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Organization: Comprehensive Healthcare Management, LLC
Re: Request for Information for Nevada Medicaid Managed Care Expansion

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REQUEST FOR INFORMATION FOR THE NEVADA MANAGED CARE EXPANSION

Section 1: Provider Networks

1.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:
The Division should focus on strategies that increase competition to drive provider service to the communities of focus. This may include adding managed health care providers to the Nevada network, and/or changing regulations to allow the establishment of Independent Physician Associations (IPAs). In an IPA, the member providers can develop at-risk agreements with the third-party plan administrators that distribute the risk and reward, and share the incentives for the care coordination and delivery of services. Additionally, IPAs are structured to partner with community organizations to expand and bridge gaps in service.

Finally, some rural and frontier communities are on the borders of other states, for which care may be more accessible outside of Nevada. Require all potential providers to provide a range of plans that allow Nevada Medicaid residents to access out of state providers at in-network rates for all levels of care.

1.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:
The Fee-For-Service (FFS) strategy for rural and frontier Nevada could be enhanced by an IPA, which is part of the value-add of any proposed Managed Care Organization. An IPA allows physicians to combine as an entity and enjoy the benefits of a larger organization. The IPA acts as an intermediary between the patient and the healthcare provider, or the MCO and the healthcare provider, negotiating rates and services on behalf of both parties, and thereby leveling the playing field.

This would also ensure that care management is being monitored by physicians and not restricted by third-party plan administrators. The requirement or allowability of an IPA to work collaboratively with an MCO allows for a shared risk model, and focuses on providing incentives not only to the third-party administrator but also directly to the physician.

Response:
Require MCOs to work with not less than 50% of the providers in a geographic area where the population is less than 100,000 people, with an enhanced fee schedule and incentives that are shared with the providers of care.

Response:
Utilize an enhanced fee structure:

Option 1: Clients living in rural and frontier counties in Nevada should have a 10% Medicaid fee enhancement above the Medicaid reimbursement rate based on the higher level of acuity of clients in these geographic regions, and the complexity of coordination of care, to include transportation and access. This would also encourage specialists or other types of providers outside of the geographic area to expand services via telehealth or with remote clinic visits. This plan must also account for the time needed for specialists to get to the rural and frontier communities, and cost of transportation. This would be a bundled payment in collaboration with a provider association.

Option 2: Create a rural health or behavioral health clinic designation which does not just pay reimbursement of "actual costs," but also includes reimbursement of the Medicaid rate, plus an identified percentage that would cover the increased administrative costs associated with the wrap around care needed in rural and frontier Nevada. This would also require any independent or provider owned rural health or behavioral health clinic to meet specific guidelines and have capped rates for services, which could align with the Medicare rate caps.

1.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:
Provide expedited reciprocity for social workers (similar to physician reciprocity), without the requirement to complete additional practicum.

1.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:
In rural and frontier communities, the objective of providing network adequacy could be achieved by implementing a variety of measures, including adjusting the standards counting midlevel clinicians toward fulfillment of patient-provider ratios, and allowing IPAs or other integrated provider systems to deliver care through alternative delivery systems, such as funding for travel to and from rural or frontier communities with a bundled rate, which would include the travel time and other expenses of traveling, i.e. fuel.

1.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:
One such barrier is that many MCOs require specialists or other providers to be exclusive to their networks, which stifles competition and reduces the number of providers through whom the MCO can offer services to residents. The competitive edge can be the monetary payment provided by the MCO, shared bonus, or other shared quality performance incentive in lieu of restricting choice to Medicaid clients.

Response:
For medical or behavioral health HRSA shortage areas, create a mandatory timeline for MCOs to enroll eligible providers within 45-days of application. There are current MCO providers that take more than 90 days, and up to six months for approval or denial of new providers to be enrolled as part of the network. There are existing MCOs that will not expand their current provider list. This creates gaps in service. Establish policy barriers that prohibit monopolies where MCO's provide access only to providers within their own structure or subsidiaries.

Section 2: Behavioral Health Care

2.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: Streamline the requirements for telehealth service, and provide a home-base site in the community where general vitals can be provided to the providing physician with limits on liability to the supporting mid-level or entry level provider or community health worker.

