of Services

Making sure Members' basic needs are met promotes engagement and further interest in bettering their overall health outcomes. In January 2023, CMS released guidance to State Medicaid Directors to expand settings options and address certain populations within Medicaid to reduce the need for future costly state plan Covered Services. By providing medically-appropriate service alternatives to traditional services and settings, In Lieu of Services (ILOS) promotes and expands capacity within community-based services that allow individuals to

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1 Holly, C. Andrilla, Davis, A. et al. "Geographic Variation in the Supply of Selected Behavioral Health Providers," American Journal of Preventive Medicine, Vol. 54, No. 6 (2018). Available at: https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext

remain in home and community-based settings. In many of our affiliates, we offer ILOS that substitute or enhance certain Covered Services with medically-appropriate cost-effective non-Covered Services to support Members' goals and desired health and well-being outcomes. Examples of potential services to be included are Program of Assertive Community Treatment (PACT/ACT) for justice-involved individuals, MST or PCIT for children with intensive behaviors, sober living facilities, and caregiver respite.

Family First Prevention Services Act Expansion

The FFPSA offers support to keep families together by using child welfare dollars to provide evidence-based prevention services to children with intensive BH needs. The State of Florida, which has many Rural counties and communities, is developing reimbursement strategies and policies to introduce nine FFSPA services into managed care through blended funding streams. We partner with the Florida Department of Children and Families, participating in the workstreams with multi-represented agencies, community-based entities, and MCOs to build sustainable funding and program components. The programs include:

1. Homebuilders
2. Motivational Interviewing
3. Multisystemic Therapy
4. Parent-Child Interaction Therapy
5. Functional Family Therapy
6. Parents as Teachers
7. Brief Strategic Family Therapy
8. Healthy Families
9. Nurse-Family Partnership

2.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?

Response:

The Division should consider MCOs with the capacity to implement incentives or Provider payment models that increase the integration and coordination of BH services statewide and in Rural communities. We believe it is important to promote health care outside of the traditional medical delivery model and implement a person-centered approach that is uniquely designed for each Member. With the proactive engagement of wraparound services and supports, such as community-based settings, we can deliver the practical application of accessible care to Members where they live and work and where their children learn and play. Anthem recommends improving and increasing community capacity to support individuals at home and incentivizing Providers to develop and provide services in homes and communities, not just in clinical settings.

We believe that by integrating care, MCOs can promote collaborative Network engagement, expand Network capacity, promote value-based programs, and improve overall outcomes. The Division should seek to work with innovative MCOs who have consistently built payment models and successfully delivered on high Health Care Payment Learning and Action Network (HCP-LAN) categories and APM. An MCO should continuously evaluate benefits and incentives to ascertain they meet population needs. To support improved health outcomes and make certain that the right programs are in place to address social determinants of health (SDOH), MCOs must track and analyze various factors that may affect one's well-being such as access to early intervention, transportation, education, and nutritious foods and provide housing support. Pay for performance or quality measures focused on the delivery of evidence-based services in the home could encourage additional Providers to incorporate such practices into their service delivery.

Provider Incentives

Pay for performance or quality measures focused on the delivery of evidence-based services in the home could encourage additional Providers to incorporate such practices into their service delivery.

As an MCO, we have the agility to partner with the State to deliver incentives and Provider payment models to make BH accessible in an easier way tailored to the needs of the different communities (as opposed to a one-size-fits-all approach). These incentives are crucial to increase access and quality. For example, we could partner with the Pediatric Access Line (PAL) program to incentivize Providers to use this resource. Similar approaches have been implemented in Mississippi, Massachusetts, and Connecticut with great success. Working with PAL, MCOs can work with codes like the Collaborative Care Model (CoCM), an evidence-based practice, and BHI codes within the managed care model and align to incenting Providers to deliver integrated and collaborative care within their scope of practices. Additionally, evaluating Provider payment models will help eliminate the same-day billing practices that can be a barrier to access to care.

Expanding and Incentivizing Certified Community Behavioral Health Centers

CCBHCs offer a unique opportunity for Members and families to fully integrate physical and BH services and for MCOs to align payment models and incentives with quality health outcomes. Expanding CCBHCs within Nevada may attract Providers to seek integration, implement Care

Coordination, increase staff, improve access, and provide wraparound community-based supports. In many affiliate markets, we have provided additional funding and support to expand Community Mental Health Centers (CMHCs) and support training that allows them to become CCBHC entities. As a result, CCBHC Providers are able to receive increased reimbursement through prospective payment models.

Section 3. Maternal & Child Health

3.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?

Response:

There are numerous tools and strategies 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. These tools include, but are not limited to, promotion of the HIE, implementation of virtual resources, and doula supports.

Health Information Exchange

Expanding Provider use of the HIE will increase early identification of pregnancy, triggering the notification of pregnancy and subsequent prenatal care. The HIE allows health care professionals to appropriately access and securely share a Member's medical information electronically. Participating in the HIE facilitates better coordination of care, access to care, improved care team visibility, and up-to-date demographics for the Member. Indiana and Washington state have implemented HIE mandates with great success.

