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Information Prepared for the:

Nevada Department of Health and Human Services, Division of Health Care Financing and Policy

In Response to the Nevada Medicaid Managed Care Expansion Request for Information (RFI)

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Proposal Submitted on:
October 17, 2023

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Department of Health and Human Services
Division of Health Care Financing and Policy
Attn: Stacie Weeks
1100 E. William St., Ste. 101
Carson City, Nevada 89701

Sent via email to: statewideMCO@dhcfp.nv.gov

Dear Stacie Weeks:

Berry, Dunn, McNeil & Parker, LLC (BerryDunn) is pleased to submit our response to the Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (Division or DHCFP) Request for Information (RFI) for the Nevada (State) Medicaid Managed Care Expansion.

We appreciate the opportunity to help inform DHCFP's upcoming procurement for the State's Medicaid Managed Care Program on January 1, 2026. Following State approval during Nevada's 82nd legislative session for the Division to finance the expansion of its Medicaid Managed Session, we understand the Division aims to extend Medicaid Managed Care program services to children, parents, and adults without children who live in the State's urban and rural counties.

We are passionate about supporting states with their healthcare transformation initiatives. With services built on applied experience and best practices, BerryDunn has dedicated Medicaid managed care specialists that work with Medicaid and health and human services clients to help improve their delivery of appropriate, medically necessary, quality healthcare to their members. Our services include procurement support and program implementations, operational readiness, managed care model development, provider network assessments, and client compliance support with state and federal healthcare policies, contracts, rules, and regulations.

Our consultants provide our clients with services that tap into our experience collaborating with state government, health and human services agencies, and managed care plans. Such experience offers different perspectives to assist states with a variety of managed care initiatives, providing key insights to Medicaid agencies seeking opportunities to improve their delivery of services, maximize federal funding, and implement innovative managed care payment models. In addition, our Health Analytics Practice Group has experience working with nonprofit, community-based behavioral health managed care organization (MCO) clients. Our teams can help our clients reduce unnecessary healthcare costs and improve program outcomes, quality, and oversight. The following document includes answers to questions presented in the RFI to reflect our experience and expertise across managed care client projects.

With this re-procurement, Nevada—a state that began its Managed Care Program more than 25 years ago—takes on the complex challenge of improving the health and welfare of beneficiaries

in its rural and remote communities. This effort will be supported by enhancing provider networks, increasing access to behavioral health services, and improving maternal and child health outcomes. During our review of the RFI, BerryDunn noted the following items associated with this scale of managed care re-procurement:

1. Engaging provider communities, community partners, DHCFP sister agencies, current and potential MCOs, Division staff, and Medicaid recipients and their representatives is critical to a successful implementation.
2. Incorporating State-led innovations focused on addressing rural access issues, value-added service models, and health equity into the 2025 procurement can improve the value of the State's managed care services, advance State health policy objectives, and help improve the healthcare of Nevadans.

If you have any questions or would like to discuss any aspect of our response further, please contact me via email at palfrey@berrydunn.com or phone at 207-541-2242. We wish DHCFP success in the planning for its new procurement and readiness reviews for the State's Medicaid Managed Care Program in 2025.

Sincerely,

Peter Alfrey
Principal

BerryDunn

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I. Provider Networks

Improving access to care is essential to ensuring a successful Managed Care Program, especially in hard-to-reach rural and remote communities. All of Nevada's 17 counties are under one or more federal Health Professional Shortage Area (HPSA) designations. Many Nevada providers do not accept Medicaid due to low rates of reimbursement or the administrative burden associated with billing Medicaid. Due to the significant shortage of primary care and behavioral health providers in Nevada, many recipients face long appointment wait and/or travel times for basic health care needs. This is especially true in rural and frontier areas of the state, where people often have no choice but to forgo necessary care or seek services at the nearest local emergency room after a condition has exacerbated.

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:

Approaches to establishing provider network adequacy standards in rural areas involve finding a balance between maintaining a choice of providers and requiring MCOs to be nimble enough to reconfigure their networks based on changes in workforce availability and service needs. This approach includes providing tech-enabled solutions, such as telehealth and enhanced supports like member transportation for appointments. Through the procurement and contracting process, the State could leverage MCOs as partners to further develop networks and grow the workforce. Successful approaches to addressing access issues can include the following activities:

1. Requiring MCOs to incorporate member input and experience into network adequacy development activities—via patient experience surveys—to help understand service access issues. This is being driven at the federal level and is reflected in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule.
2. Convening a collaborative that includes participation from MCOs, providers, and partner-agencies to develop innovative solutions.
3. Requiring local provider relation offices to be strategically placed in rural areas to assist in building provider capacity.
4. Helping ensure MCOs are positioned to hire staff who represent and understand the unique needs of the communities they serve. These staff can conduct direct outreach and engage members who may be otherwise difficult to reach. These positions are a function of the care management teams. Outreach and engagement can include screening and education on services.
5. Incorporating the use of technology-enabled solutions, such as telehealth and mobile-based services, in contractual provisions.