2.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: Develop relationships with Independent Physician/Provider Associations (IPAs), whose primary focus is to coordinate care, perform case management, and control costs.

2.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: The payment model should match evidence-based practices and be bundled to address the requirement for safety and service for two individuals to travel to and from home base locations, as well as cover the actual direct service, and wrap around coordination that is required for youth and adolescents. The PMPM nor the FFS model account for the complexity of home-based services in rural or urban communities. The actual service may only take one-hour, but the total care would begin from the departure of the office location to the home site. The payment provider model should be a prospective payment bundled package that addresses transportation, care, travel time, and care coordination.

Section 3: Maternal & Child Health

3.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: Include Independent Physician Associations (IPAs) among the managed care options available to patients accessing maternity care in rural communities. By putting the care of the mother and baby in the hands of an IPA, the family is placed at the center of a care spectrum where the entire family are part of a holistic integrated system of care that seeks to align provider payment with positive outcomes and quality improvement achievements, such as reducing low-risk cesarean deliveries; expanding best practices; and improving access to high-quality prenatal care for at-risk populations. This includes improving the quality of, and access to post-partum care, including behavioral health and improving infant outcomes with the development of strong parent-child relationships.

The strategy of building IPAs to address at-risk and rural communities creates specific objectives concerning the responsibility of care within a defined program network.

3.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: The evidence-based practices that have shown the best results focus on leveraging models that have opportunities to create transparency in primary care referrals to perinatal care providers. In lieu of episode budgets, there are payment thresholds. The model focuses on performance payments that are shared between the third-party payor and the provider network or IPA. Through an IPA, the coordination of care and collaboration is seamless and has improved outcomes in states such as Ohio. The focus is to move away from only claims data and the use of non-claims data around quality measurement, while also putting the safety of the mother and child first.

Section 4: Market & Network Stability

Section 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.

Response: The expansion to four MCO contracts across the state has increased access to care in areas of Clark County that previously did not have many providers to choose from. The new goal should be to improve the quality of care and reduce costs by increasing competition among individual care providers and provider networks. This will provide more choices to consumers, while also forcing managed care organizations to identify and employ strategies to achieve higher performance measures related to quality of life, quality of care, and improved equity in health care services throughout Nevada.

While there is a clear need to improve services in rural and frontier communities, the state should recognize that major urban counties are also still underserved. They continue to have the greatest number of underserved individuals, per capita, and the highest number of those who identify as part of the LGBTQ+ and/or BIPOC communities, which are identified as Nevada's greatest at-risk populations.

Accordingly, Nevada should be treated as a one service area under the MCO contracts, but offer alternatives to provide Individual Physician Associations (IPAs) or other alternative care management organizations to meet the diverse needs of individual counties. In a state as geographically and demographically diverse as Nevada, it is not realistic to think that a one size fits all approach to managed care will meet the needs of each county's underserved or at-risk populations. Neither will it provide innovations or strategies to improve access and quality of care. The goal should be to encourage more competition, which drives innovation.

4.1.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:
Some states have had success providing better healthcare options to residents, particularly in rural and frontier areas, by contracting with IPAs in addition to MCOs. An IPA, or Independent Physician Association, is an organization of physicians established to contract directly with third-party payors. The focus is on patient-centered, managed health care that incorporates both physical and behavioral health.

An IPA allows physicians to combine as an entity and enjoy the benefits of a larger organization to determine the service needs of the client. They are not exclusive and do not preclude providers from engaging in independent activities or activities with other organizations or networks, including MCOs. An IPA allows patients to choose their healthcare providers from a network of independent physicians and hospitals. The IPA acts as an intermediary between the patient and the healthcare provider, negotiating rates and services on behalf of both parties. This type of plan is often preferred by those who want more control over their healthcare choices and prefer to see doctors outside of traditional hospital networks. This can be a stand-alone such as MCO, a value-add.

IPAs are proven to reduce overhead and promote the development of multiple paths to accessible care through contracts with employers, accountable care organizations, and managed care organizations.

The goal of the integrated partnership model is to improve the quality and value of the care provided to citizens served by public health care programs. The integrated partnership structure utilized by IPAs allows provider organizations to voluntarily contract with DHCFP to care for DHCFP Fee-for-Service (FFS) patients, as well as managed care patients, and utilizes a payment model that holds these organizations accountable for the total cost of care and quality of services.