We are committed to helping remove barriers for Providers who want to use the HIE. It is essential that Providers are educated and encouraged to use the HIE. While some Providers and hospital systems may believe they do not have the resources to implement the HIE, it is a high-value tool. Anthem is interested in exploring ways we can reduce the financial burden on Nevada hospitals to make certain Providers have access to the HIE to provide enhanced care across the care continuum, ultimately improving health outcomes in Nevada. There is no clinical resource required as the HIE flows directly into the Member's electronic medical record (EMR), meaning no hospital staff is burdened with additional data entry. The National Rural Health Resource Center has made available a set of practical HIE resources to assist Providers in understanding and implementing HIE adoption.

Virtual Solutions

Virtual medical practices provide easy, simple access to care which dramatically improves outcomes for families. MCOs that engage with virtual medical practices can help connect pregnant Members to 24/7 evidence-based care. Virtual medical practices can address a pregnant Member's concerns right away and at home, keeping them out of the Emergency Department (ED) unnecessarily and lowering their risks. A postpartum BH screening is especially important and easily achieved with the help of a virtual medical practice. While most virtual practices are tech-based, they were designed with accessibility in mind, and to not be a barrier to health care. Care is available 24/7 by telephone, as well as text and video.

Doula Care

Doulas provide person-centered care to pregnant and postpartum women through information, education, and physical, social, and emotional support. Successful doula programs are also aligned culturally, which will be important to Nevada's Black/African American, Hispanic/Latino, and American Indian/Alaskan Native individuals. Doula support has been found to reduce the rate of cesarean births and preterm births, while also improving breastfeeding rates and reductions in postpartum depression. Community-based doulas provide a comprehensive array of services including home visits and social service navigation. They are often trained in a trauma-informed approach or grounded in a reproductive justice framework.

Developing a doula program or partnering with an MCO to extend access requires a comprehensive, shared partnership approach. Each functional area contributes to the strategy by identifying opportunities and problem solving to reduce barriers. Whether deploying a formal program supported by doula coverage or partnering to fund doula access and training, the shared approach is critical to success.

Peer Support

Peer support gives an individual a unique opportunity to walk beside someone who knows first-hand what the recovery process entails and helps them find the recovery path that works best for them. It uses the shared experience of certified professionals to promote recovery and independence. Anthem recommends utilization of Peer Support for obstetrics (OB) Members experiencing SUD. Peer Support can include:

- Virtual Peer Support Services.
- Family and group sessions.
- Mobile App with 24/7 access to a digital recovery community.

Once Members are matched with a certified Peer Recovery Supporter (PRS), they can create their own schedule and personalized goals.

3.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?

Response:

There are various Provider payment models (for example, pay-for-performance, pregnancy health homes, etc.) the Division should consider that have shown promise in other states with respect to improving maternal and child health outcomes in Medicaid populations. These models include a range of Provider incentives and increased local support.

Provider Incentives

There are several Provider incentives that can improve maternal and child outcomes that have been successful in other states. The following is an example of Provider incentives used in affiliate markets with Rural populations.

Provider Incentives for Maternal Care

To make sure the right supports are engaged from the start, we recommend a Notice of Pregnancy (NOP) incentive. With this approach, Providers earn an incentive for submitting NOP forms. When we receive an NOP, a series of alerts in our system are triggered to make certain of timely Member outreach. As a Member moves through her pregnancy, an Obstetric Quality Improvement Program (OBQIP) incentivizes OB Providers for engaging pregnant Members in prenatal care.

Providers may learn that pregnant Members are experiencing SUD. For this reason, Providers can be incentivized to complete Medication-Assisted Treatment (MAT) training. Similarly, Providers can be incentivized to participate in Screening Brief Intervention and Referral to Treatment (SBIRT) training, as well as for alcohol and drug screening, and for brief interventions.

Provider Incentives for Pediatric Care

Pediatric Providers can also help drive Member health through incentives. Participating Providers may earn incentive payments through quality performance or cost of care performance. Providers can be incentivized to administer timely immunizations for adolescents and children and making sure Members complete well-child and adolescent visits. Including incentives for screening for SDOH can also be effective in improving outcomes for both maternal and child health Providers.

Other options for pediatric Provider incentives can include quality improvement (QI) incentives that improve access and quality outcomes, increased focus on prevention and primary care, annual PCP visits, newly assigned Member PCP visits, after-hours availability, 14-day follow-up visits after inpatient discharge, and appointment availability.

Payment Models

Affiliates in California and Florida revised their reimbursement policy to require Providers to bill antepartum, delivery, and postpartum care separately, supporting the CMS findings that FFS payments enhanced quality and tracking.

Other Health Support

The Southern Nevada Health District has a Nurse-Family Partnership and Embracing Healthy Babies program that provides support for families from pregnancy through the first year of the child's life. While there is a focus on working with Black/African American families to improve family outcomes and reduce morbidity, the partnership is open to working with all populations. We recommend this approach be extended into other health districts and Rural areas.

Improve Doula Access

Nevada led the innovation by being the fourth State to allow doulas to be paid by Medicaid. However, the Nevada Medicaid reimbursement rate is low, meaning very few doulas want to become licensed in the State. Anthem recommends partnering with a doula group to develop unique payment innovations.

Section 4. Market & Network Stability

4.1.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.