6. Allowing for a Rural Telehealth Network Adequacy Waiver for instances where telehealth is available when time and distance standards are not met.
7. Requiring MCOs to submit what can be described as a rural health empowerment plan for State review that outlines MCOs' strategies for addressing medical/behavioral health, including non-medical needs, of rural and frontier communities.
8. Requiring MCOs to strengthen the availability of community-based organizations that are positioned to link the needs of communities with non-medical interventions, such as housing, transportation, and food access.
9. Recognizing that statewide access can change over time and allowing members to access providers outside of typical catchment areas when no other providers are available.

When developing network adequacy standards for managed care contracts, the State might consider anticipated Medicaid enrollment, utilization of services, and necessary providers and specialty providers based on review of historical utilization claims data. Travel time, not just a geo-analysis based on ZIP code, can also be considered, especially for rural counties. The State might also consider travel time when establishing rates. It is also important for MCOs to clearly articulate the proposed usage of telehealth as it relates to provision of services and how that may help ensure network adequacy and access to services for members.

For rural and/or frontier counties, the MCO can address any potential challenges present in these counties (e.g., broadband access and whether a centralized location or mobile-enabled technology could be used for those counties that do not have broadband). The MCO can help ensure these locations are adequately positioned to provide appropriate telehealth services. If the MCO uses subcontractors for specific services, contract language should state the same network adequacy standards apply to subcontractors as well.

The State must help ensure access; however, strict requirements may hinder MCO participation. The State may consider implementing strategies with a degree of flexibility, such as adjusting standards according to the degree of rurality, using services utilization factors, or using mid-level clinicians to satisfy member-provider ratios. Standards may include time and distance/24-hour coverage/time access and utilization of telehealth.

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:

It is important to note that the Centers for Medicare & Medicaid Services (CMS) is proposing to remove barriers to state-directed payment programs, including quality reporting measures in the 2023 Medicaid and CHIP Managed Care Access, Finance, and Quality. Beyond state-directed payment programs, the State could consider requiring some type of value-based payment

(VBP) for specific rural providers; ideally, an arrangement with no downside risk. A shared savings arrangement is a common VBP model for physicians that could be applied with other provider types as well. The VBP model could also be a tiered or multidisciplinary approach. For example, the State could define the rurality of the county, allowing for a tiered or higher shared savings percentage for more rural providers. Another option is a multidisciplinary or clinical approach in which the shared savings percentage is higher for a provider type that fills a critical need within the geographic location. The VBP arrangements would be in addition to normal reimbursement.

The State could also require MCOs to reimburse providers based on actual costs in State-defined rural areas. Another option includes MCOs being required to reimburse at a specific percentage of the fee-for-service (FFS) schedule; for example, 101% of the FFS. This percentage could be increased for more rural areas.

There are also several opportunities to expand upon enhanced financing mechanisms through existing State programs with public universities or other options. These would include creative or expanded directed payments, but also FFS and/or upper limit mechanisms with enhanced payments structured with specific rural health objectives in mind. Creative interprofessional education and graduate medical education programs like the University of Nevada, with enhanced funding mechanisms, could also be targeted to the rural health space. Our subject matter experts (SMEs) have assisted other states with similar efforts.

Enhanced Financing Mechanisms

Both acute care and behavioral health providers can use a variety of financing mechanisms, including provider assessments, upper payment limit (UPL) programs, intergovernmental transfers (IGTs), and certified public expenditures (CPEs).

Medicaid Reimbursement and UPL Programs

- **Medicaid**: Subject matter expertise in reimbursement includes revenue source analysis and payment mechanism development, as well as an understanding of the operational and administrative impacts of both existing and proposed programs. Our SMEs have helped develop entirely new and revised existing reimbursement structures for hospitals, physicians, nursing homes, and other providers to secure funding that supports these important safety net providers.
- **Medicaid Payment Limits**: Experience working with both statewide aggregate Medicaid payment caps as well as institution-specific caps is critical for successfully implementing Medicaid financing initiatives, including provider assessments. For hospitals, the Medicaid UPL is the rate Medicare would pay for the same services. Understanding the allowable UPL calculation methodologies and determining which methodology works best for individual states implementing Medicaid financing initiatives is a critical component of maximizing potential revenues.
- **UPLs**: Federal regulations place a ceiling, or UPL, on state Medicaid expenditures eligible for federal matching funds for several types of healthcare providers, including inpatient/outpatient hospitals, nursing homes, and physicians. These UPLs apply in the

aggregate to all payments to each provider type and are further differentiated among state-owned, non-state-government-owned, and privately-owned providers. UPLs for institutional care are established as the amount the federal Medicare program would pay for the same services. Because the UPL is linked to Medicare rates, and the rates that states traditionally pay are often lower than Medicare rates, a potential opportunity exists for states to receive additional federal funding up to the UPL ceiling. The UPL for physicians, dentists, and certain non-physician professional services can be set at the average commercial rate, which is typically higher than the Medicare rate. CMS recently dedicated significant attention to benchmarking methodologies for supplemental rate programs on managed care. BerryDunn SMEs have experience and expertise applying various benchmarking methodologies and responding to CMS inquiries.

