Request for Information for the Nevada Medicaid Managed Care Expansion

Response Deadline: October 10, 2023, at 4:00 PM PST

Responders must submit their Responses to the Division at StatewideMCO@dhcfp.nv.gov no later than **Tuesday, October 10, 2023, at 4:00 PM PST.**

Information in response to RFI compiled from the following members of the Nevada Advanced Practice Nurses Association, including: Dianne McGinnis, FNP; Angela Berg, DNP, Claudette Rhoades, DNP; Tracey Harig, DNP

NOTE: this information is the result of a focus group held with NAPNA Policy Committee members. They naturally wanted to begin with fundamental concepts before the facilitator could solicit comment to specific RFI questions. This is authentic information from current health care providers who participate in FFS and MCO Medicaid.

NOTE: NAPNA commends DHCFP for accurately presenting the context for rural health care in this RFI, for example: "This is especially true in rural and frontier areas of the state, where people often have no choice but to forgo necessary care or seek services at the nearest local emergency room after a condition has exacerbated. " However, it does not note that the nearest local emergency room may be 70 or 80 miles away.

What are your primary frustrations with MCOs currently that should be addressed in any future MCO contracts or expansion?

One thing to remember is that being credentialed with fee-for-service Medicaid doesn't mean credentialed with MCOs, who don't have to credential. MCO's don't have to contract with or credential any rural provider if they don't want to. If a provider is contracted with DHCFP, the 'winner' of the rural MCO contract should be REQUIRED to bring that provider into their network. If rural Nevadans lose their providers, they will access less health care and acute costs will rise.

MCOs will also increase overhead cost to providers by creating so much workload many providers can't do it themselves. This results in providers having to hire people to manage bureaucracy associated with credentialling. This, ultimately, drives up health care cost and/or reduces income to providers, especially those who operate clinics as small businesses.

The quality (accountability) measures that must be met in order to achieve incentive payments are Not Possible in many rural communities – gyms, yoga studios, nutritionists, farmers markets etc,. are not there or patient does not have access to them. Also, providers are responsible for rural patient making the needed lifestyle choices, take their appropriate medications, or going to get follow up care. Yet it is more expensive for rural patients to access specialty follow up care (e.g. colonoscopy in urban area, patient must fast, pay for hotel room), so it sometimes does not happen.

Report cards tend based on urban populations who have access to gyms and other medical infrastructure. Real rural cultural issues that need to be factored in when accountability and incentive structures are created for rural MCO contract.

Dialysis three times per week may mean a taxi to a town 50 miles away. MCOs are supposed to work with transportation providers such as MTM, but there is very poor uptake.

MCOs across the board are very difficult to work with regarding documentation and payment. Require confirmation with office of appointment, letters of medical necessity , minimum of 3 days in advance.

MCOs are in business to make money for their shareholders, so it is in their interest to deny a payment. The small rural provider might not bother to resubmit.

As we track lifestyle and follow up information, we've had MCO's request documentation; despite providing this type of information, we still get requests from the MCO's for the information we've already provided them.

MCO's will not look at NPI 2 (business), but will instead look at NPI 1 (provider) and are sending records requests for patients whose records a provider would not have.

MCOs need to make all services available in rural areas, such as screening. Rural people do die more from cancer, primarily because they don't have access to screening.

All MCO's are equally as bad, but Molina seems to be the worse.

The main concern that comes to mind is the struggle with MCOs and the apparent lack of accountability they have and the inconsistency across one Medicaid MCO to another. At least now, with the rural Medicaid participants being on Nevada Medicaid FFS, the rules are consistent and easy to follow. They do change administrators every 5-8 years or so but that's much easier on providers. The less complex rural offices just have to adapt to the Nevada Medicaid claims, eligibility and auth site. Greater chance to do it right.
With MCOs, not only could the selected MCO change, but even with the same MCO – they are all over the place in my experience. They are less regulated, but seems like it should make it better, but it does not. Anthem BCBS is probably the most functional. The rest are a joke and we have so many issues trying to get paid what we should get paid.

Fundamentally, shifting rural Nevadans to MCO will diminish access to health care and quality of health; MCOs are just too bureaucratic and frustrating for providers or patients to deal with.

What are your primary recommendations?

MCOs should be required to credential all current FFS providers.

The whole of rural Nevada should be a region so that providers do not have to repeat paperwork to be in multiple regional networks. One provider will be providing care from Fernley all the way out to West Wendover. With FFS Medicaid, providers can see patients statewide and that is how it should be.

