Request for Information for the Nevada Medicaid Managed Care Expansion

Submitted to:
Department of Health and Human Services
Division of Health Care Financing and Policy
Nevada Medicaid
StatewideMCO@dhcfp.nv.gov
October 10, 2023, at 4:00 PM PST

Submitted by:
Molina Healthcare of Nevada, Inc.
Rob Baughman
Plan President
robert.baughman@molinahealthcare.com

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.
8329 W. Sunset Rd., Ste. 100
Las Vegas, NV 89113
robert.baughmanIII@molinahealthcare.com
Cell: 775.895.7396

October 17, 2023

Stacie Weeks, Administrator
Division of Health Care Financing and Policy
1100 E. William Street, Suite 101
Carson City, Nevada 89701
StatewideMCO@dhcfp.nv.gov

RFI for Nevada Medicaid Managed Care Expansion

Dear Stacie:

We applaud the Division's efforts in requesting and gathering public input and feedback on certain requirements and expectations to consider for the upcoming expanded Medicaid Managed Care Program. As requested, Molina is submitting this electronic copy of our RFI response. As an experienced managed care plan and trusted partner to the Division, providers, stakeholders, and community-based organizations across Nevada, we are continually expanding and developing programs and support for the members we collaboratively serve. Leveraging the nationwide expertise of our sister health plans and our experiences as a trusted partner in Nevada, this executive summary offers an overview of the ideas, information, recommendations, innovations, and best practices that we describe in detail in our RFI response for the Division to consider:

Limiting Exclusive Contracting. Exclusive provider agreements limit access to care. Some states, such as Minnesota, New York, and Wisconsin, have enacted laws and regulations to curb this practice. We recommend the Division include this prohibition in the procurement and managed care plan Contracts to ensure Medicaid recipients have appropriate choice and timely access to services. For example, in Nevada, Southwest Medical Associates and Liberty Dental Plan are owned in full or in part by managed care plans. These situations typically lead to exclusive agreements or financial arrangements that are above market and limit member access to services, as was the case in Nevada. We also recommend the Division add contractual language that managed care plans cannot use exclusivity verbiage when contracting or coordinating with community-based organizations.

Increasing payments for rural providers. We recommend the State offers additional funding to providers and health systems that create collaboratives to increase access to both provider visits and rural hospitals. An increase to the Nevada FFS schedule by the State, particularly for rural and frontier providers, will help ensure provider participation. The State could offer differential adjusted payments to select rural and frontier Nevada providers that meet established performance criteria, similar to the approach employed by the Arizona Health Care Cost Containment System. Payment could include collaboration of tele-consultation that allows rural hospitals to keep their patients in the hospital.

Covering SDOH resources and supports. By adding SDOH benefits as a covered, encounterable benefit, managed care plans and providers can support members with SDOH needs that may be impacting their health or well-being. Some states are using waivers to add SDOH services as covered benefits, rather than using value-added or in lieu of services. For example, Massachusetts received CMS approval to add nutrition support as a flexible services program; North Carolina is piloting a program to add in food support and meal delivery; Oregon has added housing and nutrition as covered services; California has added enhanced care management and other SDOH supports as covered benefits; and Washington has a proposed plan to add nutrition as a covered benefit.

Capping enrollment for managed care plans. Molina recommends the Division establish multiple regionally based service areas in lieu of a statewide contracting approach. We recommend the Division require managed care plans to bid on all service areas and indicate their order of preference for award. In adopting this approach, we encourage the Division to also place a limit on a managed care plan's total enrollment. When a managed care plan has a significantly higher market share than other health plans, it places the membership and the State at risk, should the plan exit the market. A managed care plan with a large share of the membership pool can hinder recipient choice across plans due to the plan's ability to form exclusive provider arrangements, hindering a smaller plan's ability to implement value-based payment (VBP) arrangements to improve quality of care and reward providers. Members are less likely to choose a managed care plan when providers do not see the value in contracting across networks.

Advancing Data Sharing Capabilities. Access to timely, accurate, and complete data and information is key to the success of a Medicaid Managed Care Program and optimal member health. We recommend the Division evaluate the HealthHIE Nevada, electronic health record systems, the Prescription Drug Monitoring Program, and OpenBeds® for interoperability-based use cases that will provide the needed data for analysis. Without information on emergency room visits, admissions, and discharges, rural providers are at a disadvantage in meeting quality measures and providing preventive and follow-up care (along with the corresponding value-based reimbursement). Since several states border Nevada, we recommend the Division partner with neighboring states to establish mechanisms to share information, including Prescription Drug Monitoring Program data. To support continuity of care to address members' SDOH needs, we also recommend managed care plans have access to member SDOH information from the Division's partners and other stakeholders, specifically through the Homeless Management Information System and Continuum of Care Program's point of entry to track housing needs.

Expanding access to broadband and cellular communications. While we recognize that the Division has many priority areas, we recommend earmarking dollars to invest in expanding cellular or broadband access in rural areas. We recommend the Division add a question to the Medicaid enrollment form to ask recipients about their access to and the availability of reliable broadband in their area. Responses will help the Division track and understand the highest priority areas for broadband expansion.

Thank you for the opportunity to respond to this RFI and to collaborate with you to serve Nevada's Medicaid recipients statewide to ensure sufficient access to care. We value our partnership with the Division and look forward to providing additional information if needed. If you have questions or require clarification, please contact me directly.

Sincerely,

Rob Baughman

Response Template

Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion

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Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid 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: Timely access to healthcare providers is critical to positively impacting the health and well-being of Medicaid recipients. Moreover, we understand fully that recipients living in rural and frontier areas of Nevada face a variety of access barriers that we look forward to collaboratively addressing with the Division and providers. Strategies and requirements we recommend the Division consider for its upcoming procurement and managed care plan Contracts include:

- **Prohibiting exclusive contracting.** Exclusive provider agreements limit access to care. Some states, such as Minnesota, New York, and Wisconsin, have enacted laws and regulations to curb this practice. We recommend the Division include this prohibition in the procurement and managed care plan Contracts to ensure Medicaid recipients have appropriate choice and timely access to services.
- **Expanding coverage of virtual/telehealth visits and remote patient monitoring.** To facilitate use of virtual/telehealth services, we encourage the Division to allow virtual/telehealth services that are performed by Medicaid-enrolled providers be included as a covered benefit in its procurement and managed care plan Contracts regardless of the location of the provider, including across State lines. We also recommend the Division include remote patient monitoring as a covered benefit. Virtual/telehealth services and remote patient monitoring are valuable tools to expand access to healthcare services, particularly in rural and frontier areas.
- **Requiring participation of county-funded facilities.** To enhance recipient access to care and choice of providers for the next procurement, we recommend the Division require all county-funded facilities, such as community health centers, Certified Community Behavioral Health Centers, and school-based health centers, to participate in managed care plan provider networks.
- **Carving in dental**. We encourage the Division to consider adopting a carve-in dental program where managed care plans integrate dental services into their physical health Medicaid Managed Care Programs. Managed care plans will then have an additional financial incentive to keep their members healthy, which means that they are more likely to invest in dental preventive care; this can lead to increased access to dental care for members, especially those in rural and underserved areas. A dental carve-in will offer the Division several benefits including reduced costs, ceded insurance risk, and decreased program management. Members will also benefit from a dental carve-in through streamlined administration, enhanced engagement, and increased integration with physical health to ensure comprehensive and coordinated care, promoting better oral health and overall wellness.

Beyond the upcoming procurement and Contracts with managed care plans, we recommend the Division consider the following enhancements to increase provider availability and access:

- **Enhancing transportation reimbursement for rural providers.** Transportation barriers can lead Medicaid recipients to skip provider visits. Individuals living in rural communities typically have higher rates of chronic conditions which require multiple visits to outpatient healthcare facilities.

For example, in Nevada's rural communities, the prevalence of adult diabetes in rural counties is not only higher than urban counties, but it has also increased in nearly every rural county.[1] Individuals living in rural areas sometimes have to travel extended periods of time to attend a specialty care appointment. We recommend the Division increase reimbursement for non-emergency medical transportation to attract more drivers and facilitate timely access to care.

- **Allowing providers who are working at the top of their licensure to bill for additional services.** Emergency medical technicians and paramedics are trained to provide various basic and preventive healthcare services outside of their traditional duties. For example, approved as a Medicaid-covered service, community paramedicine allows emergency medical technicians and paramedics to provide services to individuals in their homes, such as taking vital signs and blood pressure readings and providing immunizations, fall prevention, wound care, and medication administration or compliance to assess the need for emergency services. However, the current fee schedule structure limits a provider's ability to bill for services outside the fee schedule. We encourage the Division to reimburse providers for these valuable services—just as they have with allowing pharmacists to bill for family planning services—which will broaden access to basic and preventive healthcare.
- **Partnering with neighboring states to share data and information.** Access to timely, accurate, and complete data and information is key to the success of a Medicaid Managed Care Program and optimal member health. Since several states border Nevada, we recommend the Division partner with neighboring states to establish mechanisms to share information, including Prescription Drug Monitoring Program data.
- **Expediting provider licensure.** We recommend the Division pursue activities to expedite the issuance of new licenses and reactivation of expired licenses for healthcare providers in rural and frontier areas to facilitate timely access to licensed providers. This process will in turn help managed care plans add new providers to their networks and expand access to care.
- **Increasing the availability and access to real-time substance use disorder (SUD) and opioid use disorder information.** The State has multiple sources that could provide valuable real-time data. We recommend the Division evaluate the HealthHIE Nevada, electronic health record systems, the Prescription Drug Monitoring Program, and OpenBeds® for interoperability-based use cases that will provide the needed data for analysis. We also encourage the use of non-claims-based data sources (e.g., comprehensive assessments) to ensure the capture of all necessary data.
- **Championing legislation.** We commend Nevada's elected officials who have helped introduce initiatives to address rural healthcare needs. Some key examples are addressing physician shortages through the Medical Student Education Authorization Act, Rural American Health Corps Act, and Maximizing Outcomes through Better Investments in Lifesaving Equipment (MOBILE) for Health Care Act. We encourage the Division to continue supporting such initiatives to enact legislation that helps address provider shortages in rural and frontier areas.
- **Gathering feedback on value-based payment (VBP).** Similar to the Division's intent to host at least three public workshops and meet with rural hospital systems to better understand local healthcare needs and challenges, we recommend the Division solicit feedback on VBP, such as provider types, fee schedules, and time and distance standards. The Division could use this information to prioritize VBP categories.

