STATE OF NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Information for the Nevada Medicaid Managed Care Expansion

RESPONSE DEADLINE: OCTOBER 17, 2023, 4:00 PM PST

October 6, 2023

Nevada Division of Health Care Financing and Policy
1100 E. William Street, Suite 101
Carson City, Nevada 89701

Re: RFI for Nevada Medicaid Managed Care Expansion

CareSource is pleased to submit the following in response to the Division of Health Care Financing and Policy (the Division) Request for Information for the Nevada Medicaid Managed Care Expansion.

Attached we address the topics presented in the Request for Information issued July 25, 2023. We have incorporated into our response the strength of our experience and capabilities of 30 years of Medicaid experience. CareSource uses innovative programs and services with a fully integrated, transparent service delivery model to ensure members can easily access their benefits to live healthier lives.

Our talented and experienced leadership team leads CareSource with perseverance and passion, partnering with our members to help them get the care and respect they deserve. As a nonprofit family of companies, we have grown into one of the largest managed care health plan systems in the country, serving 2.3 million members.

With a strong and proud history, CareSource is committed to demonstrating our chosen service to Medicaid members. We design our programs to bring best practices from our other states, but we always tailor our programming to the specific needs of our members. Building on this legacy and focused on the future, CareSource is excited to inform the State's approach to Medicaid Managed Care, creating a comprehensive approach for Nevadans.

Sincerely,

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Section I: Provider Networks

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

Response:

Strategies and Requirements to Address Provider Availability and Access

A successful managed care program (MCP) improves access to care, especially in rural and remote communities. Based on CareSource's experience developing provider networks and addressing social determinants of health (SDOH), our recommendations include combining the use of Nevada's robust telehealth capabilities with additional technologies, expanding local provider capabilities to provide increased services, and enhancing the service array for Medicaid recipients. If implemented by the Division, these strategies can assist in addressing challenges facing rural and frontier areas of the State. In addition, the State could complete a reevaluation of rates to incentivize increased access, enhance service delivery, and ensure Medicaid is covering the total cost of the provision of care for rural and frontier services areas. We will address rates more specifically in Section I: Provider Networks B.

Technology Expansion for Better Services

We recognize the progressive work the Division has completed regarding telehealth. Nevada has already addressed many existing global post-COVID-19 challenges related to access to care for telehealth services including licensing, reimbursement, and prescribing. One of CareSource's suggestions for improving access to services is the acceptance of telephonic or audio-only services. Allowing audio-only options can reduce health equity disparities especially for behavioral health (BH) services. Audio-only options allow for easy start-up for recipients and may also increase access to those without internet services, or other live-video technology. In April 2023, audio-only visits still account for 1 in 5 primary care visits and 2 in 5 BH visits among Federally Qualified Health Centers (FQHCs) in California. In the same report, primary care visits increased by 8.5 percent and BH visits increased by 23 percent from February 2020 to August 2022[1].

Another suggestion to improve access is to expand same day billing of physical health and behavioral health to telehealth for providers without the requirement of being an FQHC. There should be consideration to expand education programs to primary care providers, so they better understand their capabilities to bill for physical health and BH services. This kind of program can dramatically increase access to care for rural recipients by allowing BH check-ins while visiting with their primary care provider. In addition, the Division should consider these same billing changes for in-person rural providers to ease the strain on BH providers in rural areas.

[1] Audio-Only Telehealth Remains Common At Many Safety Net Clinics: https://www.rand.org/news/press/2023/04/11.html

In states such as Minnesota[2], digitally capable mobile health units have proven to increase access to care and close gaps in health care for recipients. We suggest introducing mobile health units in Health Professional Shortage Area (HPSA) designations and rural or frontier communities for EPSDT screenings, and women's health care initiatives such as breast cancer screenings. The mobile health units can positively impact these mentioned preventive goals as they align with the State's quality strategy. The State could also use mobile units as primary care clinics, immunization clinics, and for free adult health screenings for blood pressure, glucose, and cholesterol checks. Nevadans could no longer have to forgo regular care because of their rural location.

Provider Capabilities

Due to the significant shortage of providers in Nevada, recipients face long wait times and travel times for basic health needs. Recipients that travel lengthy distances for care also face increased cultural challenges when they leave the comfort of their communities. CareSource recommends a strategy to develop the community health workforce to strengthen local, culturally appropriate access for recipients by implementing an ease in credentialing and increasing the capabilities of current providers by expanding their allowable services.

For example, facilitating licensure for health professionals and expanding the services some are authorized to provide can improve access to telehealth by increasing the number of providers. As members of the Interstate Medical Licensure Compact and PSYPACT, Nevada already provides an expedited licensure application process. By adding universal licensing recognition, border-state license reciprocity, and revising the scope of practice for dentists and pharmacists, the State could improve interstate mobility and increase access to care.

To increase the capabilities of current Nevada providers, the State could use pharmacists for basic medical services, such as vaccines, and physician assistants could perform many physician duties under the supervision of a licensed physician. Extending the number of approved physician assistants supervised by one licensed physician could allow for better access in rural communities. Monitoring the quality of care with an increase in oversight should also be a consideration when increasing the supervisory ability.

Developing the community health workforce should be a focus to strengthen health access both now and in the future. Community Health Workers (CHW) are a critical link for serving communities, with the State currently offering licensure for the titles of CCHWI and CCHWII. We suggest the Division support more individuals in these roles through a reimbursement program for certification and continuing education. Increasing the number of CHWs could increase cultural competence and health equity for needed communities.

Traditionally, the Indian Health Service funds and contracts Community Health Representatives (CHRs) exclusively for tribal communities. A program of Healthy Southern Nevada, Promotores de Salud, trains community members to perform roles of communication, advocacy, and education for the Latino community. These positions provide trained, practiced, community health workers from Latino and tribal communities. They can act as providers outside of their traditional locations, and may create more inclusion for rural, tribal, and Latino recipients who seek care outside of their communities.

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[2] Iqbal, A., Anil, G., Bhandari, P., Crockett, E. D., Hanson, V. M., Pendse, B. S., Eckdahl, J. S., & Horn, J. L. (2022). A Digitally Capable Mobile Health Clinic to Improve Rural Health Care in America: A Pilot Quality Improvement Study. *Mayo Clinic proceedings. Innovations, quality & outcomes*, *6*(5), 475–483. https://doi.org/10.1016/j.mayocpiqo.2022.08.002

In addition, enhancing peer support services allowable throughout the Division can create more support for recipients. A certified supervisor could supervise peer support services both through training and after certification. Incentivizing certifications or financially supporting continued education courses may motivate participation in these programs.

In Lieu of Services

CareSource recommends the Division conduct a broad, comprehensive view of the current In Lieu of Services (ILOS) and reevaluate them with rural and frontier communities in mind. Recipients who gain access to care with a provider want to be able to continue and have access to follow-up care with that provider. The State should seriously consider alternative setting ILOS to support continued access to care for recipients including lactation consultants, doula services, and CHW services. For conditions such as diabetes and chronic disease management needs, online or alternative settings could allow regular management of these diagnoses.

The State should also consider home and community-based wrap around services for recipients as ILOS. Hospital stays can be lengthy and difficult on rural families, therefore encouraging recipients to receive care at home, when possible, would alleviate some of these burdens for rural communities. These services will assist rural recipients to transition back to their home from hospital care or reside safely in their own home while receiving care.

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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:

Ensuring Rural Providers Receive Sufficient Payment Rates

To ensure rural providers receive sufficient payment rates from MCPs, you will find below that we recommend increased consistency across all MCPs. The intent is to reduce provider administrative burden, account for costs associated with health care provision in rural and frontier areas and leverage all available funding sources to wrap care around rural and frontier recipients in a sustainable manner.

