COMMUNITY HEALTH ALLIANCE

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section 1: Provider Networks

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?

The Division should require each managed care organization (MCO) to research improved contracting that supports provider availability and access from similar rural states like Wyoming, Arizona, South Dakota, and Montana. Require the MCO's to publicly post/present their findings to all stakeholders.

The Division should consider requiring the MCO's to be involved in the review of what works/doesn't work in Nevada's rural areas, what needs to be changed, the implementation of those changes, and safeguards of the changes.

The Division could consider repercussions for any MCO that does not participate as mandated. Historically, policies/regulations/guidelines exist but the MCOs are not consistently held accountable.

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?

The Division should require each MCO to research and present on other state's strategies for ensuring rural providers are receiving sufficient payment rates. The Division could consider reporting and transparency requirements of provider payment rates. The Division could require removal of negotiation needs and consider requiring the utilization of current, market payment rates. Additionally, require that any provider type is treated equally no matter what type of healthcare coverage they empanel (providers should not be treated differently because they regularly engage in Medicaid visits).

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

The Division should consider requiring rural community members and rural health center staff, that are proven to be in direct involvement with provider employment and sustainability, to be part of the proposed Workforce.

Include clearly defined data reporting requirements, an assessment of current vs. future workforce needs and effective/transparent communication with all stakeholders regarding identified challenges, strategic plan progress, and any plan redirection.

Effectiveness could be measured by provider staffing sustainability within transparent reporting provided to all stakeholders.

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?

Yes. It would be best to require each of the MCO's to perform research on other similar state's (Wyoming, Arizona, South Dakota, and Montana) and post/present that information to all stakeholders. This type of research is extremely time consuming and given the exponential difference in what managed care organization employees make vs. provider group employees, I believe it is best to place this task on the plans.

The best practice that has proven to provide effective healthcare delivery is universal healthcare for all. Universal healthcare coverage may not currently be realistic for Nevada, but there are strategic aspects of what has worked in Sweden (and other Universal care areas) worth evaluating and considering. These types of changes most likely need to be initiated legislatively. The Division could consider requiring legislative involvement by the MCO's where they must present a positively impactful proposal to appropriate state officials for consideration.

Arizona has implemented an improvement plan that includes a strategic roadmap to address prioritized state issues. azhip-2021-2025.pdf (azdhs.gov) This could be used as guidance examples but would need to be modified to meet the needs of Nevada. Additionally, the implementation plan would need to be monitored for accountability.

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.

The inconsistencies, portal access issues, and varying requirements for credentialing providers across each of the MCO's is time consuming, costly, and affects the timing that a provider may initiate patient visits (thus access to patient care). It should be required that all streamline with centralized credentialing with the Division and in no way can any MCO sway from this requirement, regardless of what their corporate level policies/procedures dictate. Currently, there are inconsistencies and unnecessary requirements for contracting and credentialing varying provider types with each managed care organization. The most challenging is any provider type that is not an MD, PA or NP. If a provider is behavioral health or any type of specialty, then the practice runs into increased challenges and barriers. For example, HPN requires behavioral health providers to be credentialed by a completely different HPN/UHC team than medical providers. This is a completely different team and process. All provider credentialing and contracting requirements should be consistent, simplified, and accessible.

Each managed care organization should be required to provide realistic pay rates to each provider type and possibly increased rates to the most challenging provider types to obtain/sustain in Nevada (specialty providers that regularly see the Medicaid population and behavioral health providers). Provider pay rates should be decided on a state specific, current market value and not on what the MCO is dictated by their corporate office (who is most likely outside of Nevada).

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?

Other states have been legislatively mandated to provide the wifi access and/or telephonic equipment needed to rural community area residents.

The Division should require each MCO to research strategies that support telehealth modalities and behavioral health access from similar rural states like Wyoming, Arizona, South Dakota, and Montana. Require the MCO's to publicly post/present their findings to all stakeholders.

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?

Yes, and these best practices include removing the barriers to getting out of state or new behavioral health providers licensed, enrolled and credentialed. The wait time to get an out of state provider licensed in Nevada is currently taking up to 6 months and is the most time consuming and impacting to any provider group in Nevada.

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?

Yes. This would be a wise consideration.

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?

Requiring the removal of barriers in order to set these incentive programs up for success; require each MCO has a contract in place with the provider group that supports these lines of service and if they don't require an amendment to provide that allowance, require each MCO to invest in future providers by paying for their schooling or reimbursing for educational costs, require each MCO to research and present on best practices that support state-wide provider sustainability, require each MCO to establish a grant towards education and training for these lines of service, and require each MCO to implement a bonus program for specialty providers that are most needed in Nevada.

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?

There are provider payment models that have proven to support improved health outcomes. Pay-for-performance is one of them. I have seen that the best models are those that are clearly communicated/easy to understand in contract language and realistic for the provider team to participate in. If an MCO includes ambiguous language or complex calculations, then the provider team is less likely to put in the additional effort to ensure that they are meeting the metric requirements. If the MCO has an unrealistic threshold requirement, for example requires the provider group to meet 4 of 6 prioritized metrics with a score over 80%, and the provider group cannot realistically meet this then they are very unlikely to participate. It is important to have the provider buy-in or there is no point.

Require the MCO's to research and present their findings on payment models that support improved outcomes from Wyoming, Arizona, South Dakota and Montana.

IV. Market & Network Stability

1. <u>Service Area:</u>

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.

Our understanding is that each MCO plan is responsible for ensuring adequate access to not only primary care but specialty services, as well. In the urban area of Northern Nevada, Community Health Alliance struggles to find adequate in and out of network providers for a number of specialty areas (GI, Neurology, Behavioral Health). We have worked with the MCO's and have been unsuccessful in locating sufficient access. If it's a problem in urban areas, how could it be successful in rural areas?