- **IGTs**: IGT programs are transfers of public funds between governmental entities. The transfer may take place between one level of government and another (e.g., counties to states) or within the same level of government (e.g., state university medical school to state Medicaid agency).
- **Budget Analysis and Identification of Matching Funds on Unmatched Local Expenditures**: By statutory formula, the federal government pays between 50% and 75% of all state-incurred costs for purchasing covered services on behalf of Medicaid beneficiaries or 90%+ for new beneficiaries under the Medicaid expansion. It is not unusual for Medicaid associated costs to be overlooked and remain unclaimed for federal matching through stratified eligibility analysis and/or combined claiming methodologies.

State Plan Amendments (SPAs), Federal Waivers, and Local Agreements

Implementing a Medicaid financing initiative may require the development of SPAs, public notices, legislation, changes to Medicaid Managed Care contracts, briefing documents, and memorandums of understanding (MOUs) between state and local governments or between different state agencies. These documents often describe the rationale for the initiative, outline related calculations, and specify steps associated with initiative implementation.

- **Medicaid SPAs**: SPAs are the most frequently utilized vehicle for accomplishing Medicaid financing initiatives providing assurance that states adhere to federal rules and can claim matching funds to support program activities.
- **Medicaid Managed Care Contracts**: When undertaking a Medicaid financing initiative via Medicaid Managed Care, changes to the State's standard Medicaid MCO contract language are likely, unless an organization can enter an existing program using the language already approved in the preprint authorization vehicle.
- **Medicaid Waivers**: States often operate a portion of their Medicaid programs through 1915 or 1115 waivers, and the mechanics associated with negotiating or revising those waivers differ from the SPA process. Our SMEs have gained experience drafting and negotiating waivers for Medicaid eligibility expansion and home and community-based service (HCBS) programs.

- **State and Local Agreements**: Depending upon the structure and the entities impacted by a Medicaid financing initiative, it is possible an MOU will need to be drafted to outline the responsibilities of participating entities. Our SMEs have gained experience drafting and negotiating these agreements among affected parties.

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:

The State may consider launching this effort by conducting a workforce needs assessment to identify gaps in care across the entire service delivery system and establish potential targets. Findings from this assessment can be used to track the effectiveness of MCO efforts. Targeted activities that might address workforce shortages may include the following:

- Making available workforce training and funding
- Providing assistance with finding housing for professionals who may need to relocate
- Considering access to schools for professionals that may need to relocate with families
- Helping ensure career pathways are defined with increased compensation and skill level
- Offering competitive salaries that attract and retain skilled professionals
- Expanding the use of non-physician providers

Coupled with this effort, the State might consider establishing a quarterly collaborative among the State's MCOs, local representatives, hospitals, and key provider groups. This collaborative would meet quarterly for the first year of implementation to discuss the status of workforce development efforts against State-defined targets and share best practices.

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:

States are employing several best practices and strategies to develop provider requirements and network adequacy standards in managed care, especially with respect to meeting the healthcare needs of rural and frontier communities. For example, Oregon has adjusted its network adequacy standards based on different geographic regions, considering urban, rural, and frontier differences. To address dental access issues in rural areas, oral health providers are offered "loan repayment incentives" through the Health Care Provider Incentive Program. In

order to receive funding, providers must accept a percentage of Medicaid patients proportionate to the surrounding community.

Nebraska offers two rural loan incentive programs. These two rural incentive programs (student loans and loan repayment) are the only state-funded programs of this type to encourage health professionals to practice in state-designated shortage areas. Economic analysis based on years worked shows a significant economic benefit associated with these healthcare providers. This benefit far outweighs the financial investment in incentive programs.

- The Nebraska Loan Repayment Program assists rural communities in recruiting and retaining primary care health professionals by offering state-matching funds for repayment of health professionals' government or commercial educational debt. This program has a 93% success rate.
- The Nebraska Rural Health Student Loan Program has provided forgivable student loans to Nebraska medical, dental, physician assistant, and graduate-level mental health students who agreed to practice an approved specialty in a state-designated shortage area.

Since 2018, Alaska has made significant strides in telehealth to reach rural and remote communities despite being home to several hundred small communities unreachable by road and unconnected to any extended electrical grid. Not only do most of these communities lack full-time physicians, but they also lack access to a modern, redundant broadband transmission infrastructure. Through telehealth services, supported by agencies like the Universal Service Administrative Co. (USAC) Rural Healthcare Program (https://www.usac.org/rhc/), Alaska Communications helps rural caregivers provide emergency services, advanced diagnostics, specialized medical treatment, palliative care, and mental healthcare at levels previously not possible. "In terms of telehealth," noted Federal Communications Commission (FCC) Commissioner Michael O'Reilly in recent testimony, "what they are able to do with very small dollars in rural and remote parts of [Alaska is] very impressive … Other places using telehealth and telemedicine are really eating up some significant dollars, whereas Alaska has been very efficient and addressed the issue very thoughtfully."[1]

Out-of-network care provisions help ensure beneficiaries in rural and frontier areas have the ability to see out-of-network providers at in-network cost-sharing rates if in-network providers are not available within a reasonable distance or time frame.

- Arizona allows MCO contracts the flexibility to approve out-of-network care provisions. These provisions allow Medicaid beneficiaries to access out-of-network care under specific circumstances when in-network care is nor readily accessible. Arizona can

[1] Appleby, Chuck. November 27, 2018. *How telehealth gets to far-flung residents in Alaska*. Columbia: Health Data Management (HDMgroup). Accessed October 13, 2023. https://www.healthdatamanagement.com/articles/how-telehealth-gets-to-far-flung-residents-in-alaska

identify potential access issues throughout the state and institute measures to address access at the earliest opportunity. In addition, MCOs can employ single case agreements and direct a member to receive care from an out-of-network provider where no in-network provider is available. In many cases, MCOs arrange single case agreements or send patients out-of-network to help ensure care needs are met.