Within this structure, the DHCFP could expand the program to different geographic regions of the state, and across different models of care delivery. Furthermore, the integrated partnership structure will empower the Division to integrate health care with chemical and mental health services, safety net providers, and social service agencies, creating a truly holistic approach to care that benefits patients. The projects would produce clear incentives for quality of care and targeted savings, and would result in increased competition in the marketplace through direct contracting with providers. The threefold objective is to improve population health, provide patients with a better experience with care, and reduce per capita cost. These arrangements are value based, focusing on both quality and cost. Some MCO organizations are too large to deliver patient-centered care and care coordination. By implementing addition models of managed care, such as the IPA, there is sustainable innovation through a modified payment delivery model for "high-risk" communities, including those in rural and frontier Nevada.

Integration of care models like IPAs include non-medical factors that should incentivize partnerships between medical and non-medical organizations to effectively address patient and population health. The emphasis is on complete care, that has actuarily sound benchmarks, and an organization that is flexible to be able to act responsibility to updated health care data, trends, and technology.

Response:
Regarding mental health services, it should be mandatory for clinical providers who are working through an MCO or IPA to team with after school organizations to reach at-risk, BIPOC populations.

There are some residents who are just out of reach for Medicaid, but who lack the ability to access care through the exchange. The after school or school-based programs can provide a meaningful partnership to bring prevention and services to those just out of reach for services from Medicaid.

Section 2: Algorithm for Assignment

4.2.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:
The assignment algorithms should be based on the number of physicians in a geographic area who have the capacity to take on new clients.

Unfortunately, the current networks of MCOs do not provide a sufficient number of physicians who are actively accepting new Medicaid clients. The network only provides a list of member doctors, without

consideration for how long it takes for a client to be seen, how far they client must travel to receive services, or the willingness of in-network providers to accept new clients.

Another problem is that many MCO providers require physician networks to maintain Medicaid change forms to submit to clients as part of the registration intake process. The changes initiated by these providers may adversely impact the ability of a client or the client's family to access all of the benefits available to them through Medicaid.

Strategies for solving these problems should focus on integrating physician supportive models, wherein care providers are aligned with the MCOs, but not employed by or subsidiaries of them.

Section 5: 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?

Response:
The focus should be on increasing competition to drive provider services to the communities in need of them. This may include adding managed health care providers to the Nevada network, in coordination with, and/or changing regulations to allow the establishment of an Independent Physician Association (IPA).

An IPA is a business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations and/or managed care organizations (MCOs). There are substantial opportunities for innovation in delivery system modeling and benefit design in the creation of physician networks. Specifically, creation of practice networks involving medical homes may accelerate important and necessary changes in health care delivery.

Physicians exercise their market leverage through a variety of contracting and affiliation strategies which allow a group of physicians to speak with one voice. By allowing an IPA organization to deliver quality behavioral and primary health care for the Division, DHCFP could focus on direct incentives for providers in lieu of incentives that are focused on the third-party plan administrators. The current system incentivizes the third-party MCO, but does not provide direct incentives for those in the provider network. Create strategies that require IPAs to be integrated to ensure that it is a shared risk model, that is integrated, to focus on client care, while also ensuring those that provide the care are incentivized.

The following are the guiding principles for an IPA:

1. IPAs should organize a health care delivery system which produces optimal health outcomes for patients.
2. IPAs should promote efficiency and effectiveness in the delivery of health care to patients that produces value. The financial benefits that result from this improved care efficiency and effectiveness should go to those who provided the improved care.
3. Family physicians should utilize their unique skills and expertise in care management, in management of the interface between specialists and hospitals, and in their focus on preventive health to create value.
4. Effective management of relationships between primary care physicians, limited specialists, and hospitals is critical to the optimal care of patients, to the success of an IPA, and to the satisfaction of physician participants.
5. An IPA must be able to demonstrate their incremental value to obtain contracts with health plans and other payers for covered lives.
6. Network physicians must have clinical autonomy and assume clinical accountability to optimize an IPAs value.
7. The unique partnership embodied in the doctor/patient relationship must be preserved.
8. Physician equity in IPAs is a critical issue for maintenance of desired degrees of control and autonomy and must be carefully considered by IPA physician participants. These principles may

be valuable for physician education and for incorporation into IPA vision and mission statements.

