Comagine Health

Technical Response

RFI for Nevada Medicaid Managed Care Expansion

Proposal Due: October 17, 2023, at 4:00 pm PST

Submitted by:
Comagine Health
10700 Meridian Ave North, Suite 300
Seattle, WA 98133-9008

Authorized Comagine Health Contacts:
Dana Hawes, Chief Growth Officer
Authorized Signatory
Phone: (801) 712-0644
Email: dhawes@comagine.org

Technical Contact for Questions:
Brain Sandoval, Sr. Development Director
Phone: (206) 288-2474
Email: bsandoval@comagine.org

Page Intentionally Blank

October 16, 2023

Comagine Health
10700 Meridian Ave North, Suite 300
Seattle, WA 98133-9008

RE: RFI for Nevada Medicaid Managed Care Expansion

Dear Department of Health and Human Services; Division of Health Care Financing and Policy:

Comagine Health is pleased to submit the attached Request for Information for Nevada Medicaid Managed Care Expansion. In the following proposal, we describe and document strategies we believe will help achieve the expansion of the Medicaid Managed Care Program to all counties.

Comagine Health is a national, mission-driven, nonprofit organization that has engaged in healthcare quality consulting and quality improvement (QI) services for more than 45 years. We look forward to continued partnership with the state of Nevada on this program and other vital efforts in the future. Please feel free to contact me if you have any questions via my email below or by phone at (801) 712-0644.

Sincerely,

Dana Hawes
Chief Growth Officer
dhawes@comagine.org

Enc.

Table of Contents

Provider Networks

1A

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?

Comagine Health has no response for this question.

1B

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?

Beyond an awareness of related issues, Comagine Health does not have significant expertise in this area. That said, we strongly recommend that the Division build structured and thoughtful ways to engage with rural providers on an ongoing basis (via workgroups, committees, task forces, and the like) to explore this question and iterate on improvement opportunities identified in future negotiations with managed care plans.

Additionally, we would point the Division to a number of thoughtful reports released by the Center for Healthcare Quality and Payment Reform (accessible here: https://chqpr.org/Reports.html). One particular report entitled "A Better Way to Pay Rural Hospitals" aptly describes problems caused by current models including fee for service and global budgets, and proposes an innovative concept titled "Patient Centered Payment System" (accessible at the link above). While Comagine Health doesn't necessarily endorse this approach in full, some of the concepts raised have been praised by our clinical leadership, including:

- Standby capacity payments to support the fixed costs of essential services in rural communities. These payments would be based on the number of people living in the hospital's service area and are designed to pay for the minimum fixed costs required to adequately staff essential services.
- Service-based fees for diagnostic and treatment services based on variable costs. This fee would cover the variable costs associated with a given service only since minimum fixed costs would be covered by the standby capacity payment. In this way, they would be smaller than current fee for service payments.

- Accountability mechanisms for quality and efficiency. In return for adequate payment, hospitals should be expected to deliver evidence-based services that are effective and efficient.
- Value-based cost sharing for patients – patient out-of-pocket charges should be affordable, assuring that no one is prevented from obtaining necessary care.

While we realize these innovative approaches would represent a significant shift in approach, they may be worth consideration as Nevada looks to improve the health of our communities into the future.

1C

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?

As the operator of the Desert Meadows Area Health Education Center (https://comagine.org/program/ahec/about-nevada-ahec), Comagine Health supports the vision of a healthy pipeline for a quality and qualified health care workforce. As such, we are supportive of this requirement and would recommend that managed care organizations be encouraged if not required to engage with Area Health Education Centers (AHECs) operating in the communities they serve to better support and strengthen the pipeline of healthcare workers from within the community itself. There are three regional AHECs in Nevada, and a state coordinating office that would serve as excellent partners to managed care plans in their workforce development strategy and planning activities.

1D

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?

Best practice would include ensuring all communities meet state requirements for access to providers. Among other requirements, states are required by CMS to define time and distance standards, as well as time to first appointment for a specific set of providers. The state can add providers to the required set. In states where there are rural and frontier communities, the state needs to define adequate time and distance standards for these providers. There is flexibility in

defining these standards, but all enrollees, whether in urban, rural or frontier communities, need access to these providers.

External Quality Review of Medicaid Managed Care Organizations now (beginning in 2024) includes CMS External Quality Review (EQR) Protocol 4 – Network Adequacy Validation by the EQRO. This protocol involves having the EQRO work closely with the state to identify the scope of the validation and data sources for validation. This approach is followed by validation of network adequacy monitoring data and methods. This new protocol will ensure consistency across states in ensuring adequate MCO networks.