Response:

We believe Nevada Medicaid should continue to treat the State as one service area under managed care, rather than establishing multiple service areas. As the State expands Medicaid beyond the urban counties of Clark and Washoe to include the Rural and frontier Nevada counties, maintaining a single service area will preserve administrative simplicity and consistency in managed care processes, Provider Networks, and access to care. We recognize that many Rural residents seek care in Clark and Washoe counties currently. These are critical patterns of care and Providers serving population-dense counties will benefit from a streamlined and unified service area, rather than multiple ones. As an example, Tennessee originally had multiple service areas, then moved to different regions, but due to patterns of care and their relation to population centers as well as the benefits of administrative simplicity and consistent managed care processes, they ultimately moved to a single, statewide service area.

Managed care programs should bring additional strategies and capacity to coordinate care and services to address the health disparities that exist in Rural areas. With one service area, managed care plans can share best practices across these communities and work collaboratively with the State on shared goals without creating more burden for Rural Providers, such as maintaining adequate Member volume.

In addition, one service area enables Members to travel outside of their county for care they need without the unnecessary additional burden of potentially having to receive care in a service area for which their MCO may not serve.

Regardless of the option the Division chooses, the expanded service area must be focused on integrated, fully coordinated care with a focus on the availability of services and supports. Across the service area, managed care plans must be locally customized with respect and consideration for culturally and geographically diverse communities.

4.1.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.

Response:

Best Practices for Establishing Services

Together with our parent company and affiliates, we manage state-sponsored programs to serve Medicaid Members across 27 markets. Across these states, we leverage the expertise, experience, and best practices of our affiliates, particularly in states with similar populations and geographic makeup. To that end, we recommend the Division evaluates states that have a similar geographic makeup as Nevada with large Rural and frontier areas and concentrated urban centers, such as New Mexico, to inform best practices and the approach to establishing service areas. New Mexico also serves as a strong model for a separate purpose: The prevalence and importance of Tribal Members and Providers to the Medicaid program and broader health care system.

While Anthem recommends the Division create one service area, we suggest the Division considers the following elements when evaluating service area design:

- **Geographic distribution of the membership.** Service areas should be strategically designed to make sure Members can receive the care and services they need and Providers can easily render services with little administrative difficulty within the service area they are located. For example, Rural Members needing specialty services should be able to access these specialists who are concentrated in more populous areas of the State.
- **Geographic distribution, availability, and capacity of Providers in relation to Members' geographic location.** We recognize proximity and access to care make it easier for Members to get the services and supports they need when they need them. If certain areas have a shortage of Providers, service areas might need to be adjusted to make sure Members can access required care.
- **Patterns of care.** Considering where Members are seeking services is critical to service area designation. With Rural Members seeking services in urban areas and all 17 counties under federal Health Professional Shortage Area designations, many Nevada Providers do not accept Medicaid due to low rates of reimbursement.
- **Administrative burden and cost of the number of regions developed.** Having multiple service areas can lead to challenges and complexities with Network management, Provider reimbursement, authorization of services, claims processing, and data management.

4.2.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?

Response:

There are additional methods the Division could use to help determine the assignment algorithm in support of both market stability and competition. In addition to the vital maternal health care measures to help improve the health and wellness of pregnant women and infants, we would also recommend including metrics that measure:

- An integrated approach to physical and BH to treat the whole person
- Health equity and multi-cultural care accreditation that serve the entire health care population

We believe these other innovative measures align well with the goals of the Division's Quality Strategy and will expand the number of Members we can reach to help improve their health and well-being. Finally, we believe it is ideal for all health plans to have obtained NCQA accreditations and ratings.

Integrated Approach to Physical and Behavioral Health

As a fully integrated MCO, we develop every program to center around whole-person care from the moment a Member enrolls through their entire health care journey. Our population health strategy brings all MCO functions together to treat the whole person. In line with our strategy and the Division's goals, we recommend including integrated physical and behavioral measures to effectively design the alignment algorithm around initiatives that comprehensively address the entire population. This would include numerous measures to take into consideration to address the full range of care to assure Members' health and well-being, especially as it relates to BH, such as:

- Care Coordination
- Access
- Monitoring
- Safety
- Overuse of Opioids

We believe this integrated care approach, treating the whole person, will allow us to focus on the larger segment of the membership to improve quality of care and the lives of Members.

Health Equity Accreditation

One of the most vital aspects of whole-person, Member-centric care is Health Equity. It demonstrates the commitment to support the health and well-being of all Members, assures the provision of Culturally and Linguistically Appropriate Services (CLAS), and reduces health disparities. That is why we recommend including Health Equity Accreditation and Health Equity Accreditation Plus as measures to help determine the auto-assignment algorithm. We believe these accreditations are important to demonstrate the ability to serve a diverse membership. For example, Health Equity Accreditation demonstrates MCOs' focus on fostering a culture in support of Health Equity activities, collecting the data needed to develop language services, and Provider Networks to meet Members' cultural and linguistic needs, as well as identifying opportunities to reduce health inequities and improve care. Further, Health Equity

Accreditation Plus demonstrates a higher level of commitment, focusing on collecting data on social risk factors and social needs and offering social resources; establishing partnerships that support community-based organizations; building meaningful opportunities for Member and consumer engagement; and identifying opportunities to improve social need referral processes and the partnerships that make them possible.

