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Re: RFI for Nevada Medicaid Medical Managed Care Expansion

I. Provider Networks

Improving access to care is essential to ensuring a successful Managed Care Program, especially in hard-to-reach rural and remote communities. All of Nevada's 17 counties are under one or more federal Health Professional Shortage Area (HPSA) designations. Many Nevada providers do not accept Medicaid due to low rates of reimbursement or the administrative burden associated with billing Medicaid. Due to the significant shortage of primary care and behavioral health providers in Nevada, many recipients face long appointment wait and/or travel times for basic health care needs. 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.

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:

It's time to simplify the administrative side of Medicaid MCOs and standardize processes.

MCOs must pay rural providers fairly and adequately to attract them to the Medicaid managed care program. Fair and adequate payment includes more than the agreed upon dollar amount for a service. It also includes the cost of collecting payment. Rural providers have limited capital and resources to address payment issues. Every effort must be made to eliminate the hassle and cost of participating in the program.

Denial of payments is a huge issue that must be addressed and managed. Rural providers do not have the manpower to navigate different authorizations, billing procedures, quality metrics, appeal procedures and other rules for four managed care plans plus Medicaid Fee for Service. In most cases, they will likely forego payment to avoid the claims denial process. They simply can't devote the resources to adjudicate these claims. Monitoring the level of claims denial in rural areas will be crucial.

MCOs should be required to give several days advance notice to hospital leaders when an MCO changes its processes. Some changes seem to occur overnight, and the hospital administration is not given notice of the change. One staff member is notified directly, and the change is implemented immediately. This results in payment denials and causes cash flow problems. Rural providers will be financially strapped if this is allowed to occur.

MCOs should be prohibited from introducing and requiring their own clinical and assessment forms and treatment processes that differ from The Joint Commission or CMS requirements. Rural hospital EMRs are not prepared to have a unique set of forms for each payor.

All rural providers must file cost reports to be paid by governmental programs. MCOs will play an important role in this process. Rural providers need specific information from the MCOs to complete their reports. The state should require MCOs to provide providers information by a specific deadline so that cost reports can be prepared in a timely manner. MCOs should accept a hospital's daily census report as Notice of Admission. This would eliminate the burden of additional forms of notification and eliminate duplicate efforts.

The NHA suggests the following policies to aid and encourage rural providers to participate in the managed care program.

<u>Fair Payment</u>

- *The NHA requests that the CMS standard contract template contain language that explicitly states the payment floor for all Nevada Medicaid providers shall be the Nevada Medicaid Fee for Service (FFS) rates regardless of whether the provider is contracted with the MCO.*

- *MCOs should pay for the level of care their members are consuming. Too often, MCOs are slow in transferring patients out of the hospital. The MCOs pay the hospital an administrative fee (which doesn't cover the hospital's cost of caring for the patient) which is less than the cost of care the patient needs at the next level of care. At a minimum, hospitals should be paid at the hospital's medical/surgical rate. This rate reflects the minimum level of care provided in a hospital.*

- *DHCFP should require Medicaid MCOs to pay Critical Access Hospitals (CAH) rates established by law. Pursuant to 42 CFR 413.70, CAHs are paid at 101% of the reasonable costs of the CAH by Medicare for both inpatient and outpatient services. Following Medicare guidelines for retrospective cost reimbursement, the DHCFP reimburses CAH inpatient services at allowable costs pursuant to State Plan Amendment Attachment 4.19-A section VII.*

<u>Claims Processing and Denial of Payments</u>

The NHA requests clearly defined claims processing and payment guidelines, consistent with the Medicaid Fee for Service billing manual, be required for Medicaid MCO including:

- *Standardize timeframes for authorizations/billing/payment/denial/appeals for all Medicaid payers which match the current Nevada Revised Statutes (NRS) / Nevada Administrative Code (NAC) guidelines/Nevada FFS Medicaid Policies.*
  - *Pursuant to NAC 686A.282, MCO's definition of a Clean Claim must match the current NAC guidelines.*
  - *Require Medicaid MCOs to follow NAC 686A.290 prompt pay statute for initial receipt and review and upon receipt of additional information.*
  - *Enforcement of NRS timeframes for review, determination, additional information requests, and payment. MCOs cannot indefinitely delay payment by*

suspending claims for medical record reviews (citing staffing shortage, system issues, etc.). Maximum allowable time to be 90 days.