We look forward to working collaboratively with the Division and the State's rural healthcare providers to effectively address provider availability and access.

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[1] University of Nevada, Reno, School of Medicine, Office of Statewide Initiatives, Nevada Rural and Frontier Health Data Book—10th Edition, https://med.unr.edu/statewide/reports-and-publications/nevada-rural-and-frontier-health-data-book, February 2021, accessed September 25, 2023.

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: We understand how critical it is that rural providers receive timely, accurate, and sufficient payment from managed care plans. Strategies and requirements we recommend the Division consider include:

- **Increasing the State Medicaid provider FFS schedule for rural and frontier providers.** Research indicates that higher Medicaid payment rates are associated with higher rates of physician acceptance of new Medicaid patients. An increase to the Nevada FFS schedule by the State, particularly for rural and frontier providers, will help ensure provider participation. The State could offer differential adjusted payments to select rural and frontier Nevada providers that meet established performance criteria, similar to the approach employed by the Arizona Health Care Cost Containment System. Managed care plans would in turn pass these increases onto the appropriate providers. This approach will provide various benefits to the Division including increased provider participation in managed care plan networks, member access to care, and provider workforce capacity. Additionally, ensuring that the fee schedule covers the underlying costs of these providers helps drive a sustainable structure for these providers and a successful expansion of managed care into these areas.
- **Educating providers.** As a trusted resource to rural and frontier providers, we recommend the Division provide education to providers that will be new to the Medicaid Managed Care Program, so they understand how to effectively work with managed care plans. Such support could include engaging a specialized taskforce to provide guidance on educational topics, such as negotiating provider agreements with managed care plans and conducting reimbursement rate analysis, empowering rural providers to advocate for mutually beneficial arrangements and determining sufficient payments.
- **Laying the foundation to support investments in IT.** Health IT is a valuable tool to improve the quality, safety, effectiveness, and delivery of healthcare in rural areas. We encourage the Division to set the tone to facilitate access to technology, such as connection to HealtHIE Nevada. Without information on emergency room visits, admissions, and discharges, rural providers are at a disadvantage in meeting quality measures and providing preventive and follow-up care (along with the corresponding value-based reimbursement). A large barrier to rural provider implementation is the initial start-up cost of using platforms like HealtHIE Nevada and OpenBeds.
- **Supporting rural and frontier providers.** Due to unique circumstances rural and frontier providers face, we encourage the Division to look for opportunities to expand initiatives to reduce gaps and boost services at rural and frontier providers. One example is through initiatives such as the Central Nevada Health District, as well as through grants and bonus payments that are specifically designed to meet the needs of rural and frontier communities.
- **Allocating funds to services.** We recommend the State allocate funds from settlements, such as monies from the opioid settlement, to enhance rural healthcare and key services such as virtual/telehealth and the State's 988 crisis line.

We are steadfast in our commitment to working with the Division and rural and frontier healthcare providers to ensure they receive sufficient payment rates.

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: Molina supports a meaningful and actionable Medicaid Provider Workforce Development Strategy & Plan, particularly important to rural and frontier Nevada. We commend the State for its actions to date, including the recent bill, SB 511, that expands Medicaid rates to providers of personal care services.

First, we recommend the Division fund a study to pinpoint provider workforce gaps and needs by region. Although there is a significant amount of information available, to gain an accurate picture and allow managed care plans to focus on areas where we could have the greatest impact, we also recommend the study examine nonuse of providers, such as counting rural residents who could not find an appropriate healthcare provider. This information will provide a fuller picture of the sufficiency of the available healthcare workforce to residents in rural and frontier areas. Managed care plans can use this information as they develop their Medicaid Provider Workforce Development Strategy & Plan to ensure it reflects local needs and challenges, such as provider recruitment in underserved areas.

We also recommend the Division provide financial and legislative supports that help expand and maintain the provider workforce such as:

- Educational training and certification programs
- Grants
- Loans
- Fellowships
- Scholarship (e.g., community health worker training and certification)
- Loan forgiveness
- Faculty loan repayment
- Tax credits (e.g., offering personal tax credits to physicians, nurses, community health workers, dentists, and volunteer emergency medical technicians practicing in rural areas)

This support includes nationally- and federally-funded initiatives for allied health workers such as the Rural Public Health Workforce Training Network Program, National Health Service Corps Loan Repayment Program, Substance Use Disorder Workforce Loan Repayment Program, and Indian Health Service Loan Repayment Program. For example, the State could leverage the experience of the Oregon Health Care Provider Incentive Loan Repayment Program, established by the Oregon Legislature, which helps support underserved communities in their recruitment and retention of high-quality providers who serve patients regardless of their source of coverage or ability to pay. In exchange for services at a qualifying practice site, participants receive funds to repay qualifying educational loan debt. The Division could also partner with technical schools, such as UNLV's Perry Foundation Academy of Health, to develop online curriculum and distance learning programs for entry-level healthcare positions.

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: Tapping into the experience of our Medicaid health plan affiliates in other states, we offer the following best practices and effective strategies for the Division to consider in developing provider requirements and network adequacy standards:

- **Expanding the catchment area, so managed care plans can include providers in neighboring states to meet access requirements.** We recommend the Division expand the Nevada catchment area beyond Arizona, California, Idaho, and Utah to include Oregon. Furthermore, we recommend the catchment area be defined by a distance of 100 miles. This approach is used by the New Mexico Human Services Department, which allows managed care plans to include providers within 100 miles of any New Mexico border county in its service area.
- **Holding community town halls**. One best practice to fully understand the unique healthcare needs and perceived gaps in care is to conduct "town hall" meetings in local communities. Held in person and virtually, these events have been hosted by Medicaid program offices in Iowa and Michigan, just to name a few.
- **Exploring options to increase the number of trained and licensed allied health professionals.** We recommend the Division evaluate eligibility for certain provider types, such as physician assistants and pharmacists, to ensure they can practice up to the limit of their licensure. This will expand the range of providers in rural and frontier areas that are eligible for payment and allow managed care plans to improve network adequacy and increase recipient access to services.
- **Expanding provider types that can deliver prenatal services.** Prenatal care is typically used at lower rates in rural areas. The 2021 Nevada Rural and Frontier Health Data Book reported the rate of women receiving prenatal care in their first trimester in 10 rural counties was below the State average.[2] We recommend the Division consider allowing nurses and pharmacists in rural and frontier areas to deliver prenatal services and set up satellite OB clinics that rotate through underserved areas. Such programs have been employed in states such as Arizona, Missouri, and New Mexico. For example, New Mexico's Rural OB Access and Maternal Services program is using OB satellite clinics to expand access to care in mountainous, sparsely populated counties in the northeastern part of the State.
- **Exploring virtual/telehealth centers.** In New Mexico, the State facilitated development of an Inside Out Recovery center in Espanola. Based at a community agency in an area with a high rate of SUD, the center has a fully-equipped virtual/telehealth unit staffed by Peer Support Specialists who support individuals with SUD. These Peer Support Specialists also assist our New Mexico affiliate's members with creating an email address, registering on the telehealth platform, and scheduling virtual provider appointments to ensure timely access to services.
- **Adopting network adequacy requirements specific to rural and frontier areas.** One best practice we've observed in other states is establishing a separate set of time and distance standards for rural and frontier areas. **Table 1** provides a summary of rural access standards from various markets.

Table 1. Provider Network Adequacy Standards

Specialty	Arizona Medicaid Contract—Rural Minutes/ Miles	California Medicaid Contract—Rural Minutes/Miles	Nevada Marketplace Contract Minutes/ Miles	Nevada Medicaid Contract Minutes/Miles	Texas Medicaid Contract—Rural Minutes/Miles
Primary Care (Adult)	40/30	30/10	40/30	15/10	40/30
Pediatrics	40/30	30/10	40/30	15/10	40/30
Hospitals	95/85	30/15	75/60	45/30	45/30
OB/GYN	90/75	30/10 primary care 90/60 specialty care	--	15/10	90/75
Endocrinology (Adult & Pediatric)	--	90/60	--	60/40	--

[2] Ibid.

Specialty	Arizona Medicaid Contract —Rural Minutes/ Miles	California Medicaid Contract—Rural Minutes/Miles	Nevada Marketplace Contract Minutes/ Miles	Nevada Medicaid Contract Minutes/Miles	Texas Medicaid Contract—Rural Minutes/Miles
Infectious Disease (Adult & Pediatric)	--	90/60	--	60/40	--
Oncology—Medical/Surgical (Adult & Pediatric)	--	90/60	75/60	45/30	--
Oncology—Radiation/Radiology (Adult & Pediatric)	--	90/60	110/90	60/40	--
Rheumatology (Adult & Pediatric)	--	90/60	110/90	60/40	--
Psychiatrist (Adult)	--	90/60	75/60	45/30	75/60
Board-certified Child and Adolescent Psychiatrist (Adult & Pediatric)	60 miles	90/60	--	45/30	75/60
Psychologist (Adult & Pediatric)	60 miles	90/60	75/60	45/30	--
Qualified Mental Health Professional (Adult & Pediatric)	60 miles	90/60	--	45/30	--
Outpatient Dialysis	--	--	90/75	45/30	--
Pharmacy	40/30	--	--	15/10	--

We recommend the Division consider an approach similar to the one employed by New Mexico's Human Services Department for their Medicaid program, in which:

- 90% of rural members should travel no farther than 60 miles unless the type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the Medicaid agency.
- 90% of frontier members should travel no farther than 90 miles unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the Medicaid agency.