We believe this will help fully encompass the Division's other quality goals such as the reduction or elimination of health care disparities and addressing SDOH. Overall, the inclusion of Health Equity and Healthy Equity Plus accreditation will improve quality of care for all Nevadans.

Section 5. Value-Based Payment Design

5.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?

Response:

Anthem appreciates that Nevada Medicaid seeks to prioritize the use of value-based payments with contracted Providers in the expanded managed care program. Currently, the Division has an incentive program for its managed care plans to accelerate the use of value-based payment strategies through a one-year bonus payment arrangement based on performance. Considering the health disparities that exist in Rural communities and the rising cost of health care, these strategies are critical to securing the success and sustainability of the State's Medicaid program.

Provider Incentives and Quality Care

In keeping with national trends, we recommend potential bidders continue the progression and expansion of APMs that are innovative and control or reduce costs while improving outcomes. Potential bidders should be encouraged to move away from traditional FFS models as they do not necessarily promote or support the delivery of high-quality care. Value-based payments incentivize Providers to make real changes to how they practice medicine. As an MCO, we recognize the importance of engagement, and we believe intentionally incentivizing Providers is a powerful way to improve the health of humanity. Further, rather than simply setting goals based on the total number of Providers in APM arrangements or the total number of APM arrangements available to Providers, we suggest the Division design APM requirements with the goal of achieving quality outcomes and making sure both MCOs and Providers have mutual incentives to enter into these agreements.

MCOs should offer agreements that promote quality and address whole health with a strong consideration for the disparities experienced by individuals who live in Rural and frontier areas. In addition, we recommend all MCOs and potential bidders specifically address how they will improve outcomes for BH and SUD and promote better maternal and infant health outcomes statewide. It is important to intentionally address these matters by offering an array of specialty value-based design programs to guarantee an individualized approach for those Providers who serve the community.

5.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?

Response:

Provider Quality, Performance, and Payment

The State should strongly encourage hospital systems and Providers to use available HIE. This would help with the transference of data necessary to keep Providers and MCO informed of the most recent clinical information. Members' health and well-being could be negatively impacted due to a lack of continuity and coordination if the Division does not require hospital systems and Providers to use the available HIE.

The State should streamline metrics to promote consistency and help Providers navigate value-based agreements to make certain of desired outcomes. Aligning all MCOs and State requirements will aid Providers in achieving those outcomes regardless of whom they are contracted with. In addition, the State should consider requiring standardized screenings for Providers, such as standardized SDOH and health needs screenings, to make sure care is completed consistently regardless of what MCO a Member is assigned. This thoughtful approach creates one common goal for Providers and helps with continuity of care and promoting Provider success within value-based payment arrangements. Further, the Division may consider offering Providers a fee to incentivize them to transition to APM arrangements (payable when Providers successfully contract under an APM at a certain level).

Furthermore, we suggest the State consider quality as part of the payment structure by encouraging Providers to submit supplemental data directly to the MCO to assist in meeting the three-point weighted star measures. We also suggest any program bidders follow National Committee for Quality Assurance (NCQA) guidelines and guarantee all coding is Healthcare Effectiveness Data and Information Set (HEDIS)-compliant as this will make certain of accurate data is captured. Compliance is important as successful payments under a value-based contract rely on the Provider coding correctly. Since these Providers may not have the experience of receiving payments based on performance, they may not understand how critical it is to share information correctly to maximize their payment potential. Therefore, enforcing compliance is essential.

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

Response:

Rural Providers and Program Design

The State should promote the use of a value-based payment design with Rural Providers in the same manner they do with non-Rural Providers. However, plans should also be sensitive to the challenges faced by many Rural Providers and design programs to accommodate these unique differences.

Some of the challenges that may impact the design of the value-based programs are:

- Lower membership thresholds, which lead to a lack of qualified participation in higher-level value-based payment arrangements.
- Reduced access to new technology, such as telehealth, could lead to lower Member compliance for Members who are not physically able to see the Provider in person.
- Increase in complex health needs due to Members not being assigned to managed care plans or not reaping the full benefits of the services that a MCO provides.
- Lack of accessible equipment for Members with disabilities could result in lower levels of access in their quality of care.
- Lack of understanding of managed care from Rural Providers. Education for and engagement with these Providers will be critical.

Providers transitioning into value-based programs may need to account for a learning curve as Providers adapt to enhanced care models and move away from a traditional FFS model of care.

The Division should consider the substantial Member engagement, Provider engagement, and education efforts necessary to guarantee a successful transition to the managed care program. Considerations should also be given to any restrictions or regulations that are in place of incentives as they could be barriers.

One consideration the State could keep in mind is how to improve its telehealth access and potentially offer incentives for Providers to invest in enhancing telehealth access. Because Members in Rural areas do not have the same access to necessary specialists, their quality of care could be impacted, which could result in poorer performance and ultimately lower payment for Providers through value-based contracts. One of our strategies for improving care in Rural spaces is to offer alternative care delivery models, including telehealth and mobile health units. Currently, Nevadans living in Rural communities experience low-broadband access. Limited or lack of access to technology means Members may not get the care they need with the State’s current restrictions of requiring audio and video. Reconsidering these limitations could impact the number of Members served, general accessibility, and potentially overall quality of care.