Prior to the new Protocol 4, Comagine Health (HealthInsight), as an EQRO, conducted network adequacy reviews of 16 MCOs for the Oregon Health Authority. The state and the EQRO reviewed the data required from the MCOs, provided training, and gathered the information from the MCOs. They also scored, made recommendations to the state and MCOs, and provided MCOs the opportunity to review and update before finalizing. The state defined time and distance standards for Oregon's urban, rural, and frontier communities. Questions for MCO response included addressing these populations.

1E

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

Comagine Health has no response for this question.

Behavioral Health Care

2A

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?

Behavioral health needs continue to grow across the country post-pandemic. While the demand for behavioral care continues to rise, the workforce "supply" of behavioral health professionals continues to fall short, particularly in rural areas. Telehealth has offered a viable solution for rural communities that continue to face capacity shortages for behavioral health services. Comagine Health has been a strong advocate for telehealth services nationwide, particularly in

Nevada, where we hold an office and serve local communities through state and government contracts.

In 2021, Comagine Health launched a Nevada Telehealth Alliance (NTA) comprised of representatives of University Medical Schools, Federally Qualified Health Centers, primary care and specialty physician practices, behavioral health service providers, social service agencies, geriatric care centers, Area Health Education Centers, Rural Hospital Partners, Public Health Agencies, Nevada Hospitals, Center for Application of Substance Abuse Technologies, chronic disease education centers, and other health services providers in rural and urban locations, both large and small. This Alliance met regularly to improve Nevadans' access to health services for aged, disabled, young, and underserved communities throughout Nevada. The NTA effort produced guidance documents for telehealth, including a summary of telehealth in Nevada. Specifically, we researched efforts at the Center for Connected Health Policy (CCHP) website for the initial source for Nevada-specific telehealth information and then researched the statutes, provider manuals, etc., as they were available, including the Nevada Department of Health and Human Services Division of Health Care Financing and Policy fee schedule for "Provider Type 20 Physician, MD, Osteopath". Comagine Health also developed specific guidance for Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) as well as for Targeted Case Management (TCM) and Post-Discharge Follow-up (PDFU).

While focused primarily on a fee-for-service Medicaid population, we believe our research and work with the NTA are relevant for expanding telehealth in a managed care environment. As such, Comagine Health believes the following strategies are critical to the adoption, expansion, and delivery of telehealth for behavioral health services:

Simplify consent for telehealth services. Nevada is one of the few states that does not require consent according to the Nevada Legislature website. Should Nevada require consent in the future, we believe the following points are important:

- Advise patients as part of consent that telehealth visits are just like in-person visits only they are conducted by audio and video with the patient in one location and the provider in a different location. All the requirements for the telehealth visit are the same, although telehealth makes physical exams and vital signs more challenging.
- Provide guidance to telehealth providers on frequency of consent (e.g., prior to each visit or annually).
- Clarify that the care team or nonclinical staff with appropriate training may discuss, obtain, and document consent in the medical record.
- Understand and be able to explain the unique facets of consent and release of information as it relates to behavioral health and substance use disorder, including 42 CFR Part 2.

Create a one-stop resource with all telehealth-related information.
Researching to find all references and regulations is time-consuming. If the information is not readily available and transparent for telehealth providers, there is the risk of poor quality telehealth service delivery. Nevada does not currently have this resource, and it would be helpful for Nevada's Managed Care Program to provide the necessary guidance to their provider

networks.

Forgo In-Person Requirements.
Some states clearly state that an in-person visit is required prior to delivering telehealth services. For other states (e.g., CA), nothing is stated, and in Colorado and Texas, an in-person visit is not required prior to a telehealth visit. For Nevada, the only information we found pertains to the requirement for an in-person visit when providing telehealth ESRD services. Like medical visits, we believe that foregoing the need for an in-person visit prior to receiving behavioral health helps remove barriers to care, especially for patients already facing stigma.

Limit restrictions on distant and originating sites.
When researching Nevada Medicaid, we found no limitations on distant sites (i.e., the provider location) when delivering telehealth services to a patient at an originating site. Thus, it suggests that patients may receive services from providers located outside of Nevada, assuming all required training, licensing, and privileging has been completed. We did not find information on whether a provider may use their home as a distant site. That said, we believe that providing care from home is acceptable and consistent with the current remote work environment, provided that the care delivered is in a private space, the connection is secure, and HIPAA is not violated.