State Established Rate Floors

Our recommendation is for the Division to complete a comprehensive rate study and set actuarily sound rates for providers based on actual costs. The Division should then establish a singular rate floor for all MCPs. There is the potential for the Division to incentivize the expansion of rural access by tiering rates based on location, paying higher rates for rural and frontier providers. Division established rates could reduce provider burden, while changing the incentive of the health plan to focus on increasing quality and paying for value.

Expansion of Value-Based Payment and Shared Savings Models

The Division should also consider models that allow providers reimbursement for increasing the value of the care provided. Shared savings and value-based payment (VBP) models span the continuum of incentives including pay-for-performance programs (e.g., quality rewards), shared savings, and risk models. To ensure the maximum number of providers can participate, and to reduce the burden of provider participation, the Division should establish a common set of quality metrics required for all MCPs to utilize. A common set of metrics can establish alignment between Division goals, MCP responsibilities, and the administrative requirements of the provider to collect and report. It would also allow the Division to create benchmarks and reports which can provide current and projected trend views, supporting annual evaluations of quality metrics and goals.

While the current covered services claims are generally paid within 30 days of receipt of a clean claim, the allotted 180 days from the date of service is difficult for providers to consider timely. Processing claims can be slow and burdensome for providers' staff, especially if it is a claim needing correction, prior authorization, or one that needs an eligibility check. Creating a shorter period for registered providers will create a culture of trust toward payment for services.

Maximize Additional State and Federal Funding Sources

Finally, the State cannot ignore the exploration of all federal and State funding sources. There is an opportunity to maximize Medicaid funds by aligning funds from other federal programs. For example, to reinforce the cost of care, the State could work with the US Department of Agriculture for food subsidies, the Department of Labor for workforce development, and the Department of Housing and Urban Development for housing services. The Division can align these resources, potentially braiding additional funding sources like Medicaid, Medicare, temporary assistance for needy families (TANF), supplemental nutrition assistance program (SNAP), substance abuse and mental health services administration (SAMHSA) Block Grants, and Title 4e funds, through the MCPs for a whole health approach for recipients. The State could also direct these resources to financially support newly created initiatives for rural providers. In 2022, Maine used Federal funding to support their expanded treatment of substance use disorder (SUD) in rural Maine[1]. Maine used this funding to invest in start-up costs for providers and staff training and development.

The Health Resources and Services Administration has several grant programs specifically targeted for states, schools, hospitals, health departments to support workforce development. Specifically, there is a cost-share grant for states to implement their own Loan Repayment Program for primary medical, mental/behavioral, and dental health care clinicians working in Health Professional Shortage Areas (HPSAs)[2].

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[1] Governor Mills Announces Nearly $2 Million to Expand Substance Use Disorder Treatment in Rural Maine: https://www.maine.gov/governor/mills/news/governor-mills-announces-nearly-2-million-expand-substance-use-disorder-treatment-rural-maine

[2] Apply to the State Loan Repayment Program (SLRP): https://bhw.hrsa.gov/funding/apply-grant#slrp

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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:

Requirements and Incentives for Workforce Development Strategy & Plan

CareSource supports the implementation of a new requirement that MCPs develop and invest in a Medicaid Provider Workforce Development Strategy & Plan to improve provider workforce capacity in Nevada for Medicaid recipients. A coordinated effort to improve capacity has never been more critical. We suggest the Division approach with three key strategies: increase provider workforce through recruitment; improve workforce satisfaction through a focus on training; and increase workforce capacity through strong retention programs.

Increase Provider Workforce

In May 2023, the US Department of Labor awarded $78 million for nursing programs to strengthen the workforce in 17 states. These grants will increase the number of nursing instructors and educators. They are an example of increasing capacity for additional health care workers in the future while increasing diversity.[1] CareSource suggests Nevada seek out partnerships for funding like this to enhance MCP and State efforts for expanding development programs.

A strategic focus on the growth of workforce capacity for now and the future could positively impact accessibility statewide in Nevada. The State should account for requirements and incentives to MCPs through sound processes and reimburse MCPs for any of the final chosen requirements. In following these suggestions, Nevada could create a set of offerings for MCPs to implement. These are some examples of possible MCP initiatives:

- Recruit at 6-12 grade and college level to grow current programs with an increased number of entrants
- Use programs to re-recruit Nevadans who have operated as Direct Care Workers (DCWs) and have left the field
- Design programs to increase cross-functional competencies (e.g., pharmacists giving immunizations)

[1] US Department of Labor Awards $78M for Nursing Programs to Strengthen, Diversify Workforce to Fill Quality Jobs in 17 States: https://www.dol.gov/newsroom/releases/eta/eta20230511-0

- Collaborate with higher education and others in the development and expansion of certifications of DCWs, Home Health, and CNAs
- Provide incentive payment for recent graduates of Nevada medical schools
- Provide incentives for co-locating clinical staff (e.g., Community Health Workers [CHWs] in rural/frontier)
- Create telehealth incentives
- Offer Mobile Clinic Support (i.e., gasoline, reimbursement, enhanced payments)
- Provide Value-Based Payment (VBP) agreements incentivizing rural access, telehealth, and extended hours
- Expand availability and reimbursement to school-based health staff and school-based services

Improve Satisfaction through Training

The current shortage of health care workers, coupled with high turnover rates in the workforce, can compromise the health and safety for recipients of care. To address this crisis, we suggest an improvement in training to result in potential improved job satisfaction with these efforts:

- Increase support from direct supervisory level and State administration
- Provide resources and opportunities for upskilling in current roles, including immediate rewards for training efforts
- Develop and market pathways to long-term careers for positions so workers can find valuable reasons to develop for future performance and not want to leave the field for similar positions with less educational demand and higher pay rates

Grow Workforce Capacity through Retention

A focus on retention with individuals currently serving in health care workforce roles can have a significant impact on the industry. Retention can maintain current numbers, but offers an added benefit of having seasoned, experienced workforce to mentor and train new recruits. Our suggestions for a strong retention program include:

- Financial incentives that reward time in service, with the amount of financial incentive growing as the years in service grow
- On-demand, online reviews and regular in-person skills reviews
- Incentives for the support of sound employee recognition programs to improve morale and job satisfaction
- Supporting Continuing Education Units (CEUs) for positions where required to maintain certifications
- Organizing mentor programs, especially for rural providers
- State-provided funding to further credential existing, licensed staff through reimbursement programs

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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:

Provider Requirements and Network Adequacy Standards

States use an array of provider network standards such as time and distance, provider-to-enrollee ratios, and appointment wait time to monitor access and oversee managed care provider performance. The most frequently used standards include:

- Monitoring
- Penalties
- Time and distance
- Telehealth
- Cultural competency

In setting network adequacy standards, it is imperative to take into consideration the needs of recipients in Nevada. To meet the unique health care needs of Nevada's rural and frontier communities, CareSource suggests utilizing maximum travel time and distance to providers, quality of care or recipient satisfaction, helping rural providers access specialists and facilities, and establishing cultural competency standards.

Time and Distance Standards

While the 2020 CMS Medicaid managed care final rule[1] removed the requirement that states use time and distance standards to ensure provider adequacy, we recommend maintaining this requirement. To protect recipients in rural and frontier communities, the State should continue to take time and distance standards into consideration. CMS continues to recommend states should consider how to adapt time and distance standards based on traffic patterns, car ownership, and public transportation in both urban and rural areas. CareSource is supportive of these suggestions.

In Pennsylvania, MCPs must make available to every recipient a choice of at least two appropriate PCPs with open panels whose offices are located within a travel time no greater than 30 minutes (urban) and 60 minutes (rural). This travel time is measured via public transportation, where available[2].

Recipient Satisfaction

CareSource supports recipients and honors their voice in care. As a result, we believe an indicator of network adequacy is the measurement of the quality of care by the recipient. Too

[1] CMS: Final Rule: https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf

[2] Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes: https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/

strict of a quality standard can be challenging for rural providers when considering factors such as the size of their patient base. In the case of using Net Promoter Score (NPS) to assess satisfaction, recipients can be located farther away from their rural provider, but when they have a good experience in care, they are able to give their positive feedback. We suggest utilizing the NPS as an indicator for provider performance.