Section 6. Coverage of Social Determinants of Health

6.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?

Response:

By addressing SDOH, Nevada MCOs can improve health, reduce disparities, and appropriately allocate health care funds. ILOS are a crucial component of modern Care Management that help Medicaid Members receive the most effective services, even if they are not necessarily traditional benefits. We applaud the Division for seeking federal approval to cover housing and meal supports to increase the availability of these services for more Members and encourage the evaluation of additional ILOS. We suggest the Division review the CMS proposed rule on ILOS, which could place limitations on total cost reimbursement and require cumbersome reporting and monitoring.

Services to Improve Health Outcomes

In addition to the services the Division has already proposed, we think the following services would be beneficial. We recommend the Division allow definitions or requirements included in the Contract to be broad and that the Division work with MCOs on program specifics, which will allow for program flexibility and continued innovation from the MCOs.

Alternative Housing for HCBS Waiver Members

This service is designed to provide alternative placement for Members requiring certain services such as BH conditions, where a skilled nursing facility (SNF) or home care setting is not appropriate. Given that the HCBS waiver enrollment process takes an average of 18 months to be approved for applicants, we recommend extending the six-month period for qualifying Members until they are approved.

Asthma Remediation

Environmental asthma trigger remediations are physical modifications to a home environment that are necessary to make sure the health, welfare, and safety of the individual, or enable the individual to live well in the home without which acute asthma episodes could result in the need for emergency services and hospitalization. This ILOS helps individuals with poorly controlled asthma (as determined by an ED visit, hospitalization, two sick or urgent care visits in the past 12 months, or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care Provider has documented that the service will likely avoid asthma-related hospitalizations, ED visits, or other high-cost services. Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers.
- High-efficiency particulate air (HEPA) filtered vacuums.
- Integrated Pest Management (IPM) services.
- De-humidifiers.
- Air filters.
- Other moisture-controlling interventions.

- Minor mold removal and remediation services.
- Ventilation improvements.
- Asthma-friendly cleaning products and supplies.
- Other interventions identified to be medically-appropriate and cost-effective.

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

Caregiver Respite

Respite services are provided to caregivers of Members who require infrequent, occasional supervision. The services are provided on a short-term basis because of the absence or need for relief of those individuals who normally care for or look after them and are non-medical in nature. This service is distinct from medical respite and recuperative care and is designed specifically for the caregiver. This ILOS is for individuals who live in the community and require support in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Respite Services can include any of the following:

- Services provided by the hour on an episodic basis because of the absence of or need for relief for those individuals normally providing the care to individuals.
- Services provided by the day and overnight on a short-term basis because of the absence of or need for relief for those individuals normally providing the care to individuals.
- Services that attend to the Member's basic self-help needs and other ADLs, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those individuals who normally care for or supervise them.

Currently, Medicare provides five days of caregiver respite. Anthem believes that parity for the Medicaid program would be sufficient.

Community Navigators

This service provides Members one-on-one support from Community Navigators such as Peer Support Specialists in completing vital social documentation such as birth certificates, identification cards, driver's licenses, transportation, housing, employment applications, and other critical forms needed to live independently in the community. In addition, Community Navigators help Members understand community choices or options for services, living arrangements, and employment supports. They can provide self-advocacy skill development, community transportation navigation training, and assistance to prevent emergencies – for example, how to pay a utility bill before it escalates to the electricity being shut off.

Justice Reentry Housing Support

This service provides housing assistance for justice-involved Members re-entering community from a correctional facility. Reentry programs allow for a more effective transition to the community, can reduce recidivism, and improve health outcomes especially if an individual is at risk of being unhoused. By making these services available to Members up to 90 days before leaving a carceral facility, per CMS' Medicaid Reentry Section 1115 Demonstration Opportunity, Members will be able to establish connections to better make sure their health care needs are met. These individuals are often excluded from other programs due to their justice involvement. A specific ILOS supporting those exiting the justice system is ideal. Individuals who receive reentry housing support have demonstrated a greater likelihood of connecting with employment and long-term housing if this short-term intervention is provided before or immediately following release.[1] It also has the potential to reduce ED visits, inpatient hospital admissions, overdoses, and overdose-related issues, and improve health outcomes overall.

Pediatric-Specific Respite Care

This ILOS is for parents or caregivers of children with specialized health care needs such as Members who are on vent support. This respite period is typically longer than what is offered for caregivers to adults. Instead of a week or less, pediatric respite is up to 30 days to provide respite to family caregivers as well as prevent unnecessary hospitalization.

Sober Living Facilities

Sober living facilities are alternative destinations for individuals who are found to be publicly intoxicated (from alcohol or other drugs) and would otherwise be transported to the ED or a jail. Sober living facilities provide these individuals, primarily those who are experiencing homelessness or housing instability, with a safe, supportive environment promoting long-term recovery.

Sober living facilities provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

When using this service, direct coordination with the county BH agency is required and warm hand-offs for additional BH services are strongly encouraged. The service also includes screening and linkage to ongoing supportive services such as follow-up BH and SUD treatment and housing options, as appropriate. This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to sober living facilities. Sober living facilities must be prepared to identify Members with emergent physical health (PH) conditions and arrange transport to a hospital or appropriate source of medical care.