Most states do not limit the originating site (i.e., the patient's location) and include the patient's home. Nevada has the following specifics:

- "The originating site must be located within the State of Nevada and is the location where the recipient is.", including the patient's home. (As defined in the Telehealth Resource Guide.)
- "If the originating site is enrolled as a Nevada Medicaid provider, they may bill Healthcare Common Procedure Coding System (HCPCS) code Q3014.

Continuing to revisit site restrictions should be a part of Nevada's Managed Care plan to enhance access to behavioral health services. The more flexibility among distant and originating sites, the greater the access for necessary behavioral health care.

Clearly define school-based telehealth for behavioral health care.
School-based telehealth is an amazing opportunity to expand the reach of counseling services, particularly in schools located in rural or frontier communities where workforce challenges exist. Allowing for schools to be considered an originating site for patients (and students) removes barriers to care and allows for youth and adolescent services to be delivered where this population spends a majority of their time. We recommend that Nevada's Medicaid Managed Care Program should include strategies for enhancing school-based telehealth, particularly in underserved communities.

Allow reimbursement and provision for audio-only services to reduce inequity, especially for behavioral health.
Most state Medicaid agencies do not reimburse for audio-only telehealth [with exceptions during the public health emergency declaration (PHE)]. Based on available information, Nevada does not allow audio-only telehealth. We believe that audio-only care delivery helps mitigate barriers that could be tied to broadband access or purchasing devices necessary for synchronous video

streaming. Having a reimbursement structure for managed care plans to support audio-only visits can also help increase the frequency of contact between patients and providers and facilitate improved care coordination for behavioral health services.

Ensure coverage and payment parity.
Most states offer a select set of services for telehealth service delivery while others cover all 109 of the Category 1 and 2 telehealth codes. Nevada Medicaid states, "Services provided via telehealth have parity with in-person health care services." Like medical care, we recommend that behavioral health services coverage and payment should equal in-person visits. Coverage and payment parity among behavioral and medical health conditions are essential in promoting whole-person, coordinated care as Nevada's managed care population expands.

Allow for asynchronous behavioral health care, including eConsults.
"Asynchronous telehealth services, also known as Store-and-Forward, are defined as the transmission of a patient's medical information from an originating site to the health care provider's distant site without the presence of the recipient. The DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees" (see Medicaid Services Manual Changes Chapter 3400-Telehealth Services). It is not clear for which asynchronous telehealth services Nevada Medicaid reimburses, but we believe that asynchronous telehealth services for behavioral health should be included as a covered benefit.

None of the six codes for conducting eConsults are listed on the Nevada Department of Health and Human Services Division of Health Care Financing and Policy fee schedule for "Provider Type 20 Physician, MD, Osteopath", suggesting that these services are not covered by Nevada Medicaid. However, Nevada should strongly consider reimbursement for eConsults, given the paucity of psychiatry services in rural and frontier communities. The use of eConsults empowers and supports primary care providers' ability to care for more psychiatrically complex patients, rather than referring them to a specialty behavioral health system that is already taxed.

Maintain commensurate documentation standards for telehealth and in-person visits.
Documentation for telehealth visit requirements should remain the same for in-person visits but should also include that the visit was conducted by telehealth, patient consent, locations of the originating and distant sites, start and stop times, names and roles of all individuals participating or observing at the originating and distant sites, and back-up and emergency plan if the technology fails or patient requires emergency medical services (EMS). Most states require documentation that the visit was conducted by telehealth and often clarify that both telehealth and in-person visits and accompanying documentation must comply with all components and procedural definitions for the CPT or HCPCS code that is billed.

Allow for out-of-state care provision with appropriate credentials
Most state Medicaid agencies require licensure within the Medicaid beneficiary's state to provide telehealth services, and several also include the requirement to be a Medicaid-enrolled provider. In Nevada, providers must be licensed in the state to provide telehealth but do not need to live in Nevada (see RS 629.515). Additionally, Nevada is a member of the Interstate Medical Licensure

Compact and the Psychology Interjurisdictional Compact (PSYPACT) Psychosocial Rehabilitation (PSR) services.

