Dr. Enrique Enguidanos
Founder & CEO, CBCS

RE: RFI for Nevada Medicaid Managed Care Expansion

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? **NO ANSWER**

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? **NO ANSWER**

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? **NO ANSWER**

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? **NO ANSWER**

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. **NO ANSWER**

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? **NO ANSWER**

B. Are there best practices from other states that could be used to increase the availability of behavioral health services in the home and community setting in rural and remote areas of the State? **NO ANSWER**

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? **NO ANSWER**

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 percent 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?*

Answer:

Leverage Direct Engagement

At CBCS, we believe that the best outcomes are community driven. Our team members live in the communities serve. They are experienced at navigating the local resources that are available. Our staff have lived experience with the very challenges they now help others overcome. They may be former addicts, previously incarcerated persons or those who have experienced homelessness. This seasoned, boots-on-the-ground approach allows us to forge genuine connections with each high-utilizer, increasing the chances of compliance and success. By connecting the complex high utilizers in the Emergency Department (ED), our team can engage with the patient and their care team. The team simultaneously works to gain the trust of the patient while collaborating with the care team to locate and secure the appropriate community resources.

- INITIAL CONTACT
- CONTINUAL CONTACT
- CRISIS AVAILABILITY

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? **NO ANSWER**

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 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. **NO ANSWER**

B. Please describe any other best practices used in other states that the Division should consider when establishing its service area(s) for managed care plans that have balanced the goal of ensuring recipient choice and market competition (price control) with market stability and sufficient provider reimbursement. **NO ANSWER**

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? **NO ANSWER**

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? **NO ANSWER**

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? **NO ANSWER**

C. What considerations should the Division keep in mind for promoting the use of value-based payment design with rural providers? **NO ANSWER**

VI. Coverage of Social Determinants of Health

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? **NO ANSWER**

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? **NO ANSWER**

C. Nevada requires managed care plans to invest at least 3 percent of their pre-tax profits on certain community organizations and programs aimed at addressing social determinants of health. Are there any changes to this program that could be made to further address these challenges facing Medicaid recipients in support of improving health outcomes? **NO ANSWER**

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.

Answer:

Innovative Approach to Decreasing High Utilization of ED Services

As a doctor with more than 25 years of clinical experience in Emergency Medicine, our founder has seen communities struggle to serve patients who are resistant to typical health care solutions. As a result, they utilize more health care resources and often fail to achieve long-term quality health outcomes, thus driving up costs across the system. Our evidence-based process is the product of years of community engagement.

A significant number of high utilizers of our health care system have unique medical conditions which are often impacted by social circumstances, such as homelessness, substance use disorders, and behavioral health issues. Many are resistant to typical care coordination services. The unique circumstances surrounding these individuals make them best served by staff available live, 24/7 within the community, those familiar with their unique needs and who have an intimate knowledge of community resources.

Innovative Approach & Best Practices

Our priority is to help payers and providers improve health outcomes and control costs among high utilizers by staying focused on a few core priorities:

- Find and engage clients where they are.
- Coordinate with existing community resources.
- Provide 24/7/365 availability.

Our key performance indicators (KPIs) include ED visit reductions, hospital admissions and length of stay reductions, decreased out-patient no-show rates, decreased emergent community resource use (EMS and law enforcement calls), increased patient/provider/resource satisfaction, decreased controlled substance use, decreased homelessness, and lower costs.

To achieve target KPIs, employ six best practices:

1. **Direct patient engagement.** We meet the potential enrollees where they are, and often when they need us most. Our team is available 24/7/365 for clients and community partners.
2. **Employ live staff in every community served**. This level of intense client resource management makes a significant difference –the results are apparent within months of enrollment and community resources are used more effectively, which causes the crisis

events to decrease. Staff living within the communities that we serve are *the* main differentiator of a successful high utilization program.

3. **Constant engagement of community resources**, such as hospitals, primary care offices, substance use rehabilitation centers, psychiatric care facilities and behavioral health facilities, EMS agencies, jail services, housing authorities, law enforcement agencies, food bank services, etc. Building community relationships and expanding the interdisciplinary care team strengths the quality of care.
4. **Create individualized care plans** for each client enrolled. Customized, patient centric care plans are an indispensable treatment tool.
5. **Integrate or launch community IT systems** to promote shared client information in a HIPAA-compliant fashion, to ensure pertinent health information is made available to providers and community resources in an efficient and timely manner.
6. **Create an Immediate Access Fund**, which empowers staff by providing them with resources to deliver immediate unmet social determinants of health (SDOH) needs for enrollees, such as cell phones, transportation, clothing, food, medications, and housing.

This unique approach to care navigation is driving improved health outcomes for enrollees and delivering significant cost savings throughout the country.

Lessons from past programs:
Virginia:

Our objective in Virginia is to support the Joint Medicaid Oversight Committee in its efforts to identify innovative approaches that are improving health outcomes and reducing costs. Below is a summary of a program that CBCS is currently conducting.

In December 2021, CBCS launched a partnership with the Virginia Department of Behavioral Health and Development Services (DBHDS), establishing the High Utilizers of Virginia (HUV) program. The target program population are individuals with a recent state psychiatric hospital admission, and/or considered to be at risk for a state psychiatric hospital admission. The HUV program goals include:

- Improve the care of enrollees.
- Decrease duplication of care efforts across the healthcare community.
- Reduce mental health admissions of enrollees.
- Reduce general hospital admissions of enrollees.
- Reduce ED visits of enrollees.
- Reduce cost of care.

The HUV program emphasizes in-person engagement with individuals at time of enrollment, as well as close collaboration and coordination with local resources. Our CBCS team provides 24/7/365 program access for program enrollees, including crisis availability. As we develop customized care plans for each enrollee, we share that data with providers. Our team follows up with enrollees after each provider encounter.

Year 1 HUV results included:

- **97% reduction in state psychiatric hospital admissions**
- **82% reduction in state psychiatric hospital admit days**
- **31% reduction in ED visits**
- **$2.9M annual cost savings (based on admission and ED visit reductions)**
    - **~$53,704 savings per enrollee per year**

Our work in Virginia is just one example of a successful, innovative partnership that is improving health outcomes while reducing costs.

<u>Alaska:</u>
Our program in Alaska focused on social determinants of health (SDoH) needs. Patients with high-risk behaviors require more than standard medical care can offer in order to address the underlying social determinants that impact overall health. By adopting CBCS' holistic community-based approach, the Links Social Services program—funded by the Mat-Su Health Foundation—achieved significant results in improving patient outcomes and bottom-line cost.

Partnering with CBCS, the HUMS program achieved an average 57% reduction in ED utilization, a 47% reduction in opioid prescriptions, and over $4 million in savings over two years.

Social determinants of health have a significant impact on patient care, affecting an estimated two-thirds of patients and accounting for roughly 80% of a patient's health outcomes. At the Mat-Su Health Foundation in Wasilla, Alaska, external programs and partnerships were put in place and funded to help address these social determinants. In addition, due to the patients' comorbid behavioral health diagnoses, special resources—including a behavioral health crisis intervention team—were made available. The institution of our program increased the number of patients who continued their engagement post discharge.