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: We believe a significant factor that limits access to covered services and care is exclusive contracting between a managed care plan and a provider. As noted in the response to Question 1.A, some states, such as Minnesota, New York, and Wisconsin, have enacted laws and regulations to curb exclusive contracting, which can happen in various ways, including through providers that are fully or partially owned by managed care plans. For example, in Nevada, Southwest Medical Associates and Liberty Dental Plan are owned in full or in part by managed care plans. These situations typically lead to exclusive agreements or financial arrangements that are above market and limit member access to services, as is the case in Nevada.

Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion
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:*** The use of virtual/telehealth modalities is important to expanding member access to behavioral health services across the State. The Agency for Healthcare Research and Quality (AHRQ) found that mental health services can be effectively delivered via telehealth[1]. By using virtual/telehealth delivery systems, mental health services can be provided in a variety of rural settings, including rural clinics, schools, residential programs, long-term care facilities, and individual homes. In our experiences working with high-needs populations, we have learned that there are strategies that can expand the use of virtual/telehealth modalities to address behavioral health needs in rural areas, which include:
- **Improving access to broadband and cellular communications**. From serving Medicaid members across the State, we have learned that unreliable cell or broadband services significantly limit members' access to virtual/telehealth services. Compared to their urban counterparts, individuals in rural areas are nearly two times more likely to lack broadband access. Internet access has become an essential component of daily life, and the digital divide has contributed to the time and distance gap between doctors and patients, also known as the broadband health gap. The Connect2Health[FCC] Task Force's Advancing Broadband Connectivity as a Social Determinant of Health Initiative aims to deepen understanding of the relationship between broadband access and health outcomes. Ongoing research from this platform shows that "Internet adoption appears to have an even stronger correlation to health outcomes, even after controlling statistically for other potentially confounding factors, such as education, income, and rurality."[2] While we recognize that the Division has many priority areas, we recommend earmarking dollars to invest in expanding cellular or broadband access in rural areas, which include innovations such as:
  - **Adding devices to access virtual/telehealth care.** We recommend the Division offer devices (such as a tablet, phone, or MiFi) with additional data and minutes to complete virtual/telehealth visits.
  - **Expanding telehealth location access.** Members in rural areas need greater opportunities to access telehealth for behavioral health services. We recommend the Division incentivize providers to offer telebehavioral health services from their physical locations using dedicated offices and technology. This should include incentivizing the development of centralized locations for telehealth hubs in rural areas, such as town halls, community centers, or fire departments that have broadband and Internet.

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[1] Totten, Annette M., et al., "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews," AHRQ, https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/telehealth_technical-brief.pdf, June 2016, Accessed September 25, 2023.

[2] US Federal Communications Commission (FCC), "Advancing Broadband Connectivity as a Social Determinant of Health," https://www.fcc.gov/health/SDOH, February 7, 2022, accessed September 15, 2023.

- **Ensuring telehealth rate parity.** Expanding access to behavioral health care in rural Nevada begins with developing reimbursement structures that offer the same rates for behavioral health visits regardless of whether the visit occurred in person or virtually. We recommend standardizing this rate and further expanding the number of billing codes to include multiple types of virtual/telehealth behavioral health visits. This approach will expand access to these services and to the number of providers who can connect with members from all corners and areas of the State. Leveraging licensed behavioral health specialists in urban areas to support members in rural areas will maximize available resources.
- **Expanding covered virtual/telehealth visits.** We recommend including virtual/telehealth visits from Peer Support Specialists or Case Managers who specialize in behavioral health as a covered benefit. This approach will ensure members, particularly in rural areas, receive support for behavioral health needs, creating and maintaining a larger community with a focus on holistic care for greater long-term stability.
- **Allowing for location flexibility for Nevada-licensed providers.** We recommend the Division allow behavioral health providers licensed in the State of Nevada who are registered with the Medicaid agency in their current state but not registered with the Division to practice telebehavioral health, regardless of their physical location. By making this policy change, members can have access to a larger network of providers that is currently excluded from offering services in the State.
- **Waiving in-person requirement for controlled substance prescribing providers.** We recommend permanently removing the six-month face-to-face visit and PCP referral requirements to help licensed behavioral health providers to prescribe controlled substances by extending the rule (that was developed during the public health emergency) that allowed this visit to occur via telehealth and codifying the practice in State policy. In our clinical expertise, telebehavioral visits (using both audio and video) conducted by trained and licensed prescribers are an evidence-based and effective method to ensure safe prescribing of controlled substances as part of substance use disorder (SUD) treatment. The US Drug Enforcement Administration and SAMHSA adjusted their guidelines to allow for new buprenorphine prescriptions following audio-only telehealth encounters, no longer requiring an in-person evaluation prior to treatment initiation. In Rhode Island, through a collaboration with the Rhode Island Department of Health, a hotline was created to function as a 24-hour “tele-bridge” clinic where people with opioid use disorder can be linked with a waivered provider in real time for an initial assessment. If appropriate, the provider can initiate the use of buprenorphine through unobserved induction with linkage to longitudinal outpatient care. Patients are co-prescribed naloxone and emailed unobserved buprenorphine induction instructions, local harm-reduction information, community recovery support resources, and behavioral health services. From mid-April 2020 to mid-November 2020, the hotline fielded 93 calls, resulting in 74 new buprenorphine prescriptions.[3]
- **Adding a Medicaid enrollment question about Internet access.** We recommend the Division add a question to the Medicaid enrollment form to ask recipients about their access to and the availability of reliable broadband in their area. Responses will help the Division track and understand the highest priority areas for broadband expansion.
- **Investing in rural health.** We recommend the Division collaborate with Nevada Rural Hospital Partners to bolster their engagement as a stakeholder and directly contributes to their projects to improve resources and expand access to care in rural areas.

[3] Clark, Seth A., et al., “Using Telehealth to Improve Buprenorphine Access During and After COVID-19: A Rapid Response Initiative in Rhode Island,” Journal of Substance Abuse Treatment, https://www.jsatjournal.com/action/showPdf?pii=S0740-5472%2821%2900009-X, May 2021, accessed September 15, 2023.

- **Investing in Project ECHO®.** We recommend offering an incentive to providers to support and use Project ECHO to improve coordination and continuity with other entities and bring providers together. Managed care plans should support Project ECHO in developing and offering Nevada license renewal continuing medical education programming and expanding future educational opportunities for topics such as children's behavioral health needs.
- **Expanding the Behaviorally Complex Care Program.** This program has demonstrated success in Nevada by offering members mental health services in long-term care settings and expanding services provided in Nevada rather than having to go across State lines for care. We recommend the Division consider expanding this program to reach members in other settings, such as outpatient services and permanent housing services.
- **Funding opportunities for providers.** While there are opportunities for providers and other community-based organizations, such as Federally Qualified Health Centers or behavioral health provider groups, to receive funding through SAMHSA or other grant funding opportunities, we recommend using funds from the Division for capital start-up costs for mobile supports in rural areas to expand access. Many grant opportunities limit capital costs for necessary infrastructure support, such as renovating buildings and purchasing mobile vans, and often prohibit technology distribution. For example, the Division could offer funds directly to Certified Community Behavioral Health Centers, community mental health centers, or other behavioral health entities to expand services such as mobile medication-assisted treatment, virtual/telehealth visits, and crisis outreach services, or to set up satellite virtual care hub locations in local businesses in rural communities.

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:*** Molina and our affiliate health plans have demonstrated success implementing expanded coverage and programs to increase the availability of behavioral health services in the home and community setting in rural areas. In addition to the recommendations in the previous section, we recommend the Division consider implementing the following programs from other states:
- **Peer connection prior to discharge.** We recommend the Division support, incentivize, and increase rates for peer support involvement, in particular during discharge planning after a behavioral health hospitalization or other transitions of care. This approach will give managed care plans the flexibility to support members using Peer Support Specialists for initial and subsequent visits either in person or virtually. Our Arizona affiliate leveraged both health plan and provider Peer Support Specialists to provide support and care coordination to members prior to discharge from a behavioral health hospitalization. Our affiliate offers a Suicide Postvention program with additional outreach and high-touch care management by connecting members with Peer Support Specialists to complete more frequent outreach (compared to traditional care management) to collaboratively develop a crisis plan and connections to crisis resources. Peer Support Specialists establish effective and transformational relationships with providers, connect the member to the broader system of care, enhance care coordination, and amplify member voice and choice in program development and implementation. Through this Peer Reach-in program, our Arizona affiliate decreased behavioral health hospitalizations by 39%, increased outpatient behavioral health services by 38%, and improved access to care by 79% with improved rates of PCP visits and follow-up after emergency room use.
- **Increasing first-time diagnosis support.** We recommend incentivizing additional care management support for members with new behavioral health diagnoses to increase access to care and prevention activities. For example, our Texas affiliate can offer programs that target members with a new depression diagnosis. Eligible members with a first-time diagnosis are assigned a Behavioral Health Case Manager who offers education and support, coordinates appointment scheduling, and connects

them to resources and support. In 2022, an analysis of PHQ-9 scores in our Texas affiliate demonstrated a 61% decrease in depressive symptoms from the baseline assessment score.