Use of non-traditional providers, such as community health workers (CHWs), doulas, peer support specialists, and others can play a crucial role in enhancing access to care, improving health outcomes, and addressing cultural and linguistic barriers. Several states have recognized this potential and have taken legislative or administrative steps to integrate these providers into their healthcare networks. Incorporating non-traditional providers such as CHWs into managed care networks can help address shortages and cultural barriers.

- Peer support is an evidence-based practice for individuals with mental health conditions or challenges. In Pierce County, Washington, involuntary hospitalization was reduced by 32% by using certified peer specialists offering respite services, leading to a savings of $1.99 million in one year.[2]
- Minnesota was one of the first states to pass legislation for the certification and reimbursement of CHWs. It allows Medicaid reimbursement for CHWs who work under the supervision of a physician or advanced practice registered nurse.
- New Mexico has been known to incorporate CHWs into care teams, especially for populations with cultural or linguistic barriers.

These diverse initiatives provide examples in considering specific strategies for the State as it refines its Medicaid Managed Care approach, especially considering rural and frontier communities. The multiple state examples offer evidence that tailored provider requirements and network adequacy standards can meaningfully address the distinct healthcare needs of rural areas. The integration of non-traditional healthcare providers and the utilization of telehealth help healthcare professionals maximize their time. Enticing professionals through incentive programs and allowing healthcare providers to use flexible out-of-network provisions demonstrate efficacy in bridging healthcare disparities. Drawing on these states' experiences may help empower Nevada build a robust, inclusive healthcare network that meets the specific demands of its diverse communities, helping ensure every resident, despite their location, has access to quality care.

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,

[2] Mental Health America, Inc. May 2018. *Evidence for Peer Support.* Alexandria: Mental Health America. Accessed October 13, 2023. https://mhanational.org/sites/default/files/Evidence for Peer Support May 2018.pdf

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:

Reimbursement for services, if inadequate, can represent access issues, particularly for Medicaid recipients. To determine rate reasonability, the State may consider assessing payment rates to providers across the service delivery spectrum. The State could consider addressing reimbursement issues via:

1. **State-directed payments (SDPs).** These were highlighted in Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule as a mechanism to address provider reimbursement issues. Given the vast increase in SDP arrangements, CMS is proposing additional reporting requirements to help ensure the effectiveness of these arrangements regarding quality of services and delivery of care.
2. **Established minimum mandatory payments rates.** These rates would be used for specific services that may otherwise mirror payments made in FFS.

Another barrier to services might include an inadequate network of providers with no capacity to provide holistic care to members. For example, some managed care participants may also receive services from an HCBS waiver. There is typically no care coordination between waiver HCBS case managers and MCO care managers. While HCBS waiver populations are not included in the managed care population, a contractual and monetary incentive could help foster collaboration and data sharing between MCO care managers and waiver case managers. HCBS can be considered one of the multiple ways to help ensure members address barriers to care. In addition, the State could consider requiring MCOs to further enhance availability of community-based organizations with the ability to partner with MCOs to address health equity needs and troubleshoot barriers to care.

II. Behavioral Health Care

Nevada, like most states, has significant gaps in its behavioral health care system. These gaps are exacerbated in rural and frontier areas of the state with the remote nature of these communities. Furthermore, the U.S. Department of Justice issued a recent finding that Nevada is out of compliance with the American with Disabilities Act (ADA) with respect to children with serious behavioral health conditions.

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:

Over the past four years, Nevada has increased its Certified Community Behavioral Health Center (CCBHC) network, resulting in increased access to behavioral health services. CCBHCs use telehealth modalities for client services, which can increase client access, reduce emergency services, and provide a person-centered, trauma-informed environment.

Leveraging HCBS—such as Money Follows the Person demonstration, assistive and adaptive equipment, and individual directed goods and services—may help meet individuals and families where they are and increase access to additional medically necessary services.

Providers may choose to provide telehealth through a variety of modalities. To increase rural outreach, MCOs can offer incentive payments to providers for purchasing necessary telehealth equipment.

MCOs may use value-added funding to purchase technology such as smartphones and internet access for members. Having a provider or MCO care management staff member available to help with setup or problem solving is also beneficial.

The State may consider requiring MCOs to submit a technology-enabled access plan that outlines how they will increase access to telehealth, including an analysis of member demographics, approaches to engaging members, and strategies for expanding access to telehealth to support the needs of members.

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:

States use CMS Medicaid 1115 behavioral health waiver demonstrations and 1915(c) waivers to provide services in a home- and community-based setting. A 1915(c) waiver for children with serious emotional disorders will provide HCBS for children. The services and population can also be written into a 1115 waiver demonstration. The vehicle that authorizes the managed care authority will influence which HCBS waiver may be best. Offered HCBS services could include community living supports, personal care/attendant, respite, care coordination, supported employment, peer support, youth support and training, parent support and training, fiscal intermediary, and community transitions.