Specialty Care Access

In areas where there is an inability to increase the number of specialty providers with workforce development, creating a plan for the closest tertiary facilities is key for appropriate care. Rural providers often identify the need for specialists but encounter access issues due to provider shortages. University of Nevada, Reno has an established active program assisting PCPs in rural and frontier areas in connecting with specialists for their recipients.

Cultural Competency Standards

Nevada requires MCPs to have a comprehensive, written Cultural Competency Program (CCP). The CCP must also describe provision and coordination needed for linguistic and disability-related services. CareSource suggests utilizing these plans to expand and establish cultural competency standards for better quality of care toward recipients. To expand cultural competency, the State should require MCPs to record compliance with network providers for cultural competency training and implement standards for communicating provider cultural competency to recipients, as well as publishing cultural competency markers in provider directories.

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

Response:

Identifying and Removing Barriers to Care

Established standards from providers and managed care plans (MCPs) can create barriers to care. These barriers can limit access to covered services or block services completely. Known barriers to care include:

- Recipients' lack freedom to choose providers for care
- Requirement of referral to specialists
- Physical health and behavioral health providers required to bill separately and cannot bill on the same day
- Primary care practitioners assigned by MCPs
- Provider no show/late arrival policies
- Excluded populations (i.e., ABD, LTSS, IDD)
- Covered state Medicaid benefits that do not support a full continuum of care
- Creating administrative burden, financially difficult, or restricting MCPs from implementing In Lieu of Services (ILOS)

CareSource recommends the Division prioritize change to policies and procedures that create barriers to care, ease the burden of becoming a Medicaid provider, address transportation for recipients, and create adequate systems to communicate relevant data.

Informative Selection

The State can address known barriers to care through evaluation of current policies and procedures. Allowing recipients to choose their MCP and PCP can remove barriers associated with scheduling, in-network providers, and could remove social determinants of health (SDOH), such as transportation challenges. The State should expand education materials and communication during time of enrollment, open-enrollment, and later available options to change MCP or PCP if needed. Enhancing education on the benefit, the values and the difference between plans allows for more individual SDOH needs to be met in a timely manner.

Ease Provider Burden

To increase the number of providers who accept Medicaid in Nevada, CareSource suggests easing the burden of becoming a Medicaid provider and make it easy to continue participation once established as a Medicaid provider. These tasks are currently associated with administrative burden:

- Ease of enrollment
- Easy way to track client counts
- Time to process becoming a provider, billing, and new recipients
- Large size of the current panel size
- Low provider reimbursement rates

If the Division addresses these burdens, there could be more participation in the Medicaid program by providers in urban and rural areas.

Address Transportation

Transportation is a barrier to care for both rural and urban recipients of Medicaid in Nevada. We recommend the Division address medical and non-medical transportation to remove existing barriers to care. The current transportation contract in Washoe and Clark counties will not translate well to the rural counties; however, there are federal funds available to address rural transportation with program implementation. For example, the Alabama-Tombigbee Regional Commission 5311 Transportation Program[1] currently operates 24 vans, 11 of which are handicap equipped in four counties of rural Alabama. This service provides on demand response transportation to anyone in need.

Adequate Systems Support

Integrated technology is assisting in caring for the whole recipient by providing comprehensive medical records to providers. Many providers will invest in technology to ease administrative burden associated with being a Medicaid provider. CareSource believes integrated technology can assist in providing the best available care for recipients. It is crucial to choose adequate systems to efficiently create a culture of trust between the Division, hospital systems, and providers.

The current available system, HealthHIE Nevada, is a costly option for providers requiring $0.07 per patient record. Behavioral health and physical health are in separate systems, making integration of care difficult for PCPs. Data transportability and access is a concern when considering the foster population, or general case management for recipients with multiple providers due to chronic conditions.

We recommend adapting one system for health records in Nevada. The implementation of one system can make technology administration easier and more affordable for providers across Nevada. In addition, small clinics, mobile units, FQHCs, and other provider groups would be able to report care in real time.

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[1] Rural Transportation Program: https://www.atrcregion6.com/rural-transportation-program/

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Section II: Behavioral Health Care

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

Response:

Telehealth Modalities to Address Behavioral Health Care Needs in Rural Areas

Telehealth plays a significant role in expanding access to care, especially for recipients in rural or underserved areas. CareSource recognizes the Division's accomplishments around expanding telehealth services for Nevadans, dramatically improving access to care with the most progressive telehealth in the nation.

Telehealth Incentives

We recommend the Division incorporate telehealth into a VBP program by offering enhanced reimbursement to primary care providers and behavioral health (BH) providers who offer extended recipient access through telehealth or meet certain quality or outcome targets. For example, incentivizing providers to make appointments available to pregnant recipients during their first trimester and for using telehealth to close postpartum care gaps or provide ADHD services.

Rural Behavioral Health Strategies

We recommend that the State consider utilizing BH and physical health codes outside of FQHCs, supporting Patient Centered Medical Home (PCMH) development, participation in the Health Information Exchange (HIE), and other strategies below to address behavioral health care needs in rural areas of Nevada.

- Allow for codes under BH and primary care providers, including rural areas of the State, while not limiting to those associated with FQHCs. This will allow billing for both BH and physical health within the same face-to-face visit. We believe extending this to telehealth would also be beneficial for all providers.
- Develop and enhance the capabilities of Nevada providers to offer high quality, integrated care to patients in the most appropriate setting by supporting primary care providers to become Patient-Centered Medical Homes (PCMHs) and equipping providers to enter VBP arrangements with payers. While providers do not necessarily have to be a PCMH, the State can recognize them for having the attributes of one. This will help take the burden off providers and allow the MCP to maintain attributes, including site visits and surveys, to confirm providers are performing in a way that would define a PCMH.
- Participate in the Health Information Exchange (HIE) to appropriately access and securely share a patient's vital medical information electronically — improving the speed, quality, safety, and cost of patient care. This can increase integrated care coordination and collaboration to develop care plans while monitoring each recipient's health outcomes.

- Develop a strategy and implement changes to improve access to Medicaid services by making it easier for providers to actively participate in Medicaid, evaluating Medicaid reimbursement rates, and promoting use of telemedicine to expand the reach of providers.
- Implement program changes to help alleviate access concerns, such as additional workforce development policies needed to increase the number of providers in the State and account for the unequal geographic distribution of providers. Allow for reciprocity across state lines for telehealth services to combat these shortages.
- Employ strategies to educate providers about telehealth and provide technical assistance and training to promote telemedicine's use. For example, the state of New Mexico has leveraged its managed care plan contracts to require managed care plans to:
  - Identify, develop, and implement training for telemedicine practices.
  - Participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs.
  - Participate in Project ECHO, in collaboration with the University of New Mexico and the University of Nevada, Reno. Project ECHO employs videoconferencing to conduct virtual clinics with community providers, which allows primary care doctors, nurses, and other clinicians to expand their capacity to provide specialty care to patients in their own communities. Forward-looking telehealth is essential for recipients in rural and frontier areas of the State by providing direct access to health care without high costs.

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Section II: Behavioral Health Care

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:

Behavioral Health Access in the Home and Community Setting

With an emphasis on addressing remote care challenges across the State, we understand that rural Nevadans face a higher risk of untreated behavioral health (BH) conditions as well as greater disparities in accessing quality health care and specialty care. As a result of our deep history serving recipients in rural and frontier parts of the United States, we recognize the types of disparities in BH care and access challenges faced by rural recipients.

Together, these factors shape our understanding of the importance of a comprehensive solution that brings additional options to Nevada. We recommend the below best practices when addressing ways to increase availability of BH services in both the home and community setting in rural and remote areas of the State.

Strengthen Information Sharing

Key to the State increasing BH access is improving the ability to share information among providers. By implementing MCP contract provisions that facilitate or require data sharing across entities, the State could improve coordination and avoid duplication of services for recipients. For example, the health information exchange (HIE) can improve the completeness of patient records, resulting in a substantial effect on care. With access to the HIE, providers can collectively review previous history, current medications, and any other information during visits.