The services provided should use best practices for Members who are experiencing homelessness and who have complex health or BH conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, Critical Time Intervention, and Trauma-Informed Care (TIC).

Vehicle Modifications and Assistive Technology

With limited public transportation options in Rural and frontier communities, assisting a Member with vehicle modifications can be a solution to supporting independence and community living. Vehicle modifications and assistive technology can assist drivers with disabilities with living independently, going to school, social and community engagement, and consistent employment.

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[1] https://www.huduser.gov/portal/pdredge/pdr-edge-frm-asst-sec-041922.html

Additional Populations for Pending ILOS

We recognize that the Division has already requested approval of housing and meal supports in "Nevada Medicaid Managed Care: A Proposal for Housing Supports as In Lieu of Services", submitted on January 20, 2022. We commend these additions and recommend expanding eligibility for these supports to additional populations as described.

Medical Respite

Medical Respite or Recuperative Care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (PH or BH) or injury in their usual living environment but are not otherwise ill enough to be in a hospital. In addition, we recommend medical respite and tenancy supports be made available to postpartum mothers for up to six months. This service should also take into consideration what is available in Rural areas, and incorporate flexibility, in terms of where the service can be provided and by whom, to make sure Members in these areas can receive this service as well.

6.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?

Response:

Building Value into Nevada's SDOH Solutions

Outside of optional benefits like Value Added Services (VAS) and ILOS, Anthem thinks that the following strategies would most greatly benefit Medicaid Members and reduce costs.

Employment Supports

Employment supports are services that help eligible individuals obtain and maintain stable employment. Key principles include employment coaching, competitive employment, integration with other behavioral and social services, zero exclusion, Member preferences and choices, benefits counseling, job search, retention support, and time-unlimited support. This is currently a Covered Service in Washington and Tennessee.

Expand Telephonic Eligibility for Telehealth

Anthem understands that currently out-of-state Providers may be used if they are licensed in Nevada. However, the requirement for certain services to require video can be a challenge for Rural Members. We recommend allowing more services to be conducted telephonically, even if only in part. For example, 90% of a well-child visit could be conducted telephonically and then the child only needs to obtain their immunization in person. Expanding the types of services for which telephonic engagement is allowed can help increase access to care and improve health outcomes.

Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV)

Home visiting programs are effective and cost-effective strategies to promote maternal and early childhood health and development. Scientific studies have confirmed the positive impacts of home visiting for children and families while yielding between $3.00 - $6.00 savings to federal, state, and local governments for every dollar spent.[1]

The Nevada Department of Public and Behavioral Health (DPBH) coordinates home visiting programs in the State. Programs employ a variety of models with differing eligibility. These include the Nurse-Family Partnership (Southern Nevada Health District), Sunrise Children's Foundation (Clark County), Yerington Paiute Tribe, and several others. These programs will also connect pregnant women and new mothers to Women's, Infant, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), and Early Head Start programs. All MCOs provide maternal Case Management support for high-risk pregnancies and identify women in early pregnancy. Through aggressive case-finding and referrals, MCOs can increase Members' participation in home visiting programs.

[1] Nevada Department of Public and Behavioral Health, Nevada Home Visiting. Accessed at: https://dpbh.nv.gov/Programs/MIECHV/Nevada_Home_Visiting_(MIECHV)_-_Home/#:~:text=The%20Nevada%20Home%20Visiting%20Program,injuries%2C%20neglect%2C%20and%20abuse.

Medical Loss Ratio Requirements

We recommend the Division modify the Contract language or financial reporting requirements to allow non-benefit costs and VAS related to SDOH services to be included in the numerator of the medical loss ratio used to determine any state reimbursement. Explicitly allowing these costs would help encourage innovation and allow plans the ability to develop innovative programs to remove barriers to care and support Health Equity.

Patient Navigators

Screening rates for breast, cervical, and colorectal cancer are, in general, below recommended guidelines and characterized by large racial and ethnic disparities.[2] Using patient navigators improves screening rates; higher screening rates are associated with reduced morbidity and mortality from these cancers. Navigators can help keep individuals engaged in care, helping individuals with a positive screening test are connected to follow-up actions. Navigators or CHWs are a cost-effective means of increasing cancer screening rates.

While navigators are not a covered benefit under Medicaid, many states are considering how and where CHW services could be covered. Navigator services could also be supported by supplemental payments to high-volume Providers.

Purchase of Service Supplements

Currently, Purchase of Service supplements are provided to families to assist with excess costs of services for relatives. Individuals can use these supplements for things such as food, special diets, adaptive equipment, and utilities. Anthem recommends that the Division continue to offer Purchase of Service supplements until all populations are fully in managed care.

Quality Improvement Activities

By tying SDOH to specific quality improvement activities, MCOs can more effectively track and measure what needs are remaining. Some examples of this are the PRAPARE tool (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) or the CMS screening tool. These tools standardize what data is being collected and provide an opportunity for intervention for positive screenings.