- *Upon receipt of additional information, the MCO will approve (and pay) or deny the claim within 30 days.*
- *Reasonable time for the submission of appeals (12 months). Require MCOs to establish denial overturn guidelines based on medical necessity including the requirement MCOs are to respond within 60 days to appeals.*

- *Timely filing requirements (180 days after discharge, initial bill only) are subject to automatic exceptions and exemptions based on things such as:*
  - *The patient presenting the wrong ID card;*
  - *The patient presenting with no ID card (resulting in the patient being registered as a self-pay patient); and/or*
  - *Coordination of Benefits (COB) cases (resulting in provider filing its claim with a different payer, reasonably thought to be primary, or, other cause that is not the fault of the provider.)*

- *Require industry standards for electronic billing, remittance, payment, claims review, etc. (ERA, EFT, ANSI X12, etc.) including the enforcement of only ANSI X12 denial codes, i.e. no "local or homegrown" denial codes permitted on the remittance advice and any other correspondence between MCO and its' providers.*

- *Medicaid RFP to require MCO(s) to follow all the Medicaid FFS policies.*

- *MCOs should be required to provide CRS runs monthly during the year and within 90 days of the hospital's year end to support the timely preparation and filing of cost reports.*

<u>Elimination of Loopholes</u>

Too many claims are denied because an MCO deems a service or procedure to not be "medically necessary." This term needs to be better defined. Rural providers cannot afford to provide care to Medicaid beneficiaries and then have payment denied.

Additionally, MCOs declare patients to be "non-covered" when they are clearly covered. Eligibility should be an easy issue to resolve but it often takes hospitals months to resolve. A more efficient and timely process needs to be developed. Limiting beneficiaries to change plans only at the first of the month may also help.

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:

All of Nevada's rural counties are designated by the federal government as Health Professional Shortage Areas. In many areas, hospitals are the only place to receive health care 24 hours per day. Excluding them from an MCO's panel removes a significant benefit for Medicaid beneficiaries who live in the hospital's service area. The state should require every MCO to contract with every rural hospital if they are willing to accept payment at 101% of the reasonable cost of the CAH.

The NHA supports the implementation of time and distance standards, to the extent possible, for determining the adequacy of a Medicaid MCO's network.

Prior authorizations for care are another important issue for rural providers. Patients often travel long distances for care and have limited transportation available to them. They cannot come back another day to receive the services they need. Prior authorization requirements need to decrease, and prior authorizations need to be issued in a timely manner and the process needs to be streamlined.

<u>Prior Authorizations</u>

- *The NHA suggests that Medicaid adopt a program like California's program that allows hospitals/providers to train and certify specific staff members to make Medicaid prior authorization determinations. Staff would be required to demonstrate their capabilities for administering the rules and be subject to audit. This would avoid the delay and anxiety patients experience when waiting for a prior authorization determination.*

- *Medicaid MCOs should be required to provide authorization for scheduled services within 24 hours of the request.*

- *MCOs should be required to provide a retro authorization when circumstances related to a procedure change and more or a different medical procedure is medically necessary (i.e. a physician discovers a new issue during surgery).*

- *MCOs should be required to provide peer-to-peer review 7 days a week and physician orders pertaining to level of care should be peer reviewed (Medical Director to Medical Director).*

- *Medicaid MCOs should not require authorization when Medicaid is the secondary insurance.*

- *The NHA requests the following authorization requirements:*
    - *Electronic connectivity for requesting and issuing authorizations that must be documented between the parties.*
    - *Guidelines for requesting and obtaining authorizations be consistent for Medicaid FFS and Medicaid Managed Care and that the guidelines be adopted into policy and included in the CMS standard contract template.*
    - *Because of the frequency of member changes between MCOs, the NHA requests Universal Authorization (if one Medicaid payer provided an authorization for a service, the service is covered regardless of the final Medicaid payer paying the claim).*
    - *Authorizations must be provided quickly (real-time or by the next business day) and cannot be delayed for any reason.*