Boost Recipient Ratios

Another consideration for the State is focusing efforts to improve urban and frontier rural provider-to-recipient ratios in relation to BH services. The Nevada Rural and Frontier Data Book[1] illustrates that provider ratios are generally higher in rural areas as compared to urban areas. MCPs currently only enroll Medicaid recipients in the urban areas of Clark and Washoe counties and could contribute to the ratios.

Rate Study

Conducting a Medicaid reimbursement rate study to evaluate the sufficiency of current rates across provider types would also be another consideration for the State. Based on the results of the rate study, the State could recommend rate changes to the Legislature. Low provider reimbursement was a common theme across listening sessions and focus groups among

[1] Nevada Rural and Frontier Health Data Book: https://med.unr.edu/statewide/reports-and-publications/nevada-rural-and-frontier-health-data-book

multiple provider types. Increasing reimbursement rates may increase provider participation in the program, which could help with access issues. By developing a strategy and implementing changes to improve access to Medicaid BH services, it may make it easier for providers to actively participate in Medicaid. For example, evaluate and increase Medicaid reimbursement rates and promote use of telemedicine to expand the reach of providers.

We also recommend the State review the reports currently required of MCPs to submit and assess whether each one provides the information necessary to monitor and enforce contract requirements that are most meaningful to program success and improvements in recipient outcomes. In addition, we recommend assessing whether there are any gaps in reporting. For example, from our high-level review of reports, it did not appear that managed care plan reports provide data to understand utilization or performance outcomes or issues for special populations (e.g., adults with serious mental illness, children with autism) or reports to assess operations or outcomes associated with MCP case management activities.

Funding Opportunities

An additional consideration for the State is to pursue funding opportunities like State 1115 Demonstration Waivers for social determinants of health (SDOH) benefits. Other states have used funds in these ways:

- Arizona Health Care Cost Containment System: Homeless or at risk of becoming homeless and meet at least one specified clinical and social risk criteria.
- Massachusetts MassHealth: SDOH services available to populations participating in the Flexible Services Program or in a Specialized Community Supports Program for those meeting criteria related to BH needs and are either experiencing homelessness, justice-involved and living in the community, or facing eviction because of behaviors related to a behavioral health condition.
- Oregon Health Plan: Eligible populations for SDOH services experiencing major life transitions, including:
  - Youth with special health care needs
  - Adults and youth released from incarceration
  - Youth involved in child welfare system
  - Individuals transitioning from Medicaid only to dual eligibility status
  - Individuals who are homeless or at risk of becoming homeless
  - Individuals with high-risk clinical needs residing in regions experiencing extreme weather events

The State should also consider braided funding into a managed care plan contract through the inclusion of SAMHSA funding (MH Block Grant, SAPT Block Grant, OUD Block Grants). As such, this would ensure comprehensive delivery of the full scope of BH services.

Statewide Crisis System

CareSource encourages the development of a Statewide Crisis Delivery system in which the State would require all managed care plans to support and contract with the system. As part of an assessment of a Statewide Crisis Delivery system, the goal would be to identify region-specific current practices including needs, gaps, and opportunities along with national best practices to create a comprehensive statewide report of findings, inclusive of recommendations aimed to advance standardization in crisis delivery and experience while balancing flexibility needed to support geographic and cultural considerations.

Non-Traditional Strategies

Lastly, the State could implement non-traditional strategies to expand access. Non-traditional efforts could include increased primary care provider competence in behavioral health, reimbursing (Tribal) traditional healing, engaging communities in BH such as mental health training to Clergy, First Responders (Law Enforcement, EMTs, Fire and Rescue), and other community stakeholders through mental health first aid.

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section II: Behavioral Health Care

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:

Increasing Availability and Utilization of Behavioral Health Services in Rural Communities: Serving Children in the Home

CareSource recommends implementing a braided funding system through which Medicaid recipients can receive all available Medicaid and other federal and State funded benefits entitled to them while ensuring fund source accountability to the State and federal funders. A braided funding approach with the inclusion of Substance Abuse and Mental Health Services Administration (SAMHSA) funding (Mental Health Block Grant [MH Block Grant], Substance Abuse Prevention and Treatment Block Grant [SAPT Block Grant], Opioid Use Disorder Block Grants [OUD Block Grants]) and other State funding into a managed care plan (MCP) contract would ensure comprehensive delivery of behavioral health (BH) services that holistically wraps around the member and brings much needed alignment of resources to providers.

Additionally, CareSource believes the Certified Community Behavioral Health Clinic (CCBHC) payment model can improve utilization of BH services in rural communities with an emphasis on improving access.

As part of this recommendation, the State should consider expanding CCBHC access statewide through increased State support and partnership with SAMHSA and CMS.

Community Behavioral Health

CCBHCs are designed to safeguard access to coordinated comprehensive BH care. CCBHCs operate as an outpatient model that ensures evidence-based mental health and addiction care for individuals' needs within their community. Whether children, adults, or families, the goal of this whole person approach is to offer person-centered and family-centered care for BH and physical health, combined. State-level implementation of the CCBHC model is the key to building the comprehensive BH system that Nevadans deserve.

The proven CCBHC outpatient model could:

- Ensure access to integrated services including 24/7 crisis response and medication-assisted treatment.
- Meet strict criteria regarding access, quality reporting, staffing, and coordination with social services, justice, and education systems.

- Receive funding to support the actual costs of expanding services to fully meet the need for care in communities.

CCBHCs are not only designated clinics that provide a comprehensive range of mental health and addiction services, but they also serve anyone that walks through their door, regardless of diagnosis, insurance status, place of residence, or age.

CCBHCs should operate with a focus on the following six key program areas:

- **Staffing:** Staffing plan driven by local needs assessment, licensing, and training to support service delivery
- **Availability and Accessibility of Services:** Standards for timely and meaningful access to services, outreach, and engagement, 24/7 access to crisis services, treatment planning, and acceptance of all patients regardless of ability to pay or place of residence
- **Care Coordination:** Care coordination agreements across services and providers (e.g., Federally Qualified Health Centers [FQHCs], inpatient, and acute care), defining accountable treatment team, health information technology, and care transitions
- **Scope of Services:** Nine required services, as well as person-centered, family-centered, and recovery-oriented care
- **Quality and Other Reporting:** Required quality measures, a plan for quality improvement, and tracking of other program requirements
- **Organizational Authority and Governance:** Consumer representation in governance, appropriate state accreditation

Furthermore, The National Council for Mental Wellbeing is committed to expanding CCBHCs nationwide, with Medicaid prospective payment available to all CCBHCs. As a first step, they are working side by side with clinics, State and federal policymakers, and advocates across the nation to ensure everyone in the nation has access to a CCBHC.

To that point, Kansas and Missouri have recently passed legislation funding the expansion of CCBHCs statewide which has grown rapidly over the last several years, as noted by the Center for Health Care Strategies (CHCS)[1].

Payment and Delivery System Reform

CareSource also recommends that Nevada partner with CMS to request the following innovations in the State:

- Remove the cap on Rural Health Clinics (RHCs) requiring them to provide no more than half of their total services for BH.
- Clarify Medicare's same-day billing exceptions for FQHCs and RHCs to include substance use treatment in addition to mental health visits.
- Increase uptake of the Collaborative Care Model (CoCM), and consider increasing reimbursement rates, rethinking beneficiary co-pays, and providing additional technical assistance or guidance to the State on patient consent.
- Ensure the continuation of most pandemic- era flexibilities for telehealth services delivered in rural areas, including audio-only telehealth, within the context of established patient-provider relationships.