Allow for Transitional Case Management via Telehealth
Avoidable hospital readmissions are closely tracked by hospitals and the Center for Medicare & Medicaid Services (CMS), and CMS reduces payments to certain hospitals with high readmission rates. Many of these admissions are often directly or indirectly related to a behavioral health condition. Additionally, those readmissions can be a significant driver of per-beneficiary cost – one of the Triple Aims. Nevada has opportunities to contact and support patients post-discharge to keep them out of the hospital. As of January 1, 2013, Medicare began reimbursing for two Transitional Care Management (TCM) codes and services, and many state Medicaid agencies and other payers also cover these services. **Both TCM services and codes can and should be delivered by telehealth whenever possible!**

2B

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?

Comagine Health recommends the following practices and policies to increase the availability and accessibility of behavioral health services in rural and remote areas of the state:

First, the state should consider removing or raising the prior authorization requirements for peer support model behavioral health services. At present, Nevada requires prior authorization for peer support behavioral health services that extend beyond 18 hours per year. Most states do not have a prior authorization cap for these services, and the handful of states with such limitations have a significantly higher amount of service hours available before prior authorization becomes required. The Kaiser Family Foundation has more information about different state models here: Medicaid Behavioral Health Services. Prior authorization creates additional administrative burdens for patients and providers to clear before accessing behavioral health services and may lead to lower accessibility.

Second, the state should consider the expansion of peer service models more broadly. This approach could include ensuring that reimbursement rates are sufficiently adequate to provide livable wages and benefits to peers who perform services across levels of care and treatment settings (including outpatient care). Also, it would be helpful to generate alternative payment models to provide peer services for activities outside of treatment episodes and settings (examples include outreach and engagement, wait-list support, and aftercare support). Peer service models offer a unique form of treatment in the behavioral health space, and expanding the reach of these programs will create broader availability for needed behavioral health services.

2C

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?

Comagine Health has no response for this question.

Maternal and Child Health

3A

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?

Comagine Health is supportive of the information and recommendations submitted for this question by our partners at The Children's Cabinet, which includes the following:

Social Determinants of Health: Incentivize MCOs to support social determinants of health (SDOH) screenings through prenatal and pediatric providers. Utilize and reimburse para-professionals (CHWs) to support these providers in conducting screenings and connecting patients with non-medical supports that impact maternal and child health outcomes. Have MCOs support/promote a Coordinated Intake and Referral System that connects patients with both medical referrals and other social service referrals.

Measurement and Accountability: Require MCOs to publicly report metrics for extended post-partum coverage in the Maternity Core Set and disaggregate data by race, ethnicity, geography, language and other key demographic factors. This will help to measure the receipt and quality of postpartum care provided, and use data to set benchmarks for improvement.

Support Home Visiting Programs: Evidence-based home-visiting programs are shown to improve maternal and child health outcomes. Funding these programs through Medicaid will increase access significantly (current funding serves less than 1% of the eligible population). The Division should establish mechanisms to support home-visitors as Medicaid providers and define home-visiting services that meet Medicaid billing requirements. Require MCOs to provide incentive payments to approved home-visiting programs (federally recognized by the MIECHV program) based on quality outcomes.

Maternal Health Planning: Require MCOs to develop a comprehensive approach and plan for maternal health that includes all aspects of the maternal health continuum:

- Prenatal Care – Incentives for early entry to care; inclusion of specialists in maternal and fetal medicine; doula services; group prenatal care.
- Maternal Oral Health.
- Lactation Support.
- Maternal Mental Health.
- Access Supports including transportation and technology for telehealth/virtual health.
- Navigation and connection support programs for screenings (SDOH, mental health, substance abuse and DV) and care coordination/support (inclusive of whole family supports).

3B

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?

Comagine Health recommends the Division consider designing payment models that incentivize the use of two evidence-based models to improve outcomes for pregnant populations: the Maternity Medical Home (MMH) model (based on a patient-centered medical home model) and the Pathways Community Hub Model. Combined, these models can facilitate robust care for pregnant people, promote early entry (first trimester) and ongoing engagement in care, and support meaningful mitigation of health related social needs. Please see our response 6B for more information on the Pathways Community HUB Institute® Model (PCHI®) and its evidence base for improving prenatal and perinatal outcomes.