- *An authorization to be defined as a promise to pay and cannot be revoked after the patient is discharged in the normal course of business.*
- *No authorization should be required for emergency care and services provided up to patient stabilization.*
- *Require the MCOs to pay for emergency care and stabilization services provided, without the ability to deny or down code for being non-emergent. Medicaid MCOs should pay for the level of care provided to the beneficiary.*

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:

One of the root causes of the nursing shortage is the lack of slots for nursing students. The expansion of nursing programs did not keep up with the state's population growth. Our educational programs have limited capacity. Every year, hundreds of qualified Nevada students who want to be nurses are turned away. Unfortunately, they typically move on to other professions and are lost from the profession. Nevada should have a goal of educating every qualified student who wants to be a nurse. MCOs should support the expansion of nursing programs and other technical programs in rural areas through supplementing the pay or endowing education positions, particularly nurse educator positions. Low faculty salaries are often cited as one of the expansion obstacles identified by nursing programs.

Awards could be made to programs that agree to expand their existing student enrollment and that give priority to qualified students from rural Nevada.

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:

All Medicaid payers should be required to observe telehealth pay parity.

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.

No response.

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?

Response:

Barriers to payment for telehealth services should be eliminated. Providers should be reimbursed so that they can afford to purchase and provide adequate telehealth services.

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

No response.

C. Should the Division consider implementing certain incentives or provider payment models within its Managed Care Program to increase the availability and utilization of behavioral health services in rural communities with an emphasis on improving access to these services in the home for children?

No response.

III. Maternal & Child Health

Nevada Medicaid continues to strive to improve maternal and child health outcomes. Currently, the Division uses several contract tools to incentivize managed care plans to focus efforts on improving access to, and the utilization of, prenatal and postpartum care and infant/child check-up visits. Besides performance improvement projects, this includes a 1.5 percent withhold payment on capitation payments that managed care plans are eligible to receive if certain metrics of improvement are met for this population. For 2024 and 2025 Contract Years, the Division is implementing a quality-based algorithm that will prioritize the assignment of new recipients based on plan performance on certain HEDIS metrics that monitor prenatal and postpartum care utilization. Nevada also has a bonus payment program for its 2023 Contract Year for managed care plans that increases the percentage of total expenditures on primary care providers and services, which may include pediatric and obstetric care.

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:

Telehealth follow up care should be strengthened and prioritized.

The state must identify the most effective way to reach pregnant mothers and to communicate with them. A grant should be issued to an organization to convene focus groups to identify:

- *why pregnant women are not accessing Medicaid and receiving prenatal care,*
- *what messages would change this behavior, and*
- *the medium to deliver the message.*

Money will also be needed to implement the ideas and communication plan resulting from the focus groups. The results may differ between rural and urban mothers.

Medicaid could save hundreds of thousands of dollars if just a few NICU stays were avoided.

B. Are there certain provider payment models (e.g., pay-for-performance, pregnancy health homes, etc.) that the Division should consider that have shown promise in other states with respect to improving maternal and child health outcomes in Medicaid populations?

No Response.

IV. Market & Network Stability

1. <u>Service Area:</u>

Currently, Nevada Medicaid has four managed care plans serving two counties—urban Washoe and Clark Counties. For the upcoming expansion and procurement, the Division is considering whether all contracted plans should serve the entire state, or the State should take a different approach and establish specific service areas. For example, the Division could contract with at least two qualified plans in certain rural regions or counties but contract with more than two qualified plans in more densely populated counties. The goal would be to provide greater market stability, sufficient access to care, and quality plan choice for recipients.

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:

Rural healthcare providers have limited resources to process claims. It would be a heavy burden for them to learn the rules of four different MCOs. Because the volume is low, some healthcare providers may only see a few claims each year from a particular MCO. Many rural healthcare providers will forego payment to avoid the hassle of resolving a disputed claim.