- **Addressing housing needs.** We recommend the Division build funds or flexible funds to support those with housing needs. For example, the Health Outcomes through Meaningful Engagement (H.O.M.E.) program in Florida is a housing waiver pilot program that helps members ages 21 years and older who are living with serious mental illness or SUD and are homeless or are at risk of becoming homeless to access or maintain stable housing and additional support services, such as peer support and mobile crisis management. The program offers care coordination and housing support to high-needs members who can access sustainable housing through improved supports and avoid preventable high-cost services (like hospital events). In the second quarter of 2022, our Florida affiliate served 219 members through this program, 31% of whom had stable housing during enrollment, 77% were compliant with their medications, and 72% had fewer hospitalizations on average.
- **Partnering with pharmacies to offer long-acting antipsychotic injectables.** We recommend the Division allow managed care plans to cover services when they partner with pharmacies to offer long-acting antipsychotic injectables and expanded prescribing capabilities, ensuring the correct place and type of service on the fee schedule. This approach would require pharmacies and pharmacists to practice as providers to complete services for long-acting antipsychotic injectables and manage and prescribe medications (based on a licensed provider's diagnosis). We recommend including pharmacists as a provider type who can receive reimbursement for administering long-acting antipsychotic injectables as a covered service. For example, our affiliate health plan in Texas developed a program designed to directly impact members prescribed long-acting antipsychotic injectables with adherence gaps that may result in potentially avoidable emergency room use or hospital admissions and readmissions. Using quarterly pharmacy claims reports to identify members at risk, interventional letters are sent to both members and providers to remind them to fill long-acting antipsychotic injectable prescriptions timely and to inform them that medication may be conveniently administered at participating pharmacies. The overall goal of the program is to increase medication adherence, which benefits members' quality of life and decreases unnecessary utilization. From March through May 2023, members in our Texas affiliate who were part of the long-acting antipsychotic injectables program saw a 22% average reduction in inpatient behavioral health admissions, a 32% average reduction in outpatient behavioral health visits, and a 20% average reduction in behavioral health physician services.

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:*** Molina has experience providing innovative and comprehensive services to members to address behavioral health needs. Of the 18 states where Molina Healthcare has a subsidiary Medicaid health plan, 17 offer a full array of behavioral health benefits. Leveraging this experience, we recommend that the Division consider implementing certain incentives or provider payment models to increase access to behavioral health services that improve health outcomes such as:
- **Telemonitoring.** Remote patient monitoring and telemonitoring offers members real-time tracking of their health conditions. We recommend incentivizing or creating payment models to encourage the use of these technologies after emergency room or inpatient use.
- **Behavioral health applications.** We recommend that the Division add evidence-based app support for behavioral health needs (including for video appointments initiated in real time) as a covered benefit with direct reimbursement for services rendered in the app. Multiple modalities allow members to receive behavioral health support, including apps.

- **Behavioral health screenings.** We recommend offering incentives or direct provider payments to PCPs and OB/GYNs to complete behavioral health screenings will promote early identification of mental health or SUD needs. This will increase integration and collaboration between physical health and behavioral health providers and improve continuity of care for members.
- **School-based partnerships.** Many Molina members receive services through school-based programs and supports. In rural settings, schools act as aggregators and a place for members to receive care in a more geographically centralized location. We recommend offering schools funding opportunities to expand their behavioral health services, such as creating private spaces for mental health visits, purchasing technology to expand virtual/telehealth capabilities in schools, implementing a comprehensive service array for children with serious behavioral health conditions, and hiring and training additional licensed and non-licensed behavioral health supports, such as community health workers, to connect members to care.

While the recommendations we discussed in this response can improve access to services in the home for children, we are providing the following additional recommendations to support this population:

- **Incentivizing providers.** Finding in-home providers for children with behavioral or personal care needs can be challenging. We recommend offering incentives to UNLV, University of Nevada, Reno, and other community providers to offer services in the home for children with complex needs and that the Division include these services in the fee schedule and as part of the fee rates.
- **Expanding collaborative efforts to serve children in the home.** To support a system of care approach, we recommend the Division implement routine criteria evaluation and a collaborative analysis of service provision between Magellan (the newly established care management entity) and all managed care plans. Using our experiences with supporting this high-needs population, formalizing routine stakeholder or advisory committee meetings can improve collaboration and ensure that children, youth, and their families can receive care that is culturally responsive, community-based, and provided at the right level and the right time.
- **Offering a broad virtual/telehealth service array.** We recommend the Division expand covered services to include virtual/telehealth supportive services for youth under the age of 21. This approach will allow managed care plans to provide a broad service array, including intensive outpatient and partial hospitalization programs, to youth with high behavioral health needs and their families, particularly in rural/frontier locations. Our Washington affiliate helped pioneer access to tele-wraparound for children and their caregivers. They created a Virtual Intensive Engagement and Wrapround program that offers a suite of services for youth consisting of individual psychotherapy, family therapy, medication management services, care coordination, caregiver peer services, crisis response triage or response, and client peer services—all available through virtual/telehealth modalities. The initial results from this program show a 76% decrease in emergency room utilization and a 17% decrease in hospitalization.

Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion
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: Through our experience serving high-needs populations, Molina has learned that there are many strategies that can improve maternal and child health, including:

- **Maximizing and extending Medicaid benefit coverage.** We receive members who enroll with us late into their pregnancy and who have not had the general, preventive women's healthcare that they need. These members often have higher rates of complex pregnancies secondary to uncontrolled preexisting conditions (including hypertension, diabetes, or substance use disorder [SUD])—resulting in higher rates of preterm birth, increased severe maternal morbidity, and higher rates of NICU admissions. We recommend that the Division considers expanding coverage to women of birthing age to increase access to women's healthcare prior to pregnancy. Thirty-four states have already implemented this type of expansion, allowing members to receive preventive healthcare (i.e., depression screenings) and continued treatment of chronic conditions. New Mexico is one of many states that has added maternal child home visiting programs to the Medicaid fee schedule as a pilot. Some states are adding them to 1115 Waivers to allow managed care plans to educate and influence members and their families on EPSDT and well-child visit adherence.
- **Perinatal care trainings.** We recommend that the Division partners with managed care plans to offer trainings to perinatal care providers and members to increase awareness about midwives and doulas' roles, availability, and services.
- **High-risk pregnancy trainings.** We recommend that the Division partners with managed care plans to offer trainings to enhance education about high-risk perinatal care and support providers to expand their practices to include more high-risk members. For example, University of Utah Health educates rural maternal health providers on best practices for treating members with high-risk pregnancies. In 2015, their staff created the nation's only Pregnancy Care Extension for Community Healthcare Outcomes to offer biweekly videoconferences focused on topics suggested by university clinicians or participants. Sessions focus on topics like hypertension, SUD, hyperthyroidism, and gestational diabetes.
- **Birthing-friendly hospital designation.** CMS is establishing a birthing-friendly hospital designation to begin in the fall of 2023. This designation is a publicly-reported, public-facing hospital designation on the quality and safety of maternity care to reduce maternal mortality and morbidity. We recommend that the Division provide additional incentives for hospitals to obtain the birthing-friendly designation.

As a leader in advancing healthcare options for members through innovative strategies and solutions, we learn from our affiliates about innovations they are creating to expand access to maternal and child health in rural locations. In our New Mexico affiliate, their Rural OB Access and Maternal Services Collaborative is expanding access to care in 5 mountainous, sparsely-populated counties spanning 10,000 square miles in the northeastern part of the state. Before this work began, three of the five

counties were maternity care deserts. A key strategy of this initiative is opening satellite OB/GYN clinics in rural areas, two of which have opened already in the past year. The clinics are housed in community health centers and staffed by medical assistants or nurse practitioners who perform in-person perinatal visits. Members can meet through virtual/telehealth visits with OB/GYN providers in the nearest labor and delivery hospital. During the visits, the clinics and hospitals share information such as ultrasound images and vital signs of the member and their baby. The hospital providers bill for their services, while the satellite clinics are supported by grant funding. As a part of our recommendation to expand access to maternal and child healthcare in rural areas, we recommend incentivizing providers to offer care in rural locations by creating collaboratives, opening satellite offices, and expanding payments for telehealth services. Our additional recommendations include:

- **Expanding the doula workforce.** We commend the Division for expanding doulas as a covered service. To support and encourage doula workforce development and for doulas to enroll as Medicaid providers, we recommend that the Division considers incentives and financial assistance for doula certification and Medicaid enrollment training. We recommend that this support has a focus on doulas who can provide care for members in rural areas of Nevada or who are part of underserved racial or ethnic groups. For example, our Washington affiliate has increased their doula workforce by using funds from the Birth Equity Project to train members of local American Indian or Alaska Native tribes to work as doulas.
- **Transportation.** Members in rural/frontier areas of the State have limited access to reliable transportation options to access social determinants of health (SDOH) resources. Through our experience in multiple markets, we recommend that the Division makes supplemental transportation encounterable or an in lieu of service so managed care plans can provide transportation for members to access housing, food insecurity, employment, education, or other SDOH needs. We also recommend the Division allow members to bring their children or support person (such as a Community Health Worker, spouse, or caregiver) on the transportation ride to eliminate any barriers to care, such as a need for childcare.
- **Rural provider incentives.** We recommend increased payments for rural access to hospitals and OB/GYN providers, including for labor and delivery. We provide additional payment recommendation details and options in our response to the following question.