DHCFP is responsible for holding the MCO plans accountable for ensuring access to care, especially for children under the EPSDT rules. Has network adequacy for FFS patients in the rural and frontier areas for PCP and specialty services been assessed? If access is a known problem, how does DHCFP plan to hold the MCO's accountable for resolving the issue? Patients are forced to travel, sometimes long distances, in order to access services. We are currently addressing 1 to 2 single case agreements a month with an MCO in order to address urgent referral needs. Some of these are requesting flights to Southern Nevada. If the transportation pushed a patient into another market area (regional or county, e.g.), will that further complicate the providers accepting referrals to get reimbursed? If so, what's in it for the specialty provider? It's already difficult to locate referral partners and if their ability to provide services to a patient from another region or county becomes more complex, this will worsen the problem for the PCP and most importantly the patient. Can the Division require and enforce that the MCO's employ their own specialists like the old Southwest Medical Group of UnitedHealthCare (HPN)?

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.

Sufficient access to specialty services is the fundamental problem in Northern Nevada. Recipient choice suggests there are sufficient numbers of providers. While that sufficiency might exist for the PCP, the PCP and its agency are left holding the bag for making any medically necessary referrals. The providers do not receive sufficient compensation to cover the administrative costs of trying to follow through on the referrals. The Division should consider increasing provider reimbursement for known specialty shortages, administrative time spent addressing referral submission and follow through, as well as incentivizing the patient to follow through with the complexities of being transported long distances. E.g. in urban Northern Nevada, we may have to work on transporting a patient to Las Vegas, Salt Lake City or some place in Northern California such as UC Davis, Stanford or San Francisco.

The Division should require each MCO to research best practices that support recipient choice and price control from similar rural states like Wyoming, Arizona, South Dakota, and Montana. Require the MCO's to publicly post/present their findings to all stakeholders.

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?

If allowable under the beneficiary inducement laws, provide Medicaid recipients who choose an MCO plan with an incentive based on the amount of time they made their enrollment decision. E.g. 1-15 days – a $50 gift card; 16-30 days a $25 gift card. If recipients chooses a plan that has an allowable inducement, that would be supportive evidence that the recipients are motivated by a gift card. One of the fundamental problems is the MCO plans and therefore their in-network providers, have inadequate information to follow through on their enrollment activities. If the patient does not have an active or accurate phone number, the system defers to mailing documents that are returned with no known address. How are other state Medicaid Divisions successful with maintaining accurate eligibility documentation? Post Covid, there was national data on which states have seen the lowest drop in their Medicaid enrollment due to the end of the emergency preparedness status - how was this achieved?

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?

The value-based payment design should be applicable to all provider groups, including FQHCs, or have specific FQHC supportive language.

The minimization or removal of thresholds requirements for provider groups. These thresholds are often not realistic for the provider group (definitely unrealistic for an FQHC) and if a provider is unable to meet the threshold, then they do not receive anything. Any work they have done towards the gap closure is not recognized and the provider is less likely to participate in any future incentivized projects.
The removal of complex, formula based value- based models/agreements. These types of agreements only cause confusion for all parties and the provider teams are less likely to participate if they don't understand how they could meet the contracted metrics to receive an incentive.

Do not allow MCO's to utilize templated value-based agreements that are distributed at a corporate level. These "cookie cutter" agreements may work well in other states but are not written to address Nevada state structure, policies, and provider practice needs. These agreements are not written to apply to an FQHC. These agreements require multiple amendments, cause a poor incentive outcome for the provider group, and cause a delay in incentive payment processing.

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?

Require simplified value-based agreements that are best supported by a current baseline FFS provider agreement.

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

Keep in mind the impact of being in a rural location. As with most provider practices anywhere in Nevada, the "cookie cutter" agreements with templated metrics and outcome expectations do not work. Flexibility and adaptability with agreement writing is essential. Success will be dependent on realistic measures and provider buy-in. Provider buy-in may include the addition of individual provider incentives or bonuses.

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?

The Division should consider legal services, child care, transportation, and utility support. Consider additional housing resources, for example, shelters and housing options for individuals with Medicaid is essential.

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?

The Division should build in incentives for utilization of PRAPARE form completion and/or other available SDoH data platforms that provide the needed data for submission.

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?

Additional grants/funding to grow and sustain the Community Health Worker taskforce. Require education training provided and/or funded by the MCOs to CHWs to address HEDIS metrics that align with the value-based agreements.

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.

Look at the root causes; If one root cause is access, look at the reimbursement structure and whether administrative hassles such as prior authorizations are a deterrent for providers. If a root cause is the challenge of licensing boards taking extreme amounts of time to license new and providers trying to come into the state, then work with the Executive Branch to mandate improvement of the licensing board response times. Create a financial incentive for provider groups (including FQHCs) who are actively working to help resolve the access problems and grow the marketplace by paying for their performance specific to provider recruitment. Is the root cause poor information from DWSS specific to reliable patient information? Reward DWSS staff who have higher MCO enrollment outcomes.

The Division and the Health Plans seem quick to point the finger at the patients who are nonresponsive or not responsible for updating their personal information with the State. What is the root cause of this issue? Could improved guidance, notifications, or education be provided and on more platforms? How are patients rewarded who do maintain contact with DWSS? The patients may be more susceptible to

participating in updating their information if they receive an incentive, for example, a gift card that provides internet access or pays their utility bill. Many of these patients live every day balancing multiple crises due to their social drivers of health. It is challenging to understand why a patient would make a visit to their PCP a priority if transportation is a challenge and they have to take their kid(s) out of school to see a provider, but that involves multiple bus transfers and hours waiting in inclement weather. Finding the root cause of the issue then identifying the best fitting resources should guide these solutions.