One MCO or more than one MCO is a damned if do for providers – twice the paperwork, but damned if don't for consumers who are left without choice. Given the apparent lack of accountability for MCOs now, we are not sure which way DHCFP could exert the necessary oversight and accountability.

It is important for the state to hold MCOs feet to the fire when they deny credentialling. A provider should not be denied from an MCO just because they are credentialed with a competing insurance company.

Are there services that MCOs refuse to pay for?

Yes; everything has to have prior authorization. FFS Medicaid does too, but each one of MCOs have a different way to do a prior auth. Different password. The bureaucracy harms access to correct care.

Are there medication access challenges?

Prior authorization will continue to be a challenge.

MCOs may also have different formulary and may change formulary every quarter. For example, if you have an albuterol inhaler and the MCO gets a good deal for 3 months and the preferred changes, then the generic one gets cheaper and that becomes the preferred, a Pharmacists can't automatically change those in. Providers need to be trained to state "Generic albuterol inhaler may be OK to substitute, whichever is approved by formulary" and MCOs need to accept that statement. Otherwise, MCOs have to find the provider again. The whole process can disrupt access to medication.

RFI Questions:

I. Provider Networks

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

RESPONSE:

Providers, for the most part, do not live in rural areas and will require travel time to get to their patients. Every hour in a car is an hour where a provider is not giving care to a patient. For providers, it is still better to serve in urban area where they live and not have that unoptimizable travel time where patients are not being seen and the provider receives no compensation.

Last session the rate increase and parity helped with getting providers into rural areas. But it will likely remain un-economical for providers to offer services in rural areas. Again, if a provider is already serving rural Nevada, that provider needs to be rolled right into the MCO network.

MCOs that get rural contract should be encouraged to create their own clinics and hire their own providers.

In order to get providers to move to rural areas, having a job for spouse is also necessary. Also necessary are extracurricular and recreational activities for children, including sports, soccer, dance, cheerleading, and others, as well as having all the supporting resources for those activities as well.

Many of the not for profit clinics will have to have smart and efficient business people managing their operation. Unfortunately, there is not enough philanthropy in Nevada to support our rural clinics.

DHCFP needs to consider specialists that are essential and provide them; for example, having a state funded nurse midwife that would go to the rurals with a state car would be amazing.

MCOs need to be able to transport quickly and without the unnecessary bureaucracy.

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:

MCOs should not be allowed to establish procedure code rates that are any less than FFS rate for rural contracts; overhead and bureaucracy is very expensive for rural providers.

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:

In Southern Nevada, United has their own clinics where they will pay providers. MCO's can provide similar models to hire providers and pay for rural health care access. Point is, MCO can hire the providers and pay for clinic in rural areas. This has the potential to significantly improve the rural health care workforce. The cost of being a provider to an MCO is higher than being a provider to the state, yet MCO's want to pay less than the state's fee schedule.

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:

We've heard positive results regarding Alaska's work with Community Health Workers. There, CHWs are embedded within the community to raise health literacy of the community. Three levels of CAP Community Health Providers will be sent out to Anchorage, and they get trained with providers from other cities.

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:

A number of subspecialties will not take MCO's. They'll be enrolled in FFS for Medicaid, but they will not take MCOs. So, it narrows the pools of who is available.

II. Behavioral Health Care

Nevada, like most states, has significant gaps in its behavioral health care system. These gaps are exacerbated in rural and frontier areas of the state with the remote nature of these communities. Furthermore, the U.S. Department of Justice issued a recent finding that Nevada is out of compliance with the American with Disabilities Act (ADA) with respect to children with serious behavioral health conditions.

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?

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?

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:
Addiction is severe in rural Nevada; MCOs need to support community outreach, changing attitudes, and providing addiction treatment easily.

III. Maternal & Child Health

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

RESPONSE:
It would be great to see special populations (undocumented immigrants and underinsured working class) qualify for family planning services, particularly in the rurals, where access to clinics is limited.

Related to sexual health, I thought that this article was helpful to cite. It identified practices and challenges nationwide related to Medicaid/MCOs and sexual health, including STI prevention and treatment:

Seiler N, Horton K, Pearson WS, et al. Addressing the STI Epidemic Through the Medicaid Program: A Roadmap for States and Managed Care Organizations. *Public Health Reports*. 2022;137(1):5-10. doi:10.1177/0033354920985476

In the Seiler article, the authors mention the alarmingly increased rate of congenital syphilis- I am not an expert on this topic but given Nevada's sharp increase in syphilis, would paying for or mandating increased screening be a consideration?