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[1] Sustaining Statewide Certified Community Behavioral Health Clinic Programs: https://www.chcs.org/resource/sustaining-statewide-certified-community-behavioral-health-clinic-programs/

Re: RFI for Nevada Medicaid Managed Care Expansion

Section III: Maternal & Child Health

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

Response:

Strategies for Improved Access to Maternal and Child Health in Rural and Frontier Areas

Improving maternal and child health access in rural and frontier areas of Nevada is key to ensuring the delivery of enhanced health care services. This includes empowering all moms, including first-time moms, to strive for the best future for themselves and their babies.

We believe considerations to the tools and strategies below can help the State improve maternal and child health outcomes while providing appropriate maternal care and support needed to have a healthy pregnancy and maintaining responsible and competent care for children.

Maternal Health Care Considerations

Related to improving maternal health care, the State should consider:

- Implementing a CenteringPregnancy approach that emphasizes risk assessment, education, and support through a group setting. Whether attending group prenatal care or a childbirth education class, the goal is to promote positive perinatal outcomes offering effective, sustainable care that can enhance the health of women, their families, health care providers, and communities.
- Providing perinatal care coordination for high-risk pregnant women provided through either a contracted community partner or through the Health Plan health coordination program with adequate reimbursement.
- Offering competitive reimbursement rates and payments for doulas, alternative obstetrician (OB) services, lactation specialists and all ancillary maternal health services. We understand the State pays for these services today, however, we believe enhancing the reimbursement rates would increase these services in rural areas.
- Investing in workforce development focused on increasing access to OB/GYN, including expanded prenatal and postpartum healthcare, maternal fetal medicine specialists and neonatologists capable of treating the recipients with complex perinatal diagnoses. The State could accomplish this by:
  - Offering State supported education and training for providers
  - Increasing residency slots for students
  - Introducing a new training approach within medical schools to improve health literacy regarding managed care plans

- Promoting, adopting, and implementing provider-based education activities to include, but not limited to family planning, reproductive health, and long-acting reversible contraceptives (LARC)

- Incentivizing providers by requiring Notification of Risk for Pregnancy with identification available as early as possible to help providers understand who they are providing care to while also gaining insight to recipient's risk that may impact a healthy pregnancy or birth outcomes.
- Adapting a universal patient record program allowing data systems and providers to connect with health plans to provide quality care across the entire healthcare continuum.

Child Health Considerations

Related to improving child health care, we recommend the State consider:

- Requiring integrated care between pediatrician and OB across the healthcare continuum and systems for greater population health outcomes.
- Allowing school staff to bill children's Medicaid medical services to ensure availability of and access to a full range of medical advice and counseling.
- Performing real time monitoring of EPSDT services and report results on a continuous basis. We recommend the state pay particular attention to the following outcomes to better improve and manage measures such as:
  - Wellness Visits
  - Early Interventions
  - Vaccines
- Utilizing enhanced dental rates to encourage providers to engage recipients from rural and frontier areas to provide coverage for any dental or medical services resulting from a dental condition provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center).
- Expanding dental coverage for pregnant recipients through post-partum period. The current postpartum extension provides dental coverage for pregnant and postpartum recipients through at least 60 days after pregnancy. In North Carolina, the U.S. Department of Health and Human Services (HHS), through CMS, approved the extension of Medicaid and Children's Health Insurance Program (CHIP) coverage for 12 months after pregnancy, resulting in expanded access to high-quality, affordable health care for an additional 28,000 individuals.
- Providing comprehensive, written cultural competencies that expand and establish cultural competency standards for increased quality of care towards recipients as socio-cultural practices in rural areas may limit resources available to pregnant women, resulting in adverse health consequences. We recommend that the State should require participating providers to attend cultural competency training, prioritizing outreach to high volume and/or providers serving enrollees or located in regions with known significant health disparities. For example, an emphasis on cultural variations to improve African American birth outcomes.

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section III: Maternal & Child Health

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:

Provider Payment Models to Improve Maternal and Child Health Outcomes

CareSource recommends the following two payment models for consideration regarding the improvement of maternal and child health outcomes for Medicaid populations: pregnancy/maternal health home and episodes of care.

Pregnancy/Maternal Health Home

An exciting new model from the Build Back Better plan[1] released in Oct 2021, includes a Medicaid pathway to incentivize high-quality, team-based care for pregnant and postpartum recipients. The bill creates a new Medicaid state plan amendment option for states to provide coordinated care through a "maternal health home," which serves as a hub for pregnant and postpartum recipients to receive care from a team of medical care and social services providers. This option builds on the foundation of a new proposed requirement that all states cover pregnant recipients for 12 months postpartum, also included in the Build Back Better plan.

Medical homes can receive per-month patient care management fees and pay-for-performance payments for high performance on measures of quality, patient experience, or cost. Physicians may also be subject to payment reductions if they miss cost and quality savings targets.

Maternal health homes can use alternative payment models (APM). In these agreements, payment to providers is not limited to fee-for-service or per-recipient-per-month capitation. While these agreements need approval, they do allow the State to think differently about paying for person-centered care.

A report by Maternal Health Hub[2] discusses how alternative payment models can transform maternity care, address disparities, and improve outcomes. For example, Colorado's Medicaid maternity APM provides a strong example of designing and implementing a model to improve health equity.

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[1] Maternal Health Home Option in Build Back Better Plan Lays Groundwork for Two-Generation Success: https://ccf.georgetown.edu/2021/11/12/maternal-health-home-option-in-build-back-better-plan-lays-groundwork-for-two-generation-success/

[2] Using Alternative Payment to Transform Maternity Care, Address Disparities, and Improve Outcomes Using-Alternative-Payment-to-Transform-Maternity-Care-Address-Disparities-and-Improve-Outcomes.pdf (maternalhealthhub.org)

To continuously improve and assess health equity in their model, the Colorado team also created a Maternity Advisory Committee comprised of Black, Indigenous, and People of Color (BIPOC) birthing people covered by Medicaid when they gave birth. While still a new initiative, the Advisory Committee will be actively engaged in the development of future health equity measures. However, after operating the voluntary models for three years, Colorado plans to make their model mandatory in 2023.

Episodes of Care

Practices receive payment based on episodes of care as the base requirement. Episodes are typically defined according to a set of diagnoses and services provided over a specified service time, especially for surgical procedures. These models may bundle hospital, physician, and post-acute care services together. These models allow practices to achieve higher revenue by avoiding complications, negotiating discounts, and choosing lower-cost settings for post-acute care.

For example, Tennessee began implementing a statewide episode of care payment model under its Health Care Innovation Initiative. The perinatal episode was one of the first models implemented and presently the State supports 48 episodes in total. TennCare administers its Medicaid program through managed care, and Medicaid MCPs and TennCare jointly administer the episode of care model.

The goal of the perinatal episode is to reduce variation in costs and reward providers who deliver cost-effective, quality care, and promote patient-centered, high-value health care. The model creates payment incentives for providers to manage costs across the entire episode of care.

Providers are held financially responsible when their costs are higher than what is considered acceptable. Conversely, they are also eligible for additional payments when their costs are below what is considered commendable if certain quality metrics are met.

Re: RFI for Nevada Medicaid Managed Care Expansion

Section IV: Market & Network Stability

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

Response:

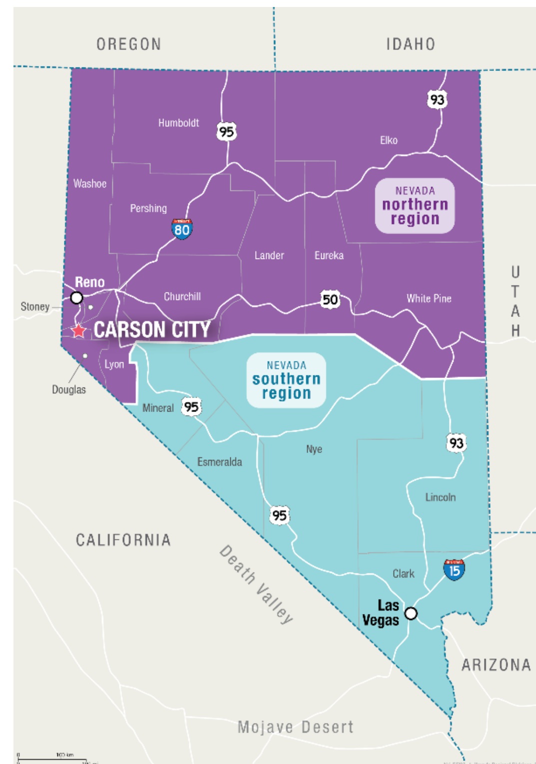
Nevada Service Areas

With the State's approval to expand the Medicaid Managed Care Program to all counties, CareSource recommends Nevada consider developing a program with regional emphasis.