As stated previously, we think the authorization, billing, collection, denial processes and quality metrics should be standardized and streamlined. The state should either require a uniform system for all MCOs or limit the number of MCOs in a county.

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:

In the area of emergency care, DHCFP should require MCOs to:

- Adopt NRS 695G.170 – medical necessary emergency services - as a contractual provision.
- Establish a requirement that the Medicaid MCOs must pay for the emergency services provided including all services medically necessary to adequately screen, treat and stabilize a patient.
- Establish a standard for provider coding, level-of care, and payments that are consistent with the American College of Emergency Physicians (ACEP), Center for Medicare and Medicaid
  (CMS), National Uniform Billing Committee (NUBC) and Nevada Medicaid policy.

C. <u>Algorithm for Assignment</u>

For the first Contract Year of the current Contract Period, recipients were assigned to managed care plans based on an algorithm that prioritized new plans to Nevada Medicaid's market. There were notable benefits and challenges to this approach. Going forward, the Division is implementing a quality-based algorithm as previously described that also presents its own unique challenges and benefits.

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?

No response.

V. Value-Based Payment Design

Nevada Medicaid seeks to prioritize the use of value-based payments with contracted providers in the expanded managed care program. Currently, the Division has an incentivize program for its managed care plans to accelerate the use of value-based payment strategies through a one-year bonus payment arrangement based on performance. With Nevada's ongoing health disparities and the rising cost of health care, these strategies are critical to ensuring the success and sustainability of the State's Medicaid program.

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:

It appears that MCOs have not embraced the current bonus payment plan. The reasons should be examined by the state.

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:

The state must monitor the level of denials by the MCOs. Many hospitals feel they receive less reimbursement from Medicaid under the managed care programs than they received under the Fee for Service program. This is because of the high level of denials by MCOs. Hospitals provide the patient with needed medical services in a timely manner and the MCOs deny the payment. This issue needs to be addressed, and incentive or penalties need to be established so that MCOs do not profit from denying too many claims.

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

Response:

The Division should consider expanding the value-based payments to cover more of the cost of care provided.

Because of the low patient volume, value- based payment programs will be difficult to execute and too complicated to administer in the early years of a managed care program in rural areas. The Division should concentrate its efforts on establishing the managed care program in rural areas and then move to value-based programs once adequate data is available.

VI. Coverage of Social Determinants of Health

Nevada Medicaid is currently seeking federal approval to cover housing supports and services and meal supports under federal "in lieu of" services authority. This allows managed care plans to use Medicaid funds to pay for these services in support of their members. Today, all four plans provide limited coverage of these services by using their profits to pay for them. The goal of seeking approval of "in lieu of" coverage for these services is to increase the availability of these services in the Medicaid Managed Care Program for more recipients.

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:

Transportation is a critical issue in rural areas. Medicaid beneficiaries should be provided transportation so that they can easily access services.

MCOs should establish middle school and high school programs that educate students on the purpose of Medicaid and how to access benefits. Stigmas associated with Medicaid should be addressed and students educated on the importance of signing up for Medicaid if they become pregnant.

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?

No Response

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:

Every three years, non-profit hospitals conduct a Community Health Needs Assessment. The MCOs should provide funding to fill the healthcare needs and gaps identified in these Assessments.

VII. Other Innovations

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

Response:

Transparency is important for trust and success of the program. Providers must be able to confirm the accuracy of the payments they receive and to have data to improve their delivery of care. We encourage DHCFP to adopt the following ideas.

<u>Data</u>

The NHA requests DHCFP to require from MCOs monthly (trended) and YTD data by hospital on the following:

- *Average days from claim receipt to payment date*
- *Average days from discharge/service date to receipt date*
- *Percentage of first-time claims submitted EDI*
- *Percentage of first-time claims auto adjudicated to include percentage of auto adjudicated claims paid and percentage of auto adjudicated claims denied*
- *Data by NPI by claim type (837I or 837P):*
    1. *Number of claims received*

II. *Number of claims paid*
III. *Number of claims pending – including an aging of pended claims*
IV. *Number of claims denied by ANSI X12 denial code*
V. *Number of claims appealed*
VI. *Number of claims overturned*
VII. *Counts for Items I – VI to be provided at the header/summary level and the line level.*