One point that I thought interesting was the "family planning expansions, which expands access to a wide range of family planning services including STI prevention and treatment to persons who otherwise would not qualify for Medicaid" (pg.6). The original referenced article is here:

Guttmacher Institute. Medicaid family planning eligibility expansions. Updated November 1, 2019. Accessed November 11, 2019. https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions

The problem of private telehealth companies (Him/Hers) treating STIs in the rurals without reporting to local health authorities has been identified; this needs to be a contract requirement.

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:
MCOs are going to expect providers to be part of Vaccines for Children Program, but that requires the provider to be involved in the reporting and monitoring; it requires a person to do the reporting. This often takes considerable time and staff support in order for a provider to be in compliance.

Additionally, MCO's requiring providers to be part of the VFC program require the safe storage of the vaccines, including back-up generators, security alarm, and two thermometers. If the MCOs require providers to participate in the VFC program, the MCO's should provide the upfront funding and infrastructure necessary to comply with the program.

Additionally, if you have somebody with Anthem or are a federal employee and don't have Medicaid version of it, I can't use the Medicaid version; I have to buy the vaccination. Then I have to waste half the vile. It doesn't even make sense to use the vaccination outside the program and only assure half the town gets the appropriate vaccine.

IV. Market & Network Stability

1. Service Area:

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:
One service area for one state. Much will depend on how the state wants to support the infrastructure, but the state should not be drawing artificial lines.

If you have providers who are willing to be rural providers, they should be able to work in all rural areas of the state.

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:
Rural considerations need to prioritize access to care over price control.

2. Algorithm for Assignment

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:
Reassignment creates an abundance of problems, as well as creating barriers to access. All provider networks are not the same; kids in the process of treatment might sometimes be out of luck due to reassignment.

Reassignment within a family to different insurance carriers is also a problem. In some cases back in January, we saw instances where families were given only 15 days to appeal the decision to break the family up to different insurance carriers.

The MCO to which a patient is reassigned must notify providers of the reassignment; do not leave it to the patient.

V. Value-Based Payment Design

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

RESPONSE:
Never heard of "bonus payment", is that physicians only? A good first step might be alerting all providers to what a "bonus payment" is. If you provide some of the reforms suggested, however, you might not need to provide "bonus payments."

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:
One tool that could benefit everybody would be a consistent software interface with regards to electronic health records. We've experienced patients who are shuffled between carriers are unable to have their medical record follow them because of inconsistencies between the EHR systems used by the carriers. EHR was intended to have quick interface; what's happened is everyone developed software that won't speak with other software. This has created an impediment for providers to access medical records. It takes 10 minutes of a 15 minutes appointment to log on and review the records; but we could lose two-thirds of our time with the patient just trying to access the appropriate EHR.

Current Nevada EHR is a system that works well, but processes cost providers $50 per member to participate. During COVID, that fee was waived; with this new MCO, that fee should again be waived in order to allows providers to access these records.

Nevada EHC has worked well and we've enjoyed working with it when it was available, but the Las Vegas Sunrise system didn't participate in it, meaning physicians didn't have access to information while patient is in hospital. This problem will be even worse in rural Nevada, where access to a provider is already a challenge.

DHCFP will have to play a strong role in managing this process.

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

RESPONSE:
Keep in mind that many providers don't even know what "value-based payment design" is, let alone rural providers specifically.

VI. Coverage of Social Determinants of Health

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

RESPONSE:
Housing is the major determinant. In some rural areas housing is substandard yet not affordable. Many live in old single-wide trailers or in RVs. Aside from housing, previously discussed matters that can help the families of providers move to rural Nevada would be beneficial, such as recreational activities for the children of providers.

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:
In Alaska, food is provided to any senior over 60 and, just as important, grants are available to repair houses. Some locations have not had water since last winter or may have no sewer systems. Funding is available to support that.

Meals on Wheels has proven to be important. CareMore is another group in Alaska with a Nifty at 50 program, which basically provided gym, jazz and other aerobics for people over 50. Some of our providers even prescribed participating in the Nifty at 50 program to alleviate depression. The MCOs should help assure those resources exist in rural communities.

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:
These contributions need to actually go to rural Nevada and not just to an organization that has an operation in rural Nevada. The state will need to guarantee that money actually goes into the area it's meant to serve and not to the wider organization.

VII. Other Innovations

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

The best option to ensure a successful MCO in rural Nevada might be to not have a rural MCO. But if this has to happen, the two most important solutions will be to credential all rural providers and not allow the MCO to pick and choose who they work with, and require contracts with all at the full Medicaid rates with the full billing charts.

The other most important aspect to assure success will be the singular consolidated software system that all MCO's and providers use.