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:

We reviewed the findings outlined in the Department of Justice report on providing access to behavioral health community-based services for children, particularly in remote regions and have seen these issues play out in other states. Nevada may consider designing a directed payment model that promotes the timely transition of children from institutional settings to the appropriate levels of care in the least restrictive settings. Some considerations include offering an enhanced funding potential to "segregated settings" that would facilitate discharge and appropriate linkages to the child's home. The goal of this program would be to help ensure there are appropriate levels of care, case management that leads to appropriate placements, and clinically appropriate and timely transition to the community. Funding for this program could be used for the following:

- Increasing the number of hospital social workers
- Training hospital discharge planners on high-needs/high-risk member needs
- Improving communication around discharge planning (beginning 30 days prior to discharge)

III. Maternal & Child Health

Nevada Medicaid continues to strive to improve maternal and child health outcomes. Currently, the Division uses several contract tools to incentivize managed care plans to focus efforts on improving access to, and the utilization of, prenatal and postpartum care and infant/child check-up visits. Besides performance improvement projects, this includes a 1.5% withhold payment on capitation payments that managed care plans are eligible to receive if certain metrics of improvement are met for this population. For 2024 and 2025 Contract Years, the Division is implementing a quality-based algorithm that will prioritize the assignment of new recipients based on plan performance on certain HEDIS metrics that monitor prenatal and postpartum care utilization. Nevada also has a bonus payment program for its 2023 Contract Year for managed care plans that increases the percentage of total expenditures on primary care providers and services, which may include pediatric and obstetric care.

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:

Creating a learning and supporting environment between urban obstetricians and maternal-fetal medicine specialists with rural family medicine, nurse practitioners, and doulas that enhances care provided to rural infants and people of childbearing age is vital to improving maternal and child health. This type of hub-and-spoke model provides access to prenatal care and timely urgent care.

The State and MCOs can invest in care coordination programs that focus on maternal and child health. Care navigators or care managers can be assigned to pregnant individuals to ensure they receive appropriate care, follow-up, and support. These professionals can also connect individuals to social services and community resources.

The State can require the use of Managed Care navigators or maternal child health specialists can be employed to offer support to high-risk people between medical visits and connect pregnant and parenting people to social supports.

Grants like the Health Resources and Services Administration's (HRSA's) Rural Maternity and Obstetrics Management Strategies (RMOMS) support this type of effort. The RMOMS grant provides funding for tele-maternity, which includes a tablet with embedded devices that monitor and report blood pressure, weight, oxygen level, glucose level, and fetal heart rates for pregnant individuals.

States can help MCOs develop models that will provide Cultural Competency Training and resources to healthcare providers to help ensure cultural competency and sensitivity in maternal and child health care. This is especially important for addressing disparities in healthcare outcomes among Medicaid populations.

Finally, requiring that MCOs pursue contracts with (and even develop access to) community-based organizations can offer a short-term alternative to providing access to maternal and childcare.

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:

In addition to the enhanced funding mechanisms described in this RFI, the State may consider leveraging the 1115 waiver demonstration to offer enhanced provider payment rates to specific provider types that may include maternal and child health providers that also include doulas.

The State may want to consider bundling maternity services that consider prenatal to post-partum services as a maternal episode of care. This payment structure incentivizes continuity of care and considers that service needs of both mother and baby.

Finally, MCO reinvestment funds can be used to increase the availability of birth centers as a possible safe and lower cost model of care.

IV. Market & Network Stability

1. Service Area

Currently, Nevada Medicaid has four managed care plans serving two counties—urban Washoe and Clark Counties. For the upcoming expansion and procurement, the Division is considering whether all contracted plans should serve the entire state, or if the State should take a different approach and establish specific service areas. For example, the Division could contract with at least two qualified plans in certain rural regions or counties but contract with more than two qualified plans in more densely populated counties. The goal would be to provide greater market stability, sufficient access to care, and quality plan choice for recipients.

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:

The decision to implement a singular service area for Nevada's Medicaid program under the Managed Care Contracts or transition to regional- or county-based service areas has implications for care delivery, management, and overall efficiency. Advantages and disadvantages for each approach are listed below.

Single Service Area (State as One Service Area):

Advantages:

Uniformity: A single service area helps ensure consistent services, rules, and coverage throughout the State.

Administrative Simplicity: Fewer administrative boundaries and potential jurisdictional challenges are present when handling service provision and contract negotiations.

Disadvantages:

Lack of Customization: A one-size-fits-all model might not adequately address the unique needs of different regions, especially considering the vast differences between urban areas such as Washoe and Clark Counties, as well as rural and remote areas across the State.

Resource Allocation Challenges: Centralizing into one service area could lead to distribution inefficiencies; some regions might receive excess resources, while others might be underserved. Telehealth is one example in which rural areas, due to potential Wi-Fi connectivity challenges, might not benefit as much as urban areas.

Multiple Regional- or County-Based Service Areas:

Advantages:

Tailored Services: Every region has a unique set of needs and challenges. Adopting a regional service area approach may pave the way for more service provisions, precisely aligning with local requirements. Building region-specific funding initiatives could establish incentives that attract providers to areas currently underserved. This strategy helps ensure healthcare services are more evenly distributed and alleviates the transportation burdens faced by residents of rural areas, bringing essential services closer to the members who need them.