Recovery Housing

Recovery housing grants stable, transitional housing for certain individuals with BH and SUDs. This benefit can be critical in supporting and maintaining recovery and allows for these Members to reside outside of institutional settings while continuing to receive care.

Require NCQA Health Plan Accreditation and Health Equity Accreditation

Accreditations such as the NCQA Health Plan Accreditation and Health Equity Accreditation are well-defined measures of a plan's adherence to industry-defined and accepted operational and quality standards. We believe that these two accreditations should be a requirement so that all MCOs are held accountable for assuring high-quality and equitable health care for Nevada's Medicaid Members.

[2] Benavidez GA, Zgodic A, Zahnd WE, et al. Disparities in meeting USPSTF breast, cervical, and colorectal cancer screening guidelines among women in the United States. Prev Chronic Dis. 2021; 18:E37.

Safe Handgun Storage

Firearm injuries are now the foremost cause of death for children (1-19 years of age). In Nevada, an average of 27 children die each year from firearms. There is robust evidence that education on safe storage (storing guns in a locking device, unloaded and away from ammunition) along with providing a suitable device, dramatically increases the percentage of guns that are safely stored and that this in turn reduces firearm injuries. MCOs should collaborate with local Providers and community-based organizations (such as American Academy of Pediatrics, ED physicians, and local hospitals) to provide firearm safety training and safe storage devices.

SDOH Data Exchange

By establishing a statewide SDOH Data Exchange, information sharing will improve across all health care stakeholders and the reach rate of health needs assessments (HNAs) will increase. This will also allow Members to be enrolled in Care Management earlier and improve care and outcomes. As part of SDOH data sharing, screenings, referrals, and outcomes would be recorded. Michigan and California currently have SDOH Data Exchanges and have realized these benefits for their Medicaid populations.

SDOH Questions in Medicaid Application

Including SDOH-related questions and information collection in the 834 file would allow SDOH information to be gathered even before Members are enrolled in managed care. Having this information upfront enables MCOs to determine the level of coordination, types of Providers, SDOH support, and Special Health Care Needs Members need as soon as they are enrolled into managed care. We believe a question related to whether individuals are exiting a correctional facility would help MCOs address specific needs for this population, as well. In Washington, each correctional facility is assigned a 3-digit code and MCOs receive this code in the 834 file. MCOs also receive information on any Member slated to go from jail to the Department of Corrections for long-term incarceration.

Standardized Health Needs Assessment

A standardized Health Needs Assessment across all MCO Providers would allow stakeholders to share information and track the completion of HNAs more easily. Many states have not solved this, so Nevada could establish a best practice by adopting this approach. A standard list of required questions would be valuable, and we would be happy to collaborate with the State and other MCOs on what questions the Division should include.

Value-Based Payment Models

By using value-based payment models that include more flexible models like population-based payments, especially in Rural areas, MCOs create opportunities to invest in SDOH services to improve quality, address disparities, and reduce costs.

6.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?

Response:

As a current MCO, we are familiar with and supportive of the 3 percent investment requirement. To help further the State in improving SDOH and making certain of the success of expanding the managed care program statewide, we recommend broadening or modifying the contractual definition of a "community organization" that qualifies for the 3 percent pre-tax profit investment. The revised definition can include investments to address Provider workforce shortages, transportation issues in Rural areas, and telehealth or other technology for Rural Members.

Given that most recommendations are already captured via the Medicaid Reinvestment Advisory Committee (MRAC), we feel it is imperative that the committee is appropriately reflective of the Medicaid population and other stakeholders. For this reason, we suggest the Division consider adding the following seats to the MRAC:

- A representative of the population of the Rural areas.
- A representative of individuals with lived experience, for example, individuals with disabilities, older adults, individuals with BH conditions, and SUDs.
- A representative of the Nevada Interagency Council on Homelessness.
- One representative from each of the MCOs.

Section 7. Other Innovations

7.A. 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.

Response:

In support of the Division's expansion of the Medicaid Managed Care (MMC) program, we recommend the following phased, innovative programmatic adjustments and best practices:

- Align the dual eligible special needs plan (D-SNP) program with the MMC Program.
- Integrate the Aged, Blind, and Disabled (ABD) population and Long-Term Services and Supports (LTSS) into the MMC Program.
- Full integration and mandatory enrollment of the foster care population as part of the statewide MMC Program expansion.

We believe these innovations will improve quality of care, health outcomes, and Member satisfaction through a more comprehensive and integrated, whole-person approach for both the ABD and foster care populations. As these program changes are significant, we recommend making these adaptations in a phased and methodical approach.

D-SNP Alignment

Anthem shares their excitement with the Division on their efforts to enhance the D-SNP program. We appreciate the goals of evaluating the program, strengthening the State Medicaid Agency Contract (SMAC), identifying new opportunities, improving program quality and Member experience, and limiting the D-SNP market to prevent oversaturation.

Align D-SNP to Medicaid Activity

For Nevada to achieve the highest level of integration, the alignment of a Medicaid plan is necessary. For this reason, we propose the Division align the D-SNP program with the MMC Program. This alignment would include individuals who require complex care such as individuals with BH diagnoses and LTSS eligibility.