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: Molina has vast experience providing innovative and comprehensive services to members to improve maternal and child health outcomes. Based on our experience, we recommend that the Division consider implementing certain incentives or provider payment models to increase access to care and improve health outcomes.

- **Increased payment for rural access.** We recommend the State offers additional funding to providers and health systems that create collaboratives to increase access to both provider visits and rural hospitals. Payment could include collaboration of tele-consultation that allows rural hospitals to keep their patients in the hospital. In response to worsening access to maternity services in rural areas, the Federal Office of Rural Health Policy created the Rural Maternity and Obstetrics Management Strategies grant program in 2019. The goal is to encourage a range of healthcare providers—such as PCPs, OB/GYNs, maternal-fetal medicine specialists, behavioral health providers, and home visiting staff—to form regional networks that can fill gaps in the maternity care continuum. For example, in Georgia, Augusta University Medical Center supports 16 virtual/telehealth programs for rural hospitals, providing 24/7/365 consults in emergency rooms and inpatient settings. Through consultations, these programs decrease the number of patients transferred, ultimately increasing

hospital census and preventing rural hospital closures. The medical center conducts training and education to better equip providers to manage patient care in rural locations including through virtual and telehealth modalities, which helps more patients stay in the community.

- **Bundled payments.** To improve maternal and child health outcomes, we recommend offering alternative payment models that incentivize providers, including bundled payments for perinatal programs—with a requirement for shared encounter data throughout pregnancy for better visibility to member's health risks and care needs. These bundled payments are often tied to the episode of care (the birth of the child) and include a bundled rate that covers care during pregnancy and through the postpartum period; this bundled payment can also be used as a blended rate for high-risk pregnancies. Arkansas, Ohio, and Tennessee have implemented bundled payments for perinatal care in their Medicaid managed care programs. In each state, the episode is initiated retrospectively by a live birth, and covers all care provided to the woman 40 weeks prior to birth, labor, and delivery, and for 60 days postpartum. Payment for infant care following birth is not included in these models. While Arkansas and Tennessee exclude high-risk pregnancies, Ohio's bundled payment approach covers complications, and payment rates are adjusted accordingly. New York also implemented a maternity care bundle beginning in 2014. It includes prenatal care, delivery, and 60 days of postpartum care for women with low- and high-risk pregnancies, as well as 30 days of newborn care post-discharge. Programs in all three states showed improvements. In Arkansas, spending on perinatal episodes decreased 3.8% compared to surrounding states[1] .In Tennessee, spending on perinatal episodes was 7.7% lower per episode than what the state would have been paid if payments had not been bundled.[2]
- **Remote patient monitoring.** High-risk members benefit from frequent monitoring and tracking of their healthcare conditions. We recommend that those members receive a Tele-kit that is reimbursable by the Division so members can receive remote patient monitoring as a covered benefit. Remote patient monitoring encourages self-monitoring, early intervention opportunities, and access to more comprehensive, high-touch care in rural locations. For example, pregnant members with higher-risk conditions (such as diabetes or hypertension) could receive a Tele-kit that includes a tablet with embedded devices that monitor and report blood pressure, weight, oxygen level, glucose level, and fetal heart rates.
- **Adding withhold payments.** We recommend that the Division modify how auto-assignment is determined using the Timeliness of Prenatal Care and Postpartum Care measures and to instead use these prenatal and postpartum care measures as part of the Performance Withhold Arrangement to measure improvement year-over-year in this metric. The Performance Withhold Arrangement sets defined, incremental year-over-year targets. This methodology aligns with the Institute for Healthcare Improvement's Plan-Do-Study-Act model for accelerating improvements with defined duration, population, and goals. We evaluate changes on a small scale for any improvements and then scale efforts to the larger population.

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[1] Medicaid and CHIP Payment and Access Commission (MACPAC), "Fact Sheet: Arkansas Perinatal Episode of Care," Advising Congress on Medicaid and CHIP Policy, https://www.macpac.gov/wp-content/uploads/2021/09/Arkansas-Perinatal-Episode-of-Care.pdf, September 2021, accessed September 7, 2023.

[2] MACPAC, "Issue Brief: Medicaid Payment Initiatives to Improve Maternal and Birth Outcomes," Advising Congress on Medicaid and CHIP Policy, https://www.macpac.gov/wp-content/uploads/2019/04/Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf, April 2019, accessed September 7, 2023.

Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion
Section 4: Market & Network Stability

4.1. <u>Service Area</u>

4.1.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: Molina recommends the Division establish multiple regionally-based service areas in lieu of a statewide contracting approach. Our recommendation is based on the vast experience and insight our organization brings to Medicaid managed care and provision of healthcare services, including in rural and frontier areas. Molina and our affiliates deliver risk-based Medicaid managed care services to approximately 4.8 million members in 18 states, including rural and frontier areas in Arizona, Mississippi, Texas, and Utah.

In using this approach, we recommend the Division consider adopting the regional service areas used by Nevada Health Link, the online health insurance marketplace. This could also include dividing Service Area 4 into smaller regions to increase focus. For reference, we've included the Nevada Health Link service areas in **Table 2**.

Table 2. Nevada Health Link Service Areas

Service Area	Areas
1	Clark County and Nye County
2	Washoe County
3	Carson City, Douglas County, Lyon County, and Storey County
4	Churchill County, Elko County, Esmeralda County, Eureka County, Humboldt County, Lander County, Lincoln County, Mineral County, Pershing County, and White Pine County

We recommend the Division require managed care plans to bid on all service areas and indicate their order of preference for award. This approach was employed by the Arizona Health Care Cost Containment System (AHCCCS) in its 2023 RFP for individuals who are elderly and/or have a physical disability and enrolled in the AHCCCS program. It was also employed by the Texas Health and Human Services Commission in its 2022 RFP for adults with disabilities and elderly persons who are enrolled in the STAR+PLUS Program and its 2023 RFP for pregnant women, newborns, children, and parents with limited income who are enrolled in the STAR & CHIP Program.

In adopting this approach, we encourage the Division to also place a limit on a managed care plan's total enrollment. When a managed care plan has a significantly higher market share than other health plans, it places the membership and the State at risk, should the plan exit the market. Moreover, a managed care plan with a large share of the membership pool can hinder recipient choice across plans due to the plan's ability to form exclusive provider arrangements, hindering a smaller plan's ability to implement value-based payment (VBP) arrangements to improve quality of care and reward providers. Members are less likely to choose a managed care plan when providers do not see the value in contracting across networks.

We also recommend the Division award two managed care plans to cover the rural and frontier service areas, providing recipient choice of managed care plans without creating undue provider administrative burden.

Finally, we recommend the Division disallow managed care plans that are owned by the same parent organization to submit separate proposals in response to the future RFP. Instead, managed care plans must indicate one single legal entity name in their proposal. This approach was employed in Arizona by the AHCCCS and will help ensure market stability for recipients. Risk to market stability increases when one corporate entity participates in Medicaid managed care under multiple managed care plans, should the corporate entity exit the market.

We believe our recommended approach is in the best interest of the State, covered population, and providers by:

- **Reducing administrative burden for providers.** Rural and frontier providers will work with no more than two managed care plans. This approach will especially benefit those providers who are unfamiliar with Medicaid managed care and those with limited resources.
- **Promoting broader provider participation and recipient choice of providers.** As the program expands to rural and frontier areas, the market will stabilize more quickly since providers will only have two managed care plans to work with. A positive provider experience can in turn entice more providers to participate in managed care plan networks, increasing access in underserved areas. Fewer managed care plan choices for recipients will also help ease their transition to Medicaid managed care and enhance their experience.
- **Facilitating scalable and sustainable services for managed care plans.** Managed care plans will have the opportunity to expand their scope without compromising quality of services to members and providers. We believe the expansion population is too small to manage on a statewide basis. Alternatively, our recommended regional contracting approach will allow managed care plans to focus their efforts on a particular region(s) and elevate the quality of services they deliver. As history has demonstrated in Nevada, when a managed care plan does not have enough membership to sustain viability, there is an increased risk of the managed care plan exiting the market and compromising continuity of care for recipients.

We will continue to work with the Division and stakeholders to ensure market stability, access to care, and quality plan choice.

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: Molina fully supports optimizing recipient choice while maintaining healthy market competition, market stability, and sufficient provider reimbursement. In other markets that our Medicaid health plan affiliates participate, best practices include:

- **Increasing the State's Medicaid provider FFS schedule.** Higher Medicaid payment rates are typically associated with higher rates of physician acceptance of new Medicaid patients. An increase to the Nevada FFS schedule by the State, particularly for rural and frontier providers, will allow managed care plans to pass such increase onto their providers. This approach will provide various benefits to the State including increased provider participation in managed care plan networks, member access to care, and provider workforce capacity.

- **Allowing exceptions for VBP arrangements.** Managed care plans should continue to have the latitude to reimburse providers below the State Medicaid fee schedule when the provider meets defined cost and quality targets under VBP. This flexibility facilitates managed care plan expansion of

  VBP arrangements.

We look forward to working collaboratively with the Division to design and implement practical and actionable strategies to maximize recipient choice and market stability.

4.2. 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: Assignment algorithms that support equitable distribution of Medicaid recipients allow both incumbent and new managed care plans to operate efficiently while creating a healthy level of competition and market stability. Sufficient membership and an equitable mix of recipient risk-acuity levels enable managed care plans to achieve the scale necessary to minimize administrative costs and allow them to reinvest profits into innovations that improve quality and health outcomes for members.