5.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: No Response.

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

Response:
While case or care management has long been identified in the MCO contracts, there has been little progress in ensuring those at-risk, under-served, English as a second language, or school-based clients have seen any actual improvements in the quality of life or quality of care. This stems from the challenges associated with coordinating primary and behavioral health care on the same day.

Ultimately, there should be a bundled rate as a value add for behavioral or primary health services, where the provider demonstrates an attempt to coordinate care. Under MSM 400, case management is for those without SED or SMI (Seriously Mentally Ill). The bonus payments should focus on the case management component for those that need behavioral health services, regardless of whether they are SMI or SED. This could be accomplished by the Community Health Worker, an IPA, or similar individual provider association, or networks that focus on patient-centered care. This value add or bonus strategy can be developed to increase care or case management, while minimizing the number of visits and the types of visits clients need to make in person, and expanding the use of telehealth and home-based programs.

In addition, there are currently no funding mechanisms, or coordination or value-added services, for someone who presents with co-morbidity issues, potentially both physical and behavioral health related, that incorporates levels of prevention to build a comprehensive approach to stop the progression, and treat the overall individual, decreasing and controlling the severity of the existing challenges.

Response:
A value-based model cannot succeed if the default is FFS. There must be a case for shifting the model design, and with a backup of FFS, you do not get the full effect of an innovative design model. When supporting enhanced payment structures that are designed to be value-based, the only rate of return seen for states is when the models are comprehensive, accountable, and share the risk. The models that are built around prospective payments to providers build in flexibility to support the delivery of nutritional or other services, while also addressing the social vulnerabilities that contribute to the longer-term disparities in health equity. The performance metrics for value-based services should be based on the implementation of activities that focus on social and health needs, which also includes safety net services that may be a value-add to the primary allowable activities of a MCO, IPA or other major organizational strategy.

Section 6: 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?

Response:
Nevada has a 24-hour workforce, but the healthcare industry has not adjusted to develop the capability to serve families outside of traditional work hours, other than by having them visit quick care facilities or hospital emergency rooms.

There are other elements of social determinants of health to include, but not limited to, education and prevention programming; case and care management; and transportation to sports or gym related activities that promote good health. The Division should consider providing incentives to managed care organizations to provide these services at times that are accessible to workers and families who can't access them during times when they are currently available.

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?

Response:
Yes. Examples include:

- Socialization programs, for seniors and adolescents (disparity)
- Nutritional assessment, supplements, home delivered meals (health and disparity)
- Non-medical transportation, beyond the supplemental benefit level (health and disparity)
- Adult day care (health)
- Bed bug treatment (health and disparity)
- Offer home visits for high-risk individuals as a substitute for in-office visits under certain circumstance (health and disparity)
- Preventative dental sealants (health and disparity)
- Community transition services (health and disparity)
- Case Management for non-SED youth and adolescents, as a billable payment (health)

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?

Response:
There should be mandatory requirements for health and behavioral health prevention and deflection. This should emphasize deflection for behavioral health by supporting specific programs; not prevention agencies, which are high-level, but rather after school or school-based initiatives that target the most vulnerable.

The focus should be on wrap-around services; especially upstream deflection and prevention programs serving socio-economic at-risk youth and adolescent populations. Additionally, the definition of "improving health outcomes" should be updated and clarified.

Without a stronger focus on deflection programs, it is more likely the child will need treatment through adulthood.

Section 7: Other Innovations

7. 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: Restrict consolidation of third-party administration organizations for at-risk providers. These create a hostile environment for providers, which often result in "strong-arm" tactics pushing some providers to exit the Medicaid payment programs.

Response: The current structure which provides a fraction of the PMPM rate for children reduces the incentive to provide youth and adolescents with comprehensive care. The care coordination for a youth or adolescent who may be facing challenges with a chronic condition or behavioral health is often more complicated than it is for adults. Balancing the PMPM will encourage better youth/adolescent service delivery.