Rural and Frontier Integration

As the State considers service area planning, we recommend a statewide plan that incorporates rural and frontier areas into a north-south regional model. In this model, as visualized in **Exhibit 1**, managed care plans (MCPs) would be required to bid the north region, south region, or statewide. Allocating the rural and frontier geographies into a north or south framework will encourage broader network coverage and provide a better recipient and provider experience. A State requirement to contract across specific regions, including rural and frontier service areas and all populations, ensure an equitable population mix to help rate predictability. This approach can also help develop a stronger infrastructure to address coverage gaps.

Exhibit 1: Northern and Southern Regional Model Option



Improved Alignment

To better align with State goals for effectiveness and efficiency, we recommend a statewide plan integrating rural and frontier services with existing urban service areas can facilitate an improved recipient and provider experience, including the following.

- **Improved recipient experience could include:**
  - Increasing access to essential services
  - Healthier outcomes for all Nevadans
  - Better integration for care coordination and care management
  - Strengthening coordination of benefits
- **Improved provider experience could include:**
  - Minimizing provider abrasion and decreasing provider burden
  - Reducing fraud, waste, and abuse

- Better coordination of services with integrated healthcare solutions for Native populations
- Leveraging better pricing controls for prescriptions

▪ **Alignment with State goals could mean:**

- Improving data collection and goal-sharing as identified in the Nevada Health Equity Action Plan (HEAP)
- Leveraging MCP infrastructure to better support and serve recipients
- Better resource coordination to help resolve care gaps
- Better resource coordination to manage workforce development and help recruit and retain necessary medical personnel
- Smoother implementation and easier recipient alignment
- Significant cost savings for the State
- Strong support for health literacy and support of healthcare equity goals identified in HEAP

Re: RFI for Nevada Medicaid Managed Care Expansion

Section IV: Network Stability

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

Response:

Best Practices for Establishing Service Areas

CareSource agrees Nevada's shift to managed care in the current service areas is an excellent way to coordinate and expand services and help minimize care gaps.

Statewide Managed Care

We recommend Nevada consider migrating from a fee-for-service (FFS) model in the rural and frontier areas to a managed care model across the state. Using a managed care model can help establish risk pools, foster patient-centered healthcare, coordinate care management, better integrate quality measurements, and help reduce healthcare costs for all populations and the State.

The model shift from FFS to value-based payment helps emphasize quality of care rather than quantity of care, and can:

- Help reduce administrative burden for providers
- Include behavioral health service reimbursement
- Help improve communication and transparency
- Mitigate financial consequences for workforce development

A 2021 analysis by HMA[1] found managed care plans (MCP) outperformed FFS and primary care case management (PCCM) programs for both Child and Adult Core Set measures, suggesting managed care has a positive impact overall on the quality of care for Medicaid recipients.

Collaborative Health Records

Nevada should consider identifying and implementing software across the service spectrum to improve interoperability, better manage care, close care gaps, and improve electronic health record efficiency. Implementing standardized healthcare software can ensure data collection continuity across the state and from all MCPs and streamline analytics and reporting for quality assessment and fiscal accountability.

Workforce Incentives

We recommend the State factor increased wages and benefits into planning. This can help bolster workforce development initiatives, address specialty shortages, and secure essential resources for the rural and frontier areas.

[1] HMA report compares quality outcomes across state Medicaid program delivery models: https://www.healthmanagement.com/insights/briefs-reports/hma-report-compares-quality-outcomes-across-state-medicaid-program-delivery-models/

The 2021 HMA-Burns proposal[2] for Arizona recommends increasing rates for lower wage workers and considers targeted increases to help with workforce recruitment, retention, and address labor shortages in a competitive market.

Ensure Quality Care

The following list illustrates how states are idealizing care and creating opportunities to meet the financial challenges of Medicaid service delivery while ensuring all beneficiaries receive the highest quality, patient-centered care.

- Kansas' Quality Management Strategy[3] identifies healthcare benchmark review needs and adapt policies to improve data capture, ensure continuity across data input and output, and determine how best to extract data for accurate quality measurements.
- Med-QUEST, the Medicaid and CHIP program in Hawaii, requires MCPs to:
  - Integrate primary care and behavioral health services, particularly for rural and frontier areas.
  - Build a delivery system leveraging all staff, including community health workers and peer supports, into the practice.
  - Address workforce shortages and provide care in remote locations.
  - Reform delivery system infrastructure to improve access.
- MassHealth, the Medicaid and CHIP program in Massachusetts, deems eligible for social determinants of health (SDOH) services, all accountable care organization-enrolled recipients, aged 0-64 who meet at least one health needs-based criteria and one risk factor and those in a specialized community.
- The Oregon Health Plan, the Medicaid and CHIP program in Oregon, deems eligible for SDOH services all recipients experiencing major life transitions.
- Pennsylvania's Community HealthChoices[4] integrated five regions into a three-region implementation phase, including the less populated central region of the state, to realize a simplified recipient experience, decreased State administration burden, enhanced quality and accountability, and increased efficiency and effectiveness.

Best Practices

We agree with Navigant's findings in the Nevada Medicaid Delivery Model Recommendation Report of 2017 that these items should be considered as an integral part of any MCP contract:

- Create an environment for full risk managed care.
- Integrate all populations into managed care.
- Review and revise reimbursement rates.
- Improve and enhance communication and transparency.
- Coordinate integration of services to avoid duplication.

[2] Health Management Associates: Examining the Adequacy and Appropriateness of Reimbursement Rates to Providers for Services Administered by the Arizona Department of Economic Security Division of Developmental Disabilities: https://des.az.gov/sites/default/files/media/Rate_Certification_Report_Final_2022JUNE30.pdf

[3] KanCare Quality Management Strategy: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-quality-management-strategy-12-09-21.pdf?sfvrsn=bc13511b_8

[4] Community Health Choices: understanding Community Healthchoices vs. Healthchoices: https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/Understanding%20Community%20HealthChoices%20vs.%20HealthChoices.pdf

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section IV: Market & Network Stability

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

Response:

Innovative Strategies for Algorithm Assignment

CareSource recommends the following algorithm considerations to help ensure market stability and create active competition for Managed Care Plans (MCPs) in Nevada.

Ensuring Market Stability

For initial assignment of membership to new and existing MCPs, create a re-enrollment period prior to go-live.

- Adopt an enrollment strategy promoting recipient choice (voluntary selection of preferred plan first, then auto-assignment for non-choosers) to minimize services disruption for current recipients.
- Post member choice, auto-assign the remaining, non-choosing recipients to existing managed care regions such as urban regions, to new MCPs entrants, resulting in promoting plan sustainability.
- Assign a percentage of new rural or frontier recipients by rate cohort to each MCP, providing for an even distribution among all MCPs to mitigate plan burden.
- Auto-assign any new members statewide to new MCPs until membership levels reach parity among all MCPs. Apply algorithms that attribute membership based on geography (urban/rural/frontier) and rate cohort to ensure similar distribution of membership across MCPs.

Active Competition for MCPs

Once market stability is reached among the MCPs, adopt an assignment strategy promoting increased quality, member satisfaction, and improve financial accountability.