Algorithms that favor auto-assignment to a managed care plan that already has a larger share of membership can lead to market imbalances and create risk for the membership and State. For instance, a situation where one managed care plan has a significantly larger membership footprint than other managed care plans can negatively impact the State's ability to reach its goals and a provider's ability to negotiate a favorable agreement. Moreover, providers are not incentivized to strategize with or participate in managed care plans with smaller market shares, and smaller managed care plans do not have the necessary scale to justify investments in innovation. These combined factors create fewer meaningful choices for recipients and providers and create market instability.

We also recommend the Division institute a maximum cap on a managed care plan's enrollment that equates to either a pre-determined percentage or an equal distribution of the eligible population, and use a round-robin member assignment methodology. This approach will create an additional layer of assurance of market stability as managed care plans will have equal opportunity to actively participate in the Medicaid Managed Care Program. In turn, a healthy level of competition will exist as they compete on quality of care and service. This equitable assignment approach is being used in Nebraska where the Department of Health and Human Services is adopting a "round-robin" method to auto-assign recipients. Initiating a membership limit will help the Division create a sustainable Medicaid Managed Care Program structure that provides recipients with meaningful managed care plan choices. When a plan reaches the cap, auto-assignments would be narrowed to the remaining managed care plan(s).

In the event the Division adopts an alternative performance-based quality methodology, we strongly recommend industry standard and proven measures be used and applied only after a managed care plan has achieved a baseline to measure performance against. This approach will help reduce biases that can lead to market instability, while promoting quality of care and service.

The assignment algorithm should also encourage recipient choice and simplify enrollment for members and their families. Specifically, we recommend the Division continue to reassign members who are disenrolled from their managed care plan to their prior managed care plan for up to 60 days after they lose eligibility. This approach will facilitate member continuity of care and reduce confusion.

Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion
Section 5: Value-Based Payment Design

5.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: Molina supports the expansion and accelerated adoption of value-based payment (VBP) arrangements with Nevada Medicaid Managed Care Program providers as an important tool to contain healthcare costs while improving health outcomes, the member and provider experience, and health equity.

Based on our experience in Nevada's Medicaid Managed Care Program and our affiliated health plans, we recommend the Division consider the following incentives and strategies to further promote expansion of VBP with providers in its upcoming procurement and contracts:

- **Adopting an equitable algorithm for assignment of Medicaid recipients.** As we noted in our response to Section IV, Market & Network Stability, assignment algorithms that support equitable distribution of recipients allow both incumbent and new managed care plans to operate efficiently. This approach also helps ensure providers participating in managed care have the membership volume necessary to participate in VBP.
- **Including multi-year VBP regional-specific targets for managed care plans**. Eleven states (Arizona, Delaware, Louisiana, Massachusetts, New Mexico, New York, Ohio, Oregon, Rhode Island, Texas, and Washington) require a glidepath or timeline (typically spanning three to five years) for managed care plans to meet VBP targets for saturation.[1] For example, New York established a multi-year Roadmap for Medicaid Payment Reform in 2015, a required component of the Delivery System Reform Incentive Payment (DSRIP) program to ensure long-term sustainability of DSRIP investments. The State committed to shifting 80% of all managed care plan payments from FFS to VBP arrangements in five years, recognizing that sustainable practices take time to develop and maintain. An independent evaluation of New York's DSRIP found that more than 80% of all Medicaid managed care payments were value-based. We recommend the Division adopt multi-year, regional-specific targets for managed care plans to achieve instead of year-over-year targets that can adversely incentivize managed care plans.
- **Implementing penalties tied to VBP participation.** We recommend the Division impose penalties, as opposed to financial rewards, on managed care plans that do not achieve regional-specific VBP participation targets. Generally speaking, individuals are motivated more by penalties as opposed to bonuses. According to a report published by the Annals of Medicine and Surgery, penalty design could be more effective than programs using rewards or a combination of rewards and penalties to improve

[1] Lin, Hanford and Eric Meinkow, "Most States Require Managed Care Organizations to Implement VBP Models with Providers," *Guidehouse*, https://guidehouse.com/insights/healthcare/2022/blogs/managed-care-implement-vbp-models, July 19, 2022, accessed August 10, 2023.

quality.[2] Penalties could be in the form of a quality performance withhold from managed care plans, such as 1% of their capitation, so that plans can earn the funds back for achieving designated quality measures.

Beyond the upcoming procurement and contracts, we also recommend the Division consider the following enhancements to improve VBP expansion, success, and sustainability:

- **Encouraging provider education on VBP.** We recommend the State institute a certification program for providers who complete education on VBP. Education could include topics such as the fundamentals of VBP, how to operate in a VBP environment, and how to develop VBP agreements with managed care plans. Managed care plans can then opt to pay an incentive to certified providers. Increasing provider familiarity and comfort with VBP will help expand participation across the State, including in rural and frontier areas.
- **Developing a safety net for providers.** Voluntarily assuming financial risk can be a daunting task for providers. Managing financial risk can be expensive, requiring providers to take on additional staff and resources. This issue can be compounded with Medicaid when providers may be operating under narrow margins. In their first year of a shared-risk agreement with a managed care plan, we recommend the State help limit a provider's downside risk exposure. For example, the State could create a fund that providers could draw upon should they encounter financial hardship during their participation in VBP.
- **Providing quality rewards to providers.** We recommend the Division reward providers who are in the top 10% for meeting defined quality metrics in their service area. This could also tie to the Division's goals in its Quality Strategy, such as increasing the use of evidence-based practices.
- **Creating bundled payments.** Bundled payments create incentives for providers to effectively and efficiently manage quality and cost for an episode. Designed to move providers towards value-based care, providers are accountable for a single, comprehensive payment for an episode. We encourage the Division to expand adoption of bundled payments, including blended maternity bundles. In the case of blended maternity bundles, defined quality measures (e.g., C-section rates, low birth weight rates, and timeliness of prenatal care) are employed to monitor performance and drive provider accountability. These bundled payments are often tied to the episode of care (the birth of the child) and include a bundled rate that covers maternal care during pregnancy and postpartum, and can also be used as a blended rate for high-risk pregnancies. Arkansas, Ohio, and Tennessee have implemented bundled payments for perinatal care in their Medicaid programs that have proven successful. In each state, the episode is initiated retrospectively by a live birth and covers all care provided to the mother 40 weeks prior to birth, labor and delivery, and for 60 days postpartum.

Incenting providers to create and sustain an integrated delivery system to achieve the Division's goals takes a concerted effort on behalf of the Division, providers, and managed care plans. We look forward to continuing to support the Division in its quest to advance VBP adoption, improve outcomes, and lower costs.

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[2] Kim, Kyung Mi, et al., "Do penalty-based pay-for-performance programs improve surgical care more effectively than other payment strategies? A systematic review," *Annals of Medicine and Surgery,* https://www.sciencedirect.com/science/article/pii/S2049080120304878?via%3Dihub, December 2020, accessed August 10, 2023.

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: Provider success in VBP arrangements is essential to the future of VBP and the Division's ability to reach its goals. Our recommendations for tools and information the State could share, develop, or improve upon include:

- **Developing an online billing course for providers.** Improving the proficiency of providers and their staff in billing and collections will enhance their comfort level in VBP participation. Since Nevada primarily uses FFS to reimburse Medicaid providers, the accuracy of the provider's coding and billing is vital to getting reliable data. Correct information, such as provider type, affiliation, and diagnosis code (including Z codes), helps ensure rendered services are accurately captured, reimbursed, and reported as encounters. In addition to education on billing, we recommend the Division also provide education on care management and virtual/telehealth services that will maximize a provider's ability to optimize member health outcomes and provider performance in VBP.
- **Requiring data feeds from hospitals.** VBP arrangements require timely access to clinical, administrative, and financial data. We recommend the Division require hospitals to provide data on emergency room visits and hospital admissions. This will allow providers participating in VBP to access current information on members to guide activities, such as emergency room diversion and post-discharge care.
- **Member contact information.** Accurate member contact information facilitates timely connection with members. We recommend the State invests in tools or systems that improve the quality of member's contact information, such as ensuring member contact information provided during the enrollment application process (e.g., email, phone number) is captured and transferred to the eligibility system and conveyed to managed care plans via the 834 file, and allowing bidirectional sharing of contact information once a managed care plan identifies new or revised contact information. During the capture process, we recommend the State request an emergency contact number from members that we can use if the member's primary number is inaccurate or no longer working. We also encourage the State to offer recipients an incentive, such as a gift card, to verify the accuracy of their contact information.
- **Educating the public on emergency room diversion.** Making sure individuals know how and when to seek care in the emergency room and alternatives to the emergency room can positively impact quality and cost. We recommend the State institute a training program to educate the public on appropriate use of the emergency room, alternatives to the emergency room, and the importance of getting routine healthcare through an established medical home.
- **Increasing understanding of factors that influence VBP design.** Designing VBP arrangements that align with local top disease states and community demographics is key to positively impacting quality, cost, and health outcomes. We recommend the Division develop a study on disease prevalence and demographics at the community level to inform future design of VBP arrangements.
- **Providing managed care plans with advance notice of quality measures.** The more time managed care plans have to plan and prepare for VBPs, the higher the likelihood of their success. Advance preparation includes, for example, developing targeted provider education programs (e.g., hosting an online continuing medical education course around quality measures) and educational toolkits.

Molina looks forward to continuous collaboration with the Division and providers to facilitate VBP success.

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

Response: We recognize the inherent challenges in VBP participation by rural providers due to lower patient volume and limited staff and financial resources. We recommend the Division provide technological support to rural providers to promote VBP participation. Rural providers may have limited access to sophisticated IT and up-to-date information to most effectively manage a population covered under a VBP arrangement. These limitations can be compounded by inadequate broadband access in rural areas, such as Lander and White Pine Counties where less than 1% of their population has fixed broadband access at or above the current Federal Communications Commission (FCC) standard as indicated in the FCC's Fourteenth Broadband Deployment Report.[3] We recommend the Division provide financial support to facilitate rural provider access to technology, such as connection to virtual healthcare technology and HealtHIE Nevada.