Beginning in October 2023, Comagine Health is collaborating with the Kirk Kerkorian School of Medicine (KSOM) at the University of Las Vegas (UNLV) Nevada Department of Obstetrics and Gynecology, UNLV School of Public Health (SPH) and other Southern Nevada partners. Together, we serve as one of five programs nationwide funded through the Health Resources and Services Administration (HRSA) Integrated Maternal Health Services (IMHS) Demonstration grant. We seek to improve care for disproportionately impacted pregnant populations in Clark County, Nevada. The work aims to establish infrastructure to coordinate care between obstetrics, primary care (including pediatrics), specialty care, and behavioral health. It also aids access to social services via the Southern Nevada Pathways Community Hub, operated by Comagine Health. The Pathways Hub coordinates a network of care coordination agencies that employ community health workers (CHW) who will work with clinical partners, care coordinators, and other community-responsive caregivers to facilitate community-based outreach and create a robust safety net for pregnant people in Clark County. This demonstration program may lay a foundation for a model that can inform the Division on models to improve maternal and child health outcomes in the coming years.

Market and Network Stability

4.1 Service Area

4.1A

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.

Comagine Health has no response for this question.

4.1B

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.

Comagine Health has no response for this question.

4.2 Algorithm and Assignment

4.2A

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?

Comagine Health has no response for this question.

Value Based Payment Design

5A

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?

Comagine Health has no response for this question.

5B

Are there certain tools or information that the state could share, develop, or improve upon, to help plans and providers succeed in these arrangements?

We recommend that any effort to support the expansion of value-based payment should be accompanied by technical assistance and resources that help payers and providers build the capacity for success. This type of support can take many forms, and as such, we encourage this effort to be informed by providers and payers, as they can best articulate what tools, resources, and supports would benefit them and their patients most. We also recommend considering formulating an ongoing stakeholder engagement strategy to inform initial and ongoing technical assistance offerings to both payers and providers in Nevada. Optimal technical assistance would include disseminating knowledge and tools via resources and trainings, as well as implementation and quality improvement support. Implementation is incredibly difficult in the context of a busy healthcare setting, which makes skills and tools for quality improvement critical for attaining sustained improvements. One approach that would maximize efficiency and synergy would be matching findings from the engagement strategy to existing technical assistance providers in Nevada that understand the area of expertise and the community in question. Lastly, the Division may consider engaging beneficiaries and their families to provide input from the patient's perspective related to incentivized services and interventions.

5C

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

Comagine Health has no response for this question.

Coverage of Social Determinants of Health

6A

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?

Comagine Health has no response for this question.

6B

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?

We commend the Division for providing the opportunity to provide input on innovative strategies to address SDOH. To that end, we recommend the Division consider aligning with the recent *Proposed Rule [CMS-1784-P] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies, and Basic Health Programs* by including requirements that require contracting with community-based organizations and community care hubs as provisioners of SDOH related services.

Communities in Nevada face many challenges, including fragmentation of community resources, insufficient resources for those who need them the most, duplication of services, and lack of a strategy/workflow. They also do not have funding mechanisms to address the barriers faced by under-resourced and marginalized populations. Further, the current system for Medicaid care coordination services is siloed and creates an environment where beneficiaries can be lost to follow up when they lose Medicaid coverage or change plans. Community Care Hubs are a model garnering recognition to help address this fragmentation and care silos. The Partnership to Align Social Care recently released a Playbook for State Medicaid Agencies on working with Community Care Hubs that contains guidance and examples of successful collaborations between Medicaid and Community Care Hubs (available online: Manatt-CCH-Medicaid-Playbook_Final-11-17-22.pdf).

One of the most mature evidence-based Community Care Hub models is the Pathways Community HUB Institute® Model (PCHI®). The Pathways Community HUB Institute® Model (PCHI® Model) uses a community-driven quality improvement framework aligned with healthcare quality goals. Through this model, the Pathways Community Hub (PCH) organizes

and manages agreements with payers and referral partners and coordinates a network of care coordination agencies that employ CHWs to conduct outreach and navigation services using the PCHI standard framework. Central to the model are the 21 Standard Pathways that help CHWs identify and track risk factors and work with participants to eliminate the risks one by one, with payment directly linked to risk reduction, defined by completed Pathways.

In 2023, Comagine Health, in collaboration with our partners, launched the Southern Nevada Pathways Community Hub (SNV Hub) in Clark County to create a community utility and no wrong door to coordinated access to care and services to address the SDOH for those most at risk in the County. The SNV Hub officially launched in January 2023 and, as of August 2023, enrolled 60 clients, of which 45 are Medicaid beneficiaries and 56 are pregnant. In this timeframe, CHWs opened more than one pathway for 100% of enrolled clients, opening a total of 434 pathways overall, the majority of which were for social services and medical referral.