- As with the initial assignment, allow members a choice of plan first, then auto-assign remaining membership.
- Similar to what you've implemented, apply State designated quality scoring to prioritize plan auto-assignment. For example, Michigan Medicaid automatically assigns a larger proportion of members to MCPs with the highest scores on those measures used by Michigan's Performance Monitoring Standards, including HEDIS® and CAHPS®.
  - Plans are assigned a score, these scores are then divided by three groups ranked by score: The top third in Group 1, middle third in Group 2, and lower third in Group 3.
  - Nevada should consider a similar methodology and include additional metrics such as Net Promoter Score® (NPS®), a customer experience metrics platform to engage members on how likely they would recommend the brand to a friend.
- Within each group demographic, including race and ethnicity or special populations, apply algorithms that attribute membership based on geography (urban/rural/frontier) and rate cohort to ensure similar distribution of membership across MCPs.

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section V: Value-Based Payment Design

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

Response:

Incentives or Strategies to Promote the Expansion of Value-Based Payment Design with Providers

CareSource has experience with value-based payment (VBP) design implementation and working with providers long-term to transition to VBP from other incentive contracts. To drive results through incentives for providers and improve care for recipients, we recommend standardized measurements with a State established program for VBP.

State Level Program

For providers, a VBP program can be more attainable and easier to participate in, potentially resulting in better quality of care for recipients, when there is alignment and consistency across MCPs. This approach can improve quality and recipient experience, as recipients are at the forefront of this model and quality is priority. Quality measures standardized across all managed care plans (MCPs) create alignment and consistency, encouraging providers to participate. With State support, there can be consistency for MCPs with some flexibility to design the program. Additionally, CareSource recommends an integrated care model where the State offers reimbursement rates for maintenance and implementation costs.

Alignment of State Initiatives

To further promote the program expectation at the State level, CareSource suggests an alignment of financial incentives with quality measures for providers participating in VBP. MCPs would be able to track provider participation in VBP and report on State initiatives regularly.

Standardized Measures

A focused set of standardized measures across all MCPs can drive performance within the Nevada provider network. We would suggest making the standardization specific to provider type and allow flexibility for MCPs to apply measures other than HEDIS® with certain provider types. For example, behavioral health could use the SAMHSA National Outcome Measures (NOMS) and Treatment Episode Data Set (TEDS). MCPs can maintain VBPs and work with providers for better performance. Providers can track their performance and change practice based on needs for the recipients.

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section V: Value-Based Payment Design

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:

Tools or Information for Plans and Providers to Succeed in Value-Based Payment Arrangements

If using a value-based payment (VBP) design program, it is imperative that providers and managed care plans (MCPs) always understand their performance toward metrics. The drive to achieve the incentive can be lost if the provider or MCP does not consistently have access to their performance. To support VBP arrangements, CareSource suggests establishing a dashboard provided by the State, access to non-traditional databases, a close loop referral system, and a MCP collaborative technical assistance service to support VBP arrangements.

State Performance Dashboard

CareSource suggests the State create share metrics for all participating MCPs to further drive Nevada population health goals. A dashboard created at the State level can support transparency for performance. It could also make participation in VBPs desirable for providers and may lead to improved results and quality of care for recipients.

Non-Traditional Database Access

The ability to consider referrals and services of social determinants of health (SDOH) and the agencies supporting SDOH services should be made available to providers when offering care to recipients. With the correct resources, providers can refer recipients to additional services during visits if given a comprehensive view of the recipient's engagement with outside organizations. Our recommendation is for the State to coordinate access to databases that are non-traditional in nature for providers, participating MCPs, and other community-based organizations (CBOs). Participating MCPs can utilize access to coordinate care with providers and CBOs, ensuring duplication of services does not occur and that the recipient receives services after referral. For example, with access to systems such as the homelessness point in time count and housing inventory counts, rental housing availability, vocational rehabilitation-employment and workforce development, educational statistics, and behavioral health (NOMs and TEDs databases if separately housed), referrals would become more streamlined and more frequently accessed.

In San Diego, Community Information Exchange (CIE)[1] has created a database that uses shared language, a resource database, and integrated technology to enhance community care planning. They are currently implementing this model throughout the country to improve communications in health care and SDOH.

[1] What is CIE?: https://ciesandiego.org/what-is-cie/

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Closed Loop Referral System

It is known that incomplete referrals lead to fragmented care for recipients. SDOH such as food, housing, and transportation stand between recipients and their referred services. A 2017 study[2] found that 50 percent of all medical specialty referrals made between clinicians and specialists are not completed due to miscommunication, misdirected referrals, or missing information. Fragmented care caused by SDOH factors and incomplete referrals can result in delay of diagnosis, treatment, and care, causing undesirable health outcomes.

CareSource recommends the State adopt a single closed-loop referral system to assist social service entities, providers and MCPs with integrated care for recipients. A closed-loop referral system could assist with:

- Data collection and validation of services
- Referral management amongst CBOs and providers
- Streamlined referrals with one contact listing for recipients
- Tracking of activity, giving a picture of whole health

As part of their Whole Person Care Initiative, the state of Arizona has a statewide closed-loop referral system, CommunityCares[3]. CommunityCares is Arizona's health information exchange (HIE), enabling the health care and community service providers of Arizona to connect on a single statewide technology platform to improve and track the referral process between social services and providers.

Collaborative Technical Assistance

Shared metrics across MCPs should inspire collaboration for the success of the technical aspects of maintenance. The MCPs could be responsible for a shared center of excellence with technical assistance supports funded and staffed by the MCPs. This should be statewide and committed to ensuring all providers have the tools necessary to engage in accountable, value-based care.

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[2] Closing the Loop: A Guide to Safer Ambulatory Referrals in the HER Era: https://www.ihi.org/resources/Pages/Publications/Closing-the-Loop-A-Guide-to-Safer-Ambulatory-Referrals.aspx

[3] Statewide Closed-Loop Referral System: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/closedloopreferralsystem.html

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section V: Value-Based Payment Design

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

Response:

Considerations for Promoting the Use of Value-Based Payment Design with Rural Providers

While CareSource suggests promoting the use of value-based payment (VBP) design with rural providers, we also recommend that the State should consider the cost of participation, leveraging the influence of collaborative rural support groups, and tiered VBP programs for better understanding and participation.

Cost of Participation

Rural providers face an additional challenge of technology investments to help improve practice processes and assist in meeting VBP and care goals. Many small practices have only a few providers. The cost of adapting the required technology to understand their performance in a VBP agreement may be too high. CareSource suggests a list of comprehensive investments for access by rural providers. By offering small, digestible recommendations of technology and training for providers, the State would:

- Remove the risk of investing toward inefficient technology
- Ensure training for rural staff is appropriate and comprehensive
- Assist the providers in understanding their performance toward quality initiatives

The National Rural Health Resource Center offers a similar resource for hospitals participating in their Small Rural Hospital Improvement Program[1].

Rural Support Group Influence

As mentioned above, due to the additional risks involved for rural providers to participate in VBP programs, additional training and consultation should be considered. In Nevada, the Rural Hospital Association of Nevada, and the University of Nevada, Reno's dedicated division of healthcare access to rural and frontier areas, could assist in training, consultation, and implementation. The State could partner with these support entities to offer programs to rural providers, rewarding providers as they report meeting value-based goals.

Value-Based Payment Programs

Creating the right value-based programs is particularly important for rural providers. For the rural provider, attempting to meet various sets of measurements for different managed care plans (MCPs) and additional measurements for the State, can make participation far more challenging and may reduce rural provider involvement. To solve for this, we suggest all MCPs use the same set of measures as previously described in Section V, Question B.

[1] Value Based Purchasing (VBP): https://www.ruralcenter.org/programs/ship/allowable-investments/value-based-purchasing

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section VI: Coverage of Social Determinants of Health

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

Response:

Cost Effective, Optional Services to Improve Health Outcomes

CareSource believes addressing social determinants of health (SDOH) is essential to promoting health equity, improving health outcomes and quality of life, and supporting economic self-sufficiency. The four components that yield the greatest return on investment for States and recipient health and life goals are housing, food, workforce development, and transportation. Although the Division has asked about programming in addition to housing and meals, we believe additional opportunities exist within those two service areas and include comments on them below.