Local Governance: Local entities often better understand regional healthcare demands, enabling the establishment of tailored healthcare practices (e.g., primary or diabetes care clinics). By procuring local funding, provider services can align more precisely with community needs. Another advantage includes engaging diverse linguistic groups, necessitating interpreters and culturally tailored care. Nevada's indigenous communities, mainly in rural and remote areas, also have unique healthcare needs.

Disadvantages:

Administrative Complexity: Multiple service areas could lead to increased administrative overhead due to the need to manage multiple contracts and jurisdictional nuances.

Inequity: There might be disparities in the quality of services or resources available in different regions, potentially leading to inequity in healthcare outcomes.

Potential for Fragmented Care: With multiple service providers, there is a risk of fragmented care, which might negatively impact patient outcomes.

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:

When establishing service areas for Medicaid managed care plans, striking a balance between recipient choice, market competition, market stability, and provider reimbursement provides a stable system for the members and providers. Some best practices based on specific state examples include consideration of geographic regions and population density, network adequacy standards, telehealth expansion, provider recruitment and retention incentives, community engagement, and market stability measures.

1. Geographic Regions and Population Density:

- Divide service areas based on geographic regions or population density. This approach helps ensure rural and urban areas receive appropriate attention and manage costs effectively.

Example – Iowa: Iowa has implemented geographic proximity requirements, mandating MCOs to maintain a certain number of primary care providers, specialists, and hospitals within a specified distance of rural beneficiaries. This helps ensure rural residents have access to essential healthcare services without the need for long-distance travel.

2. Network Adequacy Standards:

- Implement and enforce strict network adequacy standards tailored to rural areas. These standards might consider factors like travel time and distance.

Example – California: California encourages MCOs to collaborate with rural health clinics (RHCs) to expand access to care in rural areas. RHCs often serve as vital sources of primary care for rural populations, and partnerships with MCOs can help ensure their sustainability.

3. Telehealth Expansion:

- Promote the use of telehealth services to bridge the gap in access to healthcare in rural and remote areas. Encourage MCOs to include telehealth providers in their networks.

Example – Alaska: Alaska expanded telehealth services to rural and remote areas. This initiative allowed rural beneficiaries to access healthcare services conveniently and improved healthcare outcomes in these regions.

4. Provider Recruitment and Retention Incentives:

- Offer financial incentives to healthcare providers who establish practices in underserved, rural regions. These incentives can include enhanced reimbursement rates, loan repayment programs, and support for provider recruitment initiatives.

Example – North Dakota: North Dakota has implemented various incentive programs to attract and retain healthcare providers in rural areas, including loan repayment programs for physicians and nurses who practice in underserved regions.

5. Community Engagement:

- Engage with local communities and affected parties, including rural healthcare providers, to gather insights into their unique healthcare needs. Community input can effectively help tailor service areas to local requirements.

Example – Montana: Montana actively engages rural communities through advisory councils and community meetings to understand their specific healthcare challenges and needs. This input informs the development of Medicaid Managed Care service areas in the state.

6. Market Stability Measures:

- Implement measures to stabilize the rural healthcare market, such as risk-sharing agreements or reinsurance programs. These mechanisms can help manage costs while ensuring financial viability for providers in less densely populated areas.

Example – Wyoming: Wyoming has explored risk-sharing agreements with MCOs to stabilize the rural healthcare market. These agreements aim to address financial uncertainties and help ensure the availability of healthcare services in rural communities.

Embracing these best practices offers a thoughtful path for designing Medicaid Managed Care service areas. This approach prioritizes beneficiary choice, encourages healthy market competition, promotes stability, and aims for fair provider reimbursement. By adopting similar practices, the hope is to enhance the accessibility of quality healthcare, especially in rural regions.

2. Algorithm for Assignment

For the first Contract Year of the current Contract Period, recipients were assigned to managed care plans based on an algorithm that prioritized new plans to Nevada Medicaid's market. There were notable benefits and challenges to this approach. Going forward, the Division is implementing a quality-based algorithm as previously described that also presents its own unique challenges and benefits.

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:

Building on the foundation of the quality-based algorithm, the Division might explore additional innovative strategies to further enrich beneficiary enrollment.

1. **Community Health Needs Assessment (CHNA) Alignment:** Collaborate with managed care plans to conduct CHNAs and align assignment algorithms with identified community health needs. Plans that demonstrate a thorough understanding of local health needs and propose effective solutions could be prioritized in beneficiary assignments.
2. **Performance-Based Contracting:** Implement performance-based contracting that includes incentives for plans to meet specific quality and access benchmarks. High-performing plans could be rewarded with a larger share of beneficiary assignments, promoting competition based on outcomes.
3. **Beneficiary Feedback Integration:** Incorporate beneficiary feedback into the assignment algorithm. Plans that actively engage with and address beneficiary concerns and preferences could receive higher assignment rates, encouraging a patient-centered approach.