Such an alignment would promote an integrated, person-centered approach for dually eligible Members. Alignment has proven to be effective in reducing Member confusion and prioritizing access to a best-in-class health care delivery while supporting individuals in attaining their highest level of health.

Alignment of programs further enhances and streamlines the stakeholders who support these populations such as Providers and community-based organizations, reducing the administrative burden they may experience coordinating care and supports.

We believe the Division can accomplish its goals for the D-SNP program by aligning it with the existing MMC Program and avoiding a dedicated D-SNP procurement. Additionally, this will allow the Division to achieve its programmatic objectives more efficiently and avoid the cost and administrative requirements of two procurements.

To achieve this integration, especially with Nevada's active dialogue and intent to assess managed long-term services and supports (MLTSS), we propose the cancellation of standalone D-SNP procurement activities and recommend a phased approach to the implementation of D-

SNP with the MMC Program. MLTSS is key to achieving the highest level of integration and a phased approach would help reduce administrative costs and minimize abrasion to Members and Providers.

D-SNP alignment would allow the Division to focus on integrating care through the immediate implementation of a highly integrated dual eligible special needs plan (HIDE-SNP), based on the inclusion of BH. This phased approach will provide the State additional time to pursue alignment with an ABD and LTSS carve-in, with the eventual implementation of a fully integrated dual eligible special needs plan (FIDE-SNP).

D-SNP Model and Contracting Options

With coordination requirements beyond the current SMAC as well as a higher level of integration than the current data coordination offered in Nevada, a HIDE-SNP would be an ideal option to require coverage and support benefits for BH.

We propose the Division transition the current data coordination to a HIDE-SNP for Members with BH needs, embedding requirements in the SMAC and the Model of Care.

A HIDE-SNP would align well with the Division's goal to enhance the D-SNP program and create an avenue for providing MLTSS benefits. After carving MLTSS into the MMC Program, the Division can then seamlessly transition to a FIDE-SNP.

We also recommend an approach that permits states to selectively contract only with D-SNPs that offer affiliated MMC plans in the same service area. This is supported by the Integrated Care Resource Center (ICRC) and aligns well with the Division's objective to limit new contracts. This approach will also provide the Division with more flexibility in contracting. Per the CMS guidelines, while D-SNPs must have a contract with the Medicaid agency in the states where they operate, states do not have to contract with D-SNPs.

Carve-in of ABD and LTSS to Medicaid Managed Care

As discussed above, we further recommend integrating care for dually eligible ABD and LTSS Members into the MMC Program. To achieve this transition, we suggest the forthcoming MMC RFP include language to enroll the ABD population and LTSS benefits into managed care for the next Contract. This can be done in a phased approach to transition the ABD population into managed care, treating the three sub-populations as separate phases for individuals in:

- Community, Non-Waiver population in Clark and Washoe Counties.
- LTSS.
- Waiver program.

As part of this recommendation, the new D-SNP SMAC should be structured to make sure the D-SNP program benefits Members through greater Care Coordination and increased continuity of care, which promotes better health outcomes.

This would include default enrollment to the aligned D-SNP to assure Members receive continuous, quality care in a plan suited to their needs. Creating an environment where one MCO can support Members – particularly older adults and individuals with disabilities – across the continuum of Medicare and Medicaid benefits provides numerous advantages, including sustainability of existing levels of care, reduction in ED utilization, and improved continuity of care. Moreover, alignment of the D-SNP program with the MMC Program and integration of ABD/LTSS can help increase alignment of VBP strategies that increase overall program success and reduce Provider abrasion.

Foster Care Enrollment

We recommend that with the statewide expansion of the MMC Program, the Division includes integration of the foster care population on a mandatory basis. We believe that the best approach to a continuum of care that meets the unique needs of youth in child welfare is for full integration and enrollment into managed care allowing MCOs to manage the full range of benefits and services for children and their families. This will reduce fragmentation across the various social service agencies that foster care Members must engage and provide better access to the services that Members and their families need.

Research has found that 35 to 60% of children in foster care have acute or chronic physical conditions such as neurological problems, hearing loss, vision loss, obesity, asthma, growth failure, and sexually transmitted diseases. Between 30 and 60% of children in foster care experience intellectual, developmental, and physical disabilities. Additionally, an evaluation of children formerly in foster care found that more than 54% had at least one mental health condition; nearly a quarter had post-traumatic stress disorder.[1]

Statewide integration of foster care will provide the Division with a more streamlined, less administratively complex program. Allowing the MCO to be responsible for all services and supports enhances accountability for access to care and improved health outcomes and minimizes administrative burden for agencies and Providers. This will also make coordination with child welfare and other agencies more productive and effective, which will encourage a more unified system of care for these children.

Our recommended approach promotes greater stability and continuity of care for children, particularly as they move between placements and foster families. Foster care Members will be able to benefit from the experience and comprehensive care that the various MCOs can bring to bear and offer the same wide array of benefits and services that all Medicaid Members receive. We feel this is the best model to help children stay in their communities, have permanent living situations, and develop the life skills they need to be independent, well-functioning adults.

[1] Stoltzfus, E., et al. (2014, November 19). Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues. Congressional Research Service, CRS Report R42378. Retrieved December 1, 2019, from https://www.fas.org/sgp/crs/misc/R42378.pdf.