Addressing Social Needs to Improve Health Outcomes

Housing Investments

- The Division should seek policy changes to use the 1115 waiver to offer housing navigation and assistance as per new federal guidance and actions.[1,2]
- Allow Managed Care Plans (MCPs) to integrate in lieu of services (ILOS) for health-related and housing service needs, including housing deposits.

Food Investments

- The Division could secure State approval and funding to expand availability of services under programs offering food security, such as Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP).
- Require MCPs to develop community-based and faith-based organizational partnerships to provide nutritional literacy and food access.
- Require MCPs to aligning initiatives with Nevada Council on Food Security goals.

Workforce Development Investments

- The Division should require MCPs to develop partnerships and collaborations with State and community-based programs, and educational institutions to create initiatives that address training and worker shortages with:

[1] How Biden admin rules could pave way for Medicaid to be a major housing player: https://www.fiercehealthcare.com/payers/biden-administration-rules-could-pave-way-medicaid-be-major-housing-player-health-affairs

[2] Medicaid Is Emerging As A Big Player In Housing, But Success Depends On New Partnerships: https://www.healthaffairs.org/content/forefront/medicaid-emerging-big-player-housing-but-success-depends-new-partnerships

- Innovative educational and skills-training assistance.
- Funding relief through public-private partnerships.
- Job and employment support to improve workforce development outcomes.
- Providing trauma informed care programs for all healthcare workforce and caretakers.

Transportation Considerations

Transportation investments may require the Division to seek policy changes that allow maximum flexibility within the confines of Medicaid rules. The Division should leverage creativity and seek alternatives for non-emergency medical transportation service areas, particularly for rural and frontier areas. An example of this would be to require the MCPs to reimburse for the return trip when a recipient may not be present, such as a recipient drop-off in a rural location.

Alternative Services

In Lieu of Services (ILOS) allow for a holistic approach to address SDOH that are outside the traditional healthcare framework but significantly affect recipients' health outcomes and are cost effective. We recommend actual cost coverage of ILOS at full capitated rates. ILOS provide a medically necessary, cost-effective alternative for recipients, often including services such as skilled nursing or rehabilitation facilities in lieu of hospitals, outpatient crises stabilization units in lieu of inpatient acute hospital stays, and self-help or peer programming in lieu of psychosocial rehabilitation.

Likewise, the Division may want to consider all programming that supports recipients in a strategic way, maximizing Medicaid funding to provide flexibility for non-medical services that influence health outcomes. These benefits can be provided to individuals waiting on the Waiver waitlist as covered services (e.g., respite care).

Successful implementation of ILOS and HCBS

- An initiative with Los Angeles County Department of Health Services provided rental subsidies and support for those experiencing homelessness, resulting in reduced emergency department (ED) visits and inpatient days. Those receiving support reported "significant improvements" in mental health functioning. This program realized a net cost savings of 20 percent.[3]
- New York state Medicaid recipients who were homeless, reduced inpatient days and ED visits when provided with wraparound housing navigation support.[4]
- A Seattle sobering center with permanent housing showed a reduction in costs exceeding $60,000 per person per year.[5]

[3] Evaluation of Housing for Health Permanent Supportive Housing Program: https://www.rand.org/pubs/research_reports/RR1694.html

[4] Housing is Healthcare: Supportive Housing Evaluation: https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing/evaluation.htm

[5] A Pilot Study of the Impact of Housing First-Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3558756/

Re: RFI for Nevada Medicaid Managed Care Expansion

Section VI: Coverage of Social Determinants of Health

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:

Other Innovative Strategies to Address Social Determinants of Health

The next RFP for Nevada Medicaid provides an opportunity to transform the system to better solve the State's healthcare challenges. CareSource believes integrating social determinants of health (SDOH) programming into a holistic health approach helps realize health equity, better quality of life for recipients, and offers significant fiscal benefits for the State.

The following list notes some transformative innovations and initiatives other states developed and/or implemented to help realize a significant health and fiscal difference:

- **Washington:** The State's Link4Health Clinical Data Repository collects, shares, and uses integrated physical and behavioral health information from provider's electronic health record systems. The state mandates managed care plans (MCPs) participation in this effort, ensuring care teams have a comprehensive understanding of the patients' medical history.
- **Florida:** The Pathways to Prosperity initiative encourages strategic partnerships between MCPs and community-based organizations (CBOs). Specifically, Florida leaders are interested in addressing SDOH by focusing on improvements in recipient populations being served. CBO contracts are designed to directly improve health outcomes, or directly increase home and CBO services, and occur in regions where the CBO can provide services and supports. Additionally, the State anticipates using a closed-loop software system for referrals and service verification between the MCP and CBO.
- **Ohio:** The Aspire programs provide skills training and services to help prepare individuals for successful employment. Programs include basic educational assistance, transition services, life and employability skills, computer literacy, and corrections education. Programming is available in all 88 Ohio counties.
- **North Carolina:** NCCARE360 is a statewide coordinated care network with a shared platform that electronically connects recipients with identified SDOH needs to CBOs. The system uses a closed feedback loop and helps ensure MCP and CBO accountability.
- **Arizona:** The State is invested in reforming their Medicaid program to ensure health equity, improve health outcomes, and realize financial savings. In 2018, the State began requiring routine screening for SDOH and using SDOH diagnosis codes on applicable claims. This standardization creates greater transparency and MCP accountability.

CareSource

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section VI: Coverage of Social Determinants of Health

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:

Further Addressing Social Determinants of Health in Support of Improving Health Outcomes

The current required three percent investment by contracted managed care plans (MCPs) has established a focus towards social determinants of health (SDOH) services in Nevada. To continue to improve health outcomes through support of SDOH services, we offer the following suggestions:

Leveraging Funding to Improve Health Outcomes

We believe the Division has an opportunity to build stronger alliances with community-based organizations (CBOs) and better leverage funding by:

- Shifting investment funding from a standard three percent of pre-tax profit to a percent of capitation.
- Identifying and allocating preferential funding to guide distribution, such as pooled funding with all plans assessing best allocation for maximum impact and cost savings.
- Recommending categories, such as data sharing, workforce development, or maternal health, for fund allocation based on recommendations in the Nevada Health Equity Action Plan.
- Ensuring transparency in the process by specifying expenditure allowances and delineating how funding is spent.

Opportunities to Improve Health Outcomes

CareSource believes the three percent community reinvestment requirement is a good basis for helping Medicaid recipients improve their health and well-being. We recommend future opportunities that could leverage this funding to address:

- Rural SDOH need, particularly maternal and infant health.
- Programs that focus on SDOH solutions and capacity building.
- Directed reinvestment for non-emergency transportation services, particularly in rural and frontier areas.
- Workforce development for healthcare providers.
- Reentry programming for those involved with the criminal justice system.
- Specialty programs addressing needs of Native American and Indigenous populations.

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Re: RFI for Nevada Medicaid Managed Care Expansion

Section VII: Other Innovations

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

Response:

Other Innovations for Ensuring State Success

CareSource recommends the State implement a comprehensive approach to the care of Medicaid populations. Population health improvement is more attainable when advancing opportunities for all individuals to achieve optimal health regardless of age, gender, race, religion, ethnicity, disability status, or geographic residence. The State should consider including all populations in its Medicaid expansion including child welfare, Long-Term Services and Supports (LTSS), Aged, Blind, or Disabled (ABD), Intellectual and Developmental Disabilities (IDD), and Dual Eligible Special Needs Plans (D-SNP).

A comprehensive approach focuses on the individual and is designed to leverage best practices for families and communities. This approach allows MCPs to serve all populations, better understanding of covered services by recipients, and eases administrative burden for providers. An increasing number of states are expanding their Medicaid contracts to cover additional populations.