4. **Risk-Sharing Arrangements:** Explore risk-sharing arrangements that allocate financial risk between the Division and managed care plans. Plans willing to take on more risk for cost control and quality improvement could receive preferential assignments.
5. **Health Equity Focus:** Develop an assignment algorithm that prioritizes plans committed to addressing health disparities and achieving health equity. Plans that demonstrate innovative approaches for reducing health disparities may receive higher assignment rates.
6. **VBP Tiers:** Create tiers within the assignment algorithm based on VBP models. Plans that actively participate in value-based arrangements and demonstrate improved outcomes and cost savings could be placed in higher tiers for beneficiary assignments.
7. **Member Education and Decision Support:** Invest in member education and decision support tools to help beneficiaries make informed choices when selecting plans. Plans that actively contribute to member education and support could be rewarded with higher assignment rates.
8. **Quality Improvement Partnerships:** Establish partnerships between the Division and managed care plans to work jointly on quality improvement initiatives. Plans that actively engage in collaborative quality improvement efforts could receive favorable assignments.
9. **Real-Time Data Integration:** Develop a system that allows real-time data integration to monitor plan performance and beneficiary preferences. Plans that adapt quickly to changing conditions and preferences could be favored in assignments.
10. **Provider Network Expansion:** Plans that actively invest in network adequacy and provider recruitment in underserved regions could receive increased beneficiary assignments.
11. **Transparency and Accountability:** Emphasize transparency in plan performance reporting and hold plans accountable for meeting established benchmarks. Plans that consistently meet or exceed expectations could be considered for higher assignment rates.
12. **Risk-Stratified Assignment:** Implement an assignment algorithm that stratifies beneficiaries based on their risk profiles, helping ensure that higher-risk beneficiaries are matched with plans equipped to meet their specific needs.

By thoughtfully integrating some of these innovative strategies alongside the current quality-based algorithm, the Division may be able to nurture a more stable market environment and foster healthy competition. This collaborative approach is a testament to the Division's commitment to continually uplift the quality of care and access for valued Medicaid beneficiaries.

V. Value-Based Payment Design

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 incentivize 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. With Nevada's ongoing health disparities and the rising cost of health care, these strategies are critical to ensuring the success and sustainability of the State's Medicaid program.

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:

State Medicaid programs are increasingly implementing a variety of VBP models with the objective of greater efficiency and improved outcomes. Advanced financial models with VBP have included global budgeting and episode-based payments and Delivery System Reform Incentive Payments (DSRIP). The use of accountable care organizations (ACOs) in Medicare may also provide structural examples that could be attempted in Medicaid. ACOs have garnered attention as a potential blueprint for improving care coordination, controlling costs, and enhancing healthcare quality in Medicaid. The ACO model's emphasis on care integration, quality, patient-centeredness, and financial incentives can be adapted to the unique requirements of Medicaid programs, with the potential to enhance the overall effectiveness and sustainability of healthcare delivery. Thoughtful implementation involving careful planning, state-level customization, and collaboration with stakeholders that includes continuous evaluation helps ensure that the benefits of the structure effectively serve the Medicaid population needs.

Directed payments in many states have included significant VBP using preprint vehicles under the VBP option within 438 (c) pre-prints or nested within other options allowed Directed Payment designs. Directed Payment Programs provide examples throughout the country where incentives are created for access, workforce development and quality focused outcomes. For example, one of Michigan's Directed Payment programs was leveraged to enhance and maintain educational opportunities for student doctors and residents through educational contracts across the entire state. The state reported that in April 2017, approximately 50% of all Medicaid physicians in Michigan (approximately 9,600) enrolled in the program.

Beginning with the State Fiscal Year (SFY) 2017-18 rating period, California directed Managed Care Plans (MCPs) to reimburse California's 21 Designated Public Hospitals (DPHs) for network contracted services delivered by DPH systems, enhanced by either a uniform percentage ("CA DPH Capitated Uniform") or dollar increment based ("DPH FFS Uniform") on actual utilization of network contracted services. The state evaluates payments based on achieving identified goals. These may only apply to certain managed care categories of aid. The payments are enhanced

by either a uniform percentage or dollar increment. The total funding available for the enhanced network contracted payments will be limited to a predetermined amount (pool).

California implemented the directed payment structure for payments by Medi-Cal Managed Care Plans (MCPs) to contracted Designated Public Hospital systems (DPHs) who are reimbursed primarily on a capitated basis. The directed payment supports DPHs that provide critical services to Medi-Cal managed care members. For each class of providers, the state establishes two sub-pools for that provider class. The two sub-pools consist of total amounts for:

1) Uniform percent increases to payments for capitated contractual arrangements
2) Uniform dollar amount payments for fee-for-service (FFS) contractual arrangements
    a. Contracted inpatient services
    b. Contracted non-inpatient services

When MCPs contract with an eligible provider, within the designated classes, based on a capitated arrangement, they are directed to make uniform percent increases to their contracted capitated payments to these providers for payments associated with assigned Medi-Cal managed care members. This helps provide critical care and access to highly vulnerable populations served historically by DPHs.

California has multiple other Directed Payments that pay a percent of total reimbursement based on scoring metrics for pay for performance (P4P) and value (VBP) metrics.

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:

The State could consider leveraging quality improvement and population health tactics designed to monitor the success of these arrangement, with the intent being to improve and maintain access to care. As an example, the State can require or facilitate the process of working with providers to review community health needs assessments and empirical surveillance data to create tactical interventions that directly address certain statistical outliers such as infant mortality rates, smoking, and other areas of concern.