We look forward to working collaboratively with the Division and the State's rural healthcare providers to design and implement practical and actionable strategies to implement VBP arrangements that meet stakeholder needs.

[3] Federal Communications Commission, "Fourteenth Broadband Deployment Report," https://www.fcc.gov/reports-research/reports/broadband-progress-reports/fourteenth-broadband-deployment-report, January 19, 2021, accessed August 10, 2023.

Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion
Section 6: Coverage of Social Determinants of Health

6.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: Molina's affiliate health plans have experience providing in lieu of and value-added services as covered benefits to address members' social determinants of health (SDOH) needs. Some states are using waivers to add SDOH services as covered benefits, rather than using value-added or in lieu of services. We commend the Division for considering the addition of housing and meal supports as optional services and further recommend specific housing, nutrition, and other SDOH services be added as covered benefits—a practice other states are adopting. For example, Massachusetts received CMS approval to add nutrition support as a flexible services program; North Carolina is piloting a program to add in food support and meal delivery; Oregon has added housing and nutrition as covered services; California has added enhanced care management and other SDOH supports as covered benefits; and Washington has a proposed plan to add nutrition as a covered benefit. Nationally, the "food is medicine" movement seeks to integrate a range of medically tailored food and nutrition services in the healthcare system to address rising rates of chronic illness and healthcare costs; current research shows improved HbA1c, body mass index scores, and blood pressure, as well as decreased hospitalization and emergency room utilization.[1] We recommend adding the benefits listed in **Table 3**, which include converting current in lieu of or value-added services as covered, encounterable benefits.

Table 3. Recommended Covered Benefits

Category	Services to Add as Covered Benefits
Transportation	• Expand transportation benefit to cover non-medical transportation to address SDOH needs such as to community-based organization support groups • Allow managed care organizations to contract with vendors to deliver supplemental non-emergency medical transportation beyond State-contracted vendor support
Employment/Education	• Interviewing and resume support • Literacy programs, scholarships to job training programs such as truck driving and peer support, or substance use disorder (SUD) programs for members who are justice-involved • Financial support (i.e., fees for applications, cost of General Education Development [GED®] and English as a Second Language [ESL] classes) • Peer support programs (including application assistance and tutoring)
Complex Healthcare	• Home visits* • Day habilitation programs • Caregiver respite

[1]Sukys, Kristin, et al., "Mainstreaming Produce Prescriptions in Medicaid Managed Care: A Policy Toolkit and Resource Library," Center for Health Law and Policy Innovation at Harvard Law School and DC Greens, https://chlpi.org/wp-content/uploads/2023/06/Mainstreaming-Produce-Prescriptions-in-Medicaid-Managed-Care-V6.pdf, June 2023, accessed October 2, 2023.

Category	Services to Add as Covered Benefits
	• Pest Control/extermination* • Window air conditioners/fans (Low Income Home Energy Assistance Program) • Environmental accessibility adaptations • Personal care and homemaker services* • Asthma remediation (adult and child)
Housing (in Addition to Current Services)	• Temporary housing or shelter while recovering from a hospitalization* • Housing/rental deposits* • Short-term rental assistance* • Utility set-up fees* • Eviction diversion assistance such as legal help to resolve disputes before a forced eviction • Legal services for expungement to address eviction prevention and tenant rights
Nutrition (in Addition to Current Services)	• Meals available for conditions such as heart disease or diabetes* • Healthy food delivery options such as produce boxes as part of a documented care management plan • Meals and grocery delivery postpartum*

***Denotes current in lieu of services that we recommend be considered as a covered service**

6.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: As a Medicaid managed care leader tracking, monitoring, and addressing SDOH needs, we have access to knowledge and experiences in other states, allowing us to bring innovative strategies to Nevada. We recommend that the Division implement strategies similar to the following innovations from Oregon and California.

- **Covering SDOH resources and supports.** By adding SDOH benefits as a covered, encounterable benefit, managed care plans and providers can support members with SDOH needs that may be impacting their health or well-being.
  - For example, Oregon's Coordinated Care Organizations (administered through a managed care plan) offers a diverse network of providers for physical health, behavioral health, and dental care who work together in their local communities to serve members under the Oregon Health Plan (Medicaid). These organizations receive funding from the state to offer flexible services to members to address common SDOH needs, like grocery delivery, food vouchers, medically tailored meals, short-term housing (such as rental deposits and time-limited rental assistance or utility set-up fees), temporary housing or shelter while recovering from a hospitalization, items that support healthy behaviors (such as athletic shoes or clothing), cell phones or other mobile devices, and other items to help keep members healthy.
  - In 2022, the California Department of Health Care Services launched innovative programs designed to address the complex physical health, behavioral health, and SDOH needs of their high-needs Medicaid members. The California Advancing and Innovating Medi-Cal (CalAIM) initiative includes an enhanced care management benefit to address the clinical and nonclinical needs of members with complex healthcare needs and offers in lieu of services in 14 categories to address SDOH needs, including housing transition and navigation, respite care, and day habilitation programs.
- **Incentivizing managed care plans and providers to identify SDOH needs**. In our Texas affiliate, we are collaborating with state partners to implement managed care plan incentives or requirements to incorporate identified SDOH needs into existing initiatives, such as performance improvement projects, recommended value-based payment models, pay-for-quality metrics, quality improvement costs, and in lieu of services. We recommend incorporating Z codes as encounterable or as a part of risk adjustment methodology, or other alternative payment models, to encourage providers and managed care plans to develop more comprehensive strategies to track, monitor, and address SDOH needs.

- **Improving access to broadband and cellular communications.** From serving Medicaid members across the State, we have learned that unreliable cell or broadband services significantly limits members' access to virtual/telehealth services. Compared to their urban counterparts, individuals in rural areas are nearly two times more likely to lack broadband access. Internet access has become an essential component of daily life, and the digital divide has contributed to the time and distance gap between doctors and patients, also known as the broadband health gap. The Connect2Health Task Force's Advancing Broadband Connectivity as a Social Determinant of Health Initiative aims to deepen understanding of the relationship between broadband access and health outcomes. Ongoing research from this platform shows that "Internet adoption appears to have an even stronger correlation to health outcomes, even after controlling statistically for other potentially confounding factors, such as education, income, and rurality."2 While we recognize that the Division has many priority areas, we recommend earmarking dollars to invest in expanding cellular or broadband access in rural areas, which include innovations such as:
  - **Adding devices to access virtual/telehealth care.** We recommend the Division offer devices (such as a tablet, phone, or MiFi) with additional data and minutes to complete virtual/telehealth visits.
  - **Expanding telehealth location access.** Members in rural areas need greater opportunities to access telehealth for behavioral health services. We recommend the Division incentivize providers to offer telebehavioral health services from their physical locations using dedicated offices and technology. This approach should include incentivizing the development of centralized locations for telehealth hubs in rural areas, such as town halls, community centers, or fire departments that have broadband and Internet.
- **Information sharing**. To support continuity of care to address members' SDOH needs, we recommend managed care plans have access to member SDOH information from the Division's partners and other stakeholders, specifically through the Homeless Management Information System and Continuum of Care Program's point of entry to track housing needs. For example, Humboldt County (in Nevada) holds a monthly meeting to discuss SDOH topics, which could be expanded to other counties.
- **SDOH resource platform.** To help members access SDOH resources, we recommend that managed care plans continue to have the flexibility to use multiple platforms and methods, rather than having to use a Division-mandated SDOH platform. This ensures that managed care plans can use integrated solutions to deliver whole-person care.
- **Transportation.** Members in rural and frontier areas of the State have limited access to reliable transportation options to access SDOH resources. As demonstrated in our affiliated health plans, we recommend the Division make supplemental transportation encounterable or as an in lieu of service for managed care plans to provide transportation for members to access housing, food, employment, education, or other SDOH needs. We also recommend allowing members to bring their children or support person (such as a Community Health Worker, spouse, or caregiver) on the transportation ride to eliminate any barriers to care, such as a need for childcare or mobility support.
- **Enhanced care management.** We recommend the Division cover a higher level of care management (i.e., increased frequency of care management visits, outreach, and engagement) to support members, in particular children and youth that are at the highest risk for adverse outcomes. By covering a higher level of care management, Case Managers will have the time to focus on SDOH needs of higher risk members and ensure that they use the in lieu of services or value-added benefits we offer. As previously referenced, our California affiliate offers enhanced care management for their high-needs members, including members at risk for frequent emergency room use or hospital utilization, those with serious mental illness or SUD, those transitioning from incarceration, children

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[2] US Federal Communications Commission (FCC), "Advancing Broadband Connectivity as a Social Determinant of Health," https://www.fcc.gov/health/SDOH, February 7, 2022, accessed September 15, 2023.

and youth in the child welfare system, members experiencing homelessness, or pregnant and postpartum members at risk of adverse perinatal outcomes. Increased coordination between primary, specialty, and behavioral health providers improves continuity of care for members, such as for children in challenging family situations.

