From: Kenneth Mckay <Drkenmckay@healthymindslv.com>
Sent: Monday, October 9, 2023 7:09 PM
To: DHCFP StatewideMCO <StatewideMCO@dhcfp.nv.gov>
Subject: RFI for Nevada Medicaid Managed Care Expansion

Ken McKay, Ph.D.

1. 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?
    No response
    b. Beyond utilizing state directed payments for rural health clinics and federally qualified health centers as outlined in state law, are there other requirements that the Division should consider for ensuring that rural providers receive sufficient payment rates from managed care plans for delivering covered services to Medicaid recipients? For example, are there any strategies for ensuring rural providers have a more level playing field when negotiating with managed care plans?
    No response
    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?
    Student loan repayment would attract and retain people to work with this population. If any agencies or service providers working with this population are not an approved site, helping them navigate the process would bolster their staffing stability and retention to work with this population. The application process is time-consuming and challenging to navigate, and offering to assist would entice people to choose this line of work over others. I know multiple providers who would love to avail themselves of student loan repayment opportunities but are overwhelmed by the task and choose the path of least resistance. Since becoming a site, I have had 3 staff happily report they're committed to working in my Medicaid clinic for the next 3 years as a result.
    d. Are there best practices or strategies in developing provider requirements and network adequacy standards in managed care that have been effective in other states with respect to meeting the unique health care needs of rural and frontier communities?
    No response

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.

Having 5 contracts with 5 different sets of rules buried in lengthy contracts is dizzying. The contracts aren't specific enough to cover specific situations, so payors interpret (or make up as they go along) the absence of direction differently. Example: The state and one MCO allow Type 17 clinics to enter group NPIs into 24J. The other 3 MCOs do not for different stated reasons. Medicaid representatives who answer the phone say MCOs are supposed to do things the same as the state. MCO representatives say that's not true. The result is that CADCs are able to practice within their scope for patients under 2 payors but not the other 3. Clinics have to carefully govern patient assignment to providers in view of all the seemingly minor differences that add up to one giant headache for providers credentialed with all 5 Medicaid products. These differences sometimes disrupt care for patients who switch MCOs because the rules under one MCO no longer apply with the other. Establishing a required boiler plate contract that brings some uniformity would be helpful, particularly for policies that affect continuity of care.

Transportation for minors to facility-based services, such as IOP and PHP, is effectively unavailable. Most transportation providers require legal guardians to accompany the child to the appointment, but the services last 3-6 hours and are to be delivered out of the guardian's presence. Transportation providers will not drive the adults back home; they call it dead-ending. The result is that either healthcare clinics provide (and pay for) an attendant to sit in the vehicle during the transport (unreimbursed) so minors can access this level of care, or the children simply won't receive the care. Decision-makers point to policies that say it's legal guardian's responsibility to transport their children to appointments. The fact is that legal guardians aren't transporting kids to services, but responsibility becomes diffused. Decision-makers convey a message/tone along the lines of "this is out of my hands" or "there's nothing my agency can do about it," and everyone proceeds with the reality that children are not receiving the care they need.

2. 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?

    Providers would be eager to contract with payers that are purchasing blocks of time to serve a given population. With, say, 10 hours/wk allocated to a given payer/population, the burdens of scheduling and payment are reduced. Rural resources could be mobilized to ensure patients keep appointments to ensure purchased blocks of time aren't wasted by no shows. This arrangement will be appealing to providers and improve patient access and engagement.

    b. Are there best practices from other states that could be used to increase the availability of behavioral health services in the home and community setting in rural and remote areas of the State?

    No response

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?
You ask about value-based reimbursement below, so I will duplicate my responses.
Ask for a 1-page handout providers would receive describing reimbursement models beyond fee-for-service. Take the handout to 3 mental health providers or agencies and ask them if they understand the plan and would enroll in it.
Request 10 references from existing providers engaged with the plan in reimbursement models other than fee-for-service for each applicant and see what they say.
Identify factors that constitute value beyond availability and access.
Consider incentives for providers using electronic records and who will give administrative access to carriers to collaborate and verify availability.

3. 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?
    No response
    b. Are there certain provider payment models (e.g., pay-for-performance, pregnancy health homes, etc.) that the Division should consider that have shown promise in other states with respect to improving maternal and child health outcomes in Medicaid populations?
    No response
4. Market & Network Stability
    a. Service Area
        i. 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.
        One state: Telehealth and licensing allow providers to practice throughout the state. Things are already complex enough with multiple payers, and this extra wrinkle is just going to make things even more complex.
        ii. Please describe any other best practices used in other states that the Division should consider when establishing its service area(s) for managed care plans that have balanced the goal of ensuring recipient choice and market competition (price control) with market stability and sufficient provider reimbursement.
        No response
    b. Algorithm for Assignment
        i. Are there other innovative strategies that the Division could use in its Medicaid programs with respect to the assignment algorithm that promotes market stability while allowing for a “healthy” level of competition amongst plans?
        No response
5. 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?

No response

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?
Partner with university systems that are educating and training professionals, and put together a course on healthcare reimbursement. 99% of providers out here can't envision reimbursement occurring in any other fashion than FFS, in part, because no one teaches them.
Partner with professional associations to deliver continuing education or information about VBR. De-mystify it. I have to subscribe to openminds.com and pay for special seminars to find people who can help me wrap my head around it and implement it. How about a how-to? Or a checklist of things for providers to do to prepare for VBR or a guide to determining whether you're ready for VBR?
Solicit input from providers when defining and operationalizing value. Particularly if we are going to share the risk (but even if we aren't), we ought to have an understanding of the following:
    i. **who operationalizes each outcome**
    ii. **what data sources are being used**
    iii. **who gathers, stores, has access to, analyzes, and reports data?**
    iv. **To demonstrate value, we will align on what targets need to be met. Will we measure a baseline for comparison? Will we use a control group? Both?**
    v. **From there, how much improvement or difference/variance is enough?**

c. What considerations should the Division keep in mind for promoting the use of value-based payment design with rural providers?
No response

6. 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?
    No response
    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?
    Encourage or reward providers for including v/z codes in their diagnoses and payors for collecting, reviewing, and acting on them. Upon receive of these codes on claims, MCOs could treat the codes as referrals for targeted SDH interventions. Mental health professionals may hear about issues when they're still big enough to see and small enough to solve. This strategy makes the referral at the time of claims submission, killing 2 birds with one stone, and it would be the MCO's responsibility to enact the requisite interventions.
    c. Nevada requires managed care plans to invest at least 3 percent of their pre-tax profits on certain community organizations and programs aimed at addressing social determinants of health. Are there any changes to this program that could be made to further address these challenges facing Medicaid recipients in support of improving health outcomes?
    No response
7. Other Innovations

a. 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.
No response

Thanks!
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Vision: Raising Nevada's mental health ranking from 51st to 1st

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