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

Response:

Developing effective VBP models catering to the specific needs of rural and underserved areas involves engaging local communities. Valuing and helping to implement provider telehealth capabilities improves access and keeps members involved in their healthcare. The State may also want to implement provider risk-adjustment for higher acuity members involving diverse patient populations. Adjusting for the additional services involved in these members assists in building financial protections for healthcare providers serving in these areas.

Models that prioritize care coordination and data sharing are complications built into the geographic dispersal of rural providers. Building models that focus on relevant outcome

measurements, patient-centered care, and the use of community health workers as well as reimbursement for sustaining informal support workers can further enhance care quality. Flexibility in model design, continuous monitoring, policy advocacy, provider training, and a focus on long-term sustainability assist states in helping ensure that the VBP models are tailored to remote and underserved regions, impact the populations intended, and ultimately improve healthcare access and outcomes in rural and remote communities.

VI. Coverage of Social Determinants of Health (SDOH)

Nevada Medicaid is currently seeking federal approval to cover housing supports and services and meal supports under federal "in lieu of" services authority. This allows managed care plans to use Medicaid funds to pay for these services in support of their members. Today, all four plans provide limited coverage of these services by using their profits to pay for them. The goal of seeking approval of "in lieu of" coverage for these services is to increase the availability of these services in the Medicaid Managed Care Program for more recipients.

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:

In the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule, CMS highlighted services that can be considered as in lieu of services (ILOS) targeted toward specific populations. For example, outside of housing and meal support, transportation services at a sobering center can serve to divert emergency room visits and housing transition navigation services as appropriate examples of ILOS. The State can also services such as non-medical transportation, education, community service, vocational training, and caregiving.

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:

CMS's most recent Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule identifies strategies for implementing and monitoring innovative programs in managed care that are anchored in building on the CMS Health Equity Framework. In response to CMS efforts, we have assisted states in advancing efforts in increasing access to services through procurement opportunities such as building in requirements for MCOs to develop an internal organizational culture and capacity to focus on health equity. The goal across each activity is to help MCOs focus on SDOH across all aspects of their Medicaid business efforts; strengthen their community capacity to provide high-quality, member-centered services; and consider the effectiveness of the non-medical interventions and the role of community-based organizations to improve health outcomes. In addition to infusing Health Equity in the procurement and MCO contract space, states like North Carolina are requiring MCOs to offer a "Healthy Opportunities Pilot" that makes available fund approved services related to housing, food, transportation, and interpersonal safety and toxic stress that have a direct impact on health. Addressing health equity requires a commitment to continuous improvement and ongoing evaluation of efforts.

Notable strategies include:

1. Include a health equity lead among key staff members to champion initiatives that would foster a cultural capacity to keep health equity and SDOH at the forefront.
2. Establish a health equity committee at the highest level of the MCO's organizational structure to identify innovative approaches for addressing the non-medical and medical needs of members based on data-driven, informed models.
3. Require MCOs to couple telehealth availability with tech-enabled solutions, such as web-based applications, that empower members to manage their own care.
4. Partner with communities and affected parties to strengthen the ability to coordinate non-medical services.

For additional mechanisms to promote health equity, please see the CMS fact sheet regarding health equity: CMS Health Equity Fact Sheet.

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:

The State's community reinvestment requirements direct MCOs to reinvest a portion of annual pretax dollars to fund, at a minimum, Project Echo and Nevada's Perinatal Quality Collaborative. Given concerns inherent with expanding Medicaid Managed Care to rural and remote areas, the State could consider issuing a "Rural Community Reinvestment Strategy" that provides a uniform framework for key areas and communities in need of additional supports outside of Medicaid/ CHIP services. For example, the State could consider directing MCOs to reinvest pretax dollars in workforce development, targeting priority occupations, including childcare givers among other professionals. Other areas of reinvestment may include:

- Infrastructure development intended to increase service availability and/or housing
- Getting rides to non-medical appointments
- Apprenticeship programs for targeted populations
- College tuition support
- Community investment (parks, playgrounds, access to healthy food)
- Loan repayments

Reinvesting Medicaid funds to advance health equity is a powerful way to holistically address the needs of members. This type of effort requires cross-sector collaboration to be effective and to foster innovation. Studies have shown that such cross-sector collaboration can yield substantial long-term gains, with returns on investment often exceeding expectations through the establishment of enduring partnerships.

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.

Response:

Effective communications will be critical to support the expansion of State's Medicaid Managed Care Program. Below are some best practices for the State to consider:

1. Provider training is critical in learning to work within the managed care framework. Provide training around contracting with MCOs, negotiating rates, prior authorization requirements, and claims payment processing.
2. Find ways to streamline across the managed care program where possible so that providers do not have to follow separate processes for each MCOs. Require that MCOs have a web-based platform to streamline the review and approval of prior authorization requests.
3. Setting up a detection system for identifying early warning signs after implementation by:
    - Requiring MCOs to submit claims payment status reports (paid, appended, denied)
    - Taking value in member and provider experiences by setting up a mechanism to triage, track and trend issues
    - Looking at the whole picture of how the system is developing by bringing together findings across all information modalities