- **Increasing the use of Community Health Workers.** Molina's Community Health Workers, in various capacities across our affiliate health plans and in Nevada's Medicaid Managed Care Program, assess and address SDOH needs in the community. We recommend the Division increase the Community Health Worker workforce by offering scholarships for trainings in rural locations.
- **Youth homelessness.** In our experience supporting members in Nevada's Medicaid Managed Care Program and in our affiliate health plans, we've learned that offering services to support youth who are homeless or at risk of homelessness is critical. Supportive services may include connecting youth members with educational programs and career trainings or opportunities; ensuring access to preventive and ongoing behavioral and physical health supports; and offering SDOH supports such as rapid rehousing, permanent supportive housing, and shared housing. To address youth homelessness, we recommend the Division offer youth homeless programs and supports, such as the Basic Center Program and Head Start, as covered benefits for children and youth.
- **Expanding Medicaid eligibility thresholds.** It can also be challenging to offer child members support when the rest of their family is not eligible for coverage. We recommend that if a youth or child is eligible for Medicaid, but other family members are not, they can gain eligibility through an increase in the federal poverty level threshold to 165% for families. This increase allows managed care plans to provide more holistic support to the entire family system and meet their SDOH needs.

6.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: Molina has seen significant impact from the Nevada Medicaid Managed Care Program and would like to encourage the Division to continue to require investments to address SDOH. We commend the Division for implementing this program and request that managed care plans preserve the flexibility to expand supplemental behavioral health services and identify recipients without thresholds. This approach allows the plans to continue to support Medicaid-adjacent organizations most impactful to the communities we support.

Response Template

Rob Baughman
Plan President
Molina Healthcare of Nevada, Inc.

Re: RFI for Nevada Medicaid Managed Care Expansion
Section 7: Other Innovations

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

Response: As an experienced managed care plan and trusted partner to the Division, providers, stakeholders, and community-based organizations, we are continually expanding and developing programs and support for the members we serve. Leveraging the nationwide expertise of our affiliated health plans and our experience in the State, we are proposing these additional innovations and best practices for the Division to consider:

- **Limiting community-based organization exclusivity.** We view our relationships with community-based organizations as true partnerships that help us support all Medicaid members with greater efficiency. Based on our experiences and the experiences of our affiliate health plans in other states with existing contract provisions, we recommend the Division add contractual language that managed care plans cannot use exclusivity verbiage when contracting or coordinating with community-based organizations. We do not believe it is in the best interest of the Medicaid population to limit access in any manner.
- **Sharing members' contact information.** When managed care plans do not have accurate contact information for members, we experience challenges connecting with them. We recommend the Division invest in tools or systems that can create a centralized location for members' contact information. For example, the Division can use this centralized location and develop a subsequent process to capture and transfer member contact information (e.g., emails, phone numbers) from the enrollment application to the eligibility system and convey it to managed care plans via the 834 enrollment file. During this process, we recommend the Division request an emergency contact number to add to the file that managed care plans can use in case the member's number on record is inaccurate or no longer working. We also encourage the Division to offer recipients an incentive, such as a once-a-year gift card, to verify their contact information.
- **Expanding managed care-covered populations.** We recommend the Division include provisions in the Contract that allow the State to eventually fold in additional populations, including aged, blind, and disabled (ABD), serious emotional disturbance (SED), long-term services and supports (LTSS), foster care, and women of child-bearing age (who meet the income thresholds for women who are pregnant to provide more effective prenatal care). These provisions will ensure stability in the program and continuity of care for members, which carving-out populations into separate programs could disrupt.
- **Aligning Medicaid and Medicare.** We recommend that dual eligible members be aligned with the same managed care plan for Medicare and Medicaid when they choose their Medicare plan instead of reverting back to Medicaid FFS. This alignment would also allow for seamless enrollment coordination between Medicaid and Medicare benefits for the member.
- **Simplifying administrative practices.** Expanding and standardizing services and pricing helps to reduce fragmentation and simplifies the administrative process for providers, stakeholders, the Division, and managed care plans. We recommend pricing consistency with fewer consolidated, provider-specific rate cells and benefits standardization that is straightforward. This will simplify how the Division maintains

benefits, pricing, and oversight, which will increase program savings for the Division and managed care plans. Offering narrow rate cells will benefit the Division as it is expanding managed care into new regions by standardizing incentive and bonus payments since they are calculated using the same baseline figures.

- **Simplifying documentation.** Having fewer and aligned sources of information eases the burden of document management for the Division, reduces confusion for providers and managed care plans, and supports consistency across payers. We recommend the Division streamline and align documentation, including Medicaid Service Manual Chapters, fee schedules, web announcements, provider-type billing guides, monthly files with prior authorization and provider-specific rates, and email clarifications. Inconsistency across multiple sources of information can lead to errors, questions, inconsistent benefit application, and considerable time researching and confirming the Division's guidance and requirements.
- **Improving access to broadband and cellular communications**. From serving Medicaid members across the State, we have learned that unreliable cell or broadband services significantly limits members' access to virtual/telehealth services. Compared to their urban counterparts, individuals in rural areas are nearly two times more likely to lack broadband access. Internet access has become an essential component of daily life, and the digital divide has contributed to the time and distance gap between doctors and patients, also known as the broadband health gap. The Connect2Health Task Force's Advancing Broadband Connectivity as a Social Determinant of Health Initiative aims to deepen understanding of the relationship between broadband access and health outcomes. Ongoing research from this platform shows that "Internet adoption appears to have an even stronger correlation to health outcomes, even after controlling statistically for other potentially confounding factors, such as education, income, and rurality."[1] While we recognize that the Division has many priority areas, we recommend earmarking dollars to invest in expanding cellular or broadband access in rural areas, which include innovations such as:
  - **Adding devices to access virtual/telehealth care.** We recommend the Division offer devices (such as a tablet, phone, or MiFi) with additional data and minutes to complete virtual/telehealth visits.
  - **Expanding telehealth location access.** Members in rural areas need greater opportunities to access telehealth for behavioral health services. We recommend the Division incentivize providers to offer telebehavioral health services from their physical locations using dedicated offices and technology. This approach should include incentivizing the development of centralized locations for telehealth hubs in rural areas, such as town halls, community centers, or fire departments that have broadband and Internet.
- **Measuring year-over-year success.** In our experience, monitoring and tracking member outcomes and improvements using year-over-year performance targets (defined by the Division) best enable continuous improvement. We recommend the Division use the Institute for Health Care Improvement's Model for Improvement and the Plan-Do-Study-Act method as tools to set measurable aims to accelerate improvement. We recommend that these aims should be time-specific and measurable with defined populations and anticipated outcomes. For example, one aim could be to reduce adverse events by a targeted percentage year over year. Using these types of annual performance goals, such as an aim statement, sets a defined measuring stick to evaluate managed care plan performance.
- **Expanding Nevada health districts.** We commend the Division's innovative action to create the Nevada health districts, including the Central Nevada Health District, and recommend further developing and expanding health districts to cover all regions.

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[1] US Federal Communications Commission (FCC), "Advancing Broadband Connectivity as a Social Determinant of Health," https://www.fcc.gov/health/SDOH, February 7, 2022, accessed September 15, 2023.

- **Providing support to members during enrollment.** During our initial contact with members, we have received feedback that they had challenges enrolling in Medicaid and that they found the process confusing. We recommend that the Division partner with managed care plans to create a simplified enrollment process for members, with the goal of improving the trusting relationships between the member and the managed care plan from the beginning. We recommend the Division provide enrollment support and education to members, such as expanded partnerships with schools or community-based organizations or to use a community and neighborhood model that can offer help enrolling in a managed care plan.
- **Expanding waivers for foreign physicians.** The Conrad 30 program allows each state's health department to request J-1 visa waivers for up to 30 foreign physicians per year. In addition to the J-1 visa waiver, non-immigrant H-1B visas are sometimes used to fill employment gaps. We recommend expanding waivers for foreign physicians through these employer-sponsored visas for specialty occupations, including medical doctors and physical therapists.
- **Expanding the workforce.** By partnering with high schools and community colleges in underserved areas, the Division can identify individuals interested in all levels of healthcare careers. We recommend the Division offer grants and career pathway opportunities, including loan forgiveness, to students in certain healthcare career paths when they return to their community or another Nevada community.
- **Implementing harm reduction services.** To decrease the impacts and prevalence of opioid use, we recommend that the Division collaborate with other State entities and stakeholders to distribute settlement proceeds from pharmaceutical companies to providers willing and capable of implementing harm reduction programs for youth and adults, with a focus on rural areas. For example, these funds can be used to increase block grant funds for substance use disorder programs, implement safe syringe exchange locations, distribute naloxone, and train community-based organizations and the general community about the risks of opioid use and how to administer naloxone. We commend the work that has already been done by the Southern Nevada Health District and Washoe County Health Department as they were the first in the country to implement harm reduction vending machines. We recommend further expansion of these vending machines to other areas of the State. As a managed care plan, we commit to collaborating with our provider and community-based partners to implement harm reduction services and supports.
- **Submitting Community Engagement Plans.** We recommend the Division require managed care plans to describe and submit Community Engagement Plans as part of the next Nevada Medicaid procurement. Community Engagement Plans should be multifaceted and include efforts to offer education in alignment with Nevada Medicaid goals. We recommend the Division consider specific procurement questions related to managed care plans' innovative community partnerships and programs and include evaluation criteria based on demonstrated results.
- **Increasing population health transparency.** We recommend the Division offer managed care plans and providers access to the Division's Medicaid program information to encourage greater transparency and understanding about population needs. To provide this population health information, the Division may need to offer incentives to providers and managed care plans to use standardized systems, such as the HealtHIE Nevada or electronic health records.
- **Increasing availability to applied behavior analysis providers.** In our experience, it can be challenging to connect our child members with applied behavior analysis services. It often takes multiple phone calls to numerous providers before we can identify a provider with availability. The wait times for members to get a provider appointment can be three to six months and sometimes longer. We recommend the Division create a database that provides information regarding applied behavior analysis provider availability, which will help managed care plans connect members to providers.