Currently, the PCHI Model is implemented in more than 48 communities in 18 states. Communities implementing the PCHI Model build a care coordination network that leverages the skills of CHWs to find and engage those at greatest risk for poor health outcomes. There is significant evidence behind this model, most notably for pregnant populations. The outcomes from the initial pilot in Ohio were so significant that the Ohio Commission on Minority Health scaled the Pathways Community HUB model to address the high disparity in infant birth outcomes, particularly among people of color to every community in the state. One study[1] from this work found:

- High risk mothers in a community hub service area where the members were enrolled in the hub were 1.55 times less likely to deliver a baby needing Special Care Nursery or NICU care when compared to high-risk members who did not receive hub services through delivery.
- Active use of Community Hubs combined with traditional health plan care management to reduce non-clinical barriers to care leads to a lower total cost of care in baby's first year of life. "For every dollar spent on Community Hub activities for our members, there was a savings of $2.36".

The Pathways Community HUB Institute Model has been recognized by the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and the Centers for Disease Control (CDC) as a method to integrate services, improve outcomes, reduce duplication, and lower costs. The PCHI Model meaningfully engages hard-to-reach members to close gaps in care while streamlining contracting, standardizing data, limiting risk, leveraging resources, and producing a return on investment with measurable health improvement.

Safety net providers and physician practices that serve large volumes of high-need populations are often undercapitalized and may lack the infrastructure to hire additional personnel to deliver and supervise ongoing SDOH services. These practices could leverage the option of referring to a community care hub, such as a Pathways Community Hub (PCH), to facilitate access to these

[1] *Lucas, B., Detty, A. "Improved Birth Outcomes through Health Plan and Community Hub Partnership." 2018*

services and ensure bi-directional communication until a patient's health-related social needs are meaningfully resolved. PCHs allow eligible Medicaid providers to leverage local community assets that have intricate knowledge of the social service system and are often the experts in social care navigation. **We strongly recommend that Medicaid specifically outline contracting requirements for Managed Care Organizations to work with community care hubs, including certified Pathways Community Hubs where they exist in Nevada, as a no wrong door approach to addressing local community needs.**

We also recommend NV Medicaid align reimbursement with the CMS quality strategy by:

- Aligning a portion of the payment criteria with outcomes to pay for the resolution of each identified health-related social need. This process will create a value-based quality improvement framework implemented at the community level that will result in needs being met, not just identified.
- Addressing health-related social needs in the community setting. Care coordination networks of community-based organizations need to be eligible for direct reimbursement for the SDOH related services and outcomes performed by the CHWs in their networks.

CMS aims to have all Medicare beneficiaries and most Medicaid beneficiaries enrolled in accountable care programs by 2030 and is committed to promoting health equity through its value-based initiatives. Value-based care ties the amount health care providers earn for their services to the results they deliver for their patients, such as the quality, equity, and cost of care. Through financial incentives and other methods, value-based care programs aim to hold providers more accountable for improving patient outcomes.

The second evaluation report for the Accountable Health Communities Model (May 2023) showed that navigation alone did not increase beneficiaries' connection to community services or SDOH resolution. Nearly 60% of navigation-eligible beneficiaries reported having multiple needs. Food and housing were the most prevalent needs among this population, which significantly affect health and have been associated with higher rates of acute care. After completing navigation, almost two-thirds of beneficiaries had no SDOH resolved, and connection to community services or SDOH resolution did not increase. The Accountable Health Communities Model proved that simply paying for services without accountability does not drive SDOH resolution and improved health outcomes. The PCHI Model of care coordination ties payment to confirmed connection to community services and SDOH resolution.

6C

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?

We encourage the Division to increase the rigor, transparency, and standard requirements for the selection process used by the managed care plans when selecting how to invest. Currently, each plan uses its own method for selecting recipients for these funds; not all selection methods are open to a broad competitive process. This approach reduces the opportunities for investment in new and innovative program models and risks perpetuating inequities by not creating a forum for an open bid process that enables new or historically unconnected Community-Based Organizations to participate or engage.

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.

Given the severity and importance of substance use disorders, Comagine Health recommends the continued support and expansion of certified 12-step programs, family therapy, recovery coaches, and peer support groups to help beneficiaries with substance use disorders. The expansion of managed care presents an opportunity to ask questions and explore new approaches to supporting patients and providers in getting people the help they need to recover.