DHCF should require MCOs to submit standard monthly and year-to-date reporting on the following:

- *Utilization*
  - *Inpatient*
    - *Number of admits*
    - *Number of re-admits*
    - *Number of days*
    - *Case Mix Index*
    - *Number of trauma cases*
    - *Number of trauma days*
    - *Number of administrative days paid*
  - *Outpatient*
    - *Number of emergency room visits*
    - *Number of ambulatory surgery visits*
    - *Number of primary care visits with average wait time*
    - *Number of specialty visits with average wait time*
    - *Number of behavior health visits split by mild to moderate and serious*
- *New Member Reporting*
  - *New member assignment to Primary Care Physician (PCP) – to be completed within 30 days of assignment.*
    - *Number of PCP assignments based upon member selection*
    - *Number of PCP assignments auto assigned; members who made no choice that were assigned by default algorithm.*
    - *Number of PCP assignments passively enrolled; members who were defaulted to a PCP based upon prior assignment and/or family member assignment.*
  - *Date of new member's first visit to assigned PCP – to be completed within 60 days of member's assignment to PCP.*
  - *New member education training – NMMCO to provide confirmation that all new NMMCO members have received Medicaid new member training on covered benefits and how to access care.*
- *HEDIS – current available year HEDIS Aggregated Quality Factor Score.*

Transparency

- *The NHA requests DHCFP to post on its website:*
    - *the annual medical loss ratios required per 42 CFR 438.8 for each MCO (aggregate and by population).*
    - *DHCFP's actuary's Per Member Per Month (PMPM) capitation rate sheets (aggregate and by population) and data book.*

Reporting

- *For determining network adequacy, the NHA requests DHCFP require MCOs to report only Medicaid providers the MCOs have under contract.*

- *Request for consideration any limitations on access such as the number of beds available for Medicaid patients, limits on taking new Medicaid patients, etc. including but not limited to mental health services and post-acute providers such as Skilled Nursing Facilities (SNF), Home Health Agencies, and Long-Term Acute Care Hospitals (LTAC)*

- *Current Medicaid MCO provider networks should be reported and submitted monthly to DHCFP and posted to the DHCFP website.*

Compliance and Enforcement

- *The NHA requests DHCFP ensure it can and will assess penalties to a MCO when it fails to meet required performance measures (i.e., out of compliance more than 3 months in a row).*

- *The NHA requests clear guidelines on Utilization Management practices be adopted into Medicaid policy and into the CMS standard contract template for the MCOs and their subcontractors.*
    - *MCOs should be required to pay for medically necessary care consistent with NRS 695G.055 (medical necessity defined).*
    - *MCOs will not be allowed to unilaterally change the level of care authorized after service has been rendered and all authorizations must be provided in writing.*
    - *MCOs should be required to follow all State of Nevada Medicaid Policies:*
        - *If an MCO does not use InterQual for level of care determination, the MCO must create a cross walk to InterQual from its level of care determination tool which it will use to ensure compliance to InterQual. This crosswalk should be part of the bid process.*
        - *Ensure MCOs follow InterQual clinical levels as they are mapped to revenue codes in Nevada Medicaid policy.*

Private Hospital Medicaid Provider Fee Program

With the approval of the Private Hospital Medicaid Program by Nevada hospitals, great thought must be given to assure hospitals are fully and timely reimbursed for the care they provide to MCO Medicaid

patients. We request the creation of a task force to develop appropriate contractual terms to be placed in MCO contracts.

The following are a few items that should be considered:

- *payment initiatives under MCO contracts through directed payment initiatives based on actual claims utilization as authorized by 42 CFR section 438.6(c).*

- *the MCO's directed payment PMPM add-on should be based upon a statewide pool approach for inpatient services and hospital outpatient and Emergency Room services.*

- *the directed payment program funds should be added to the capitation rates as a separate line item so they can be tracked separately. The contract language would include the following concepts:*
    - *MCO participation is required in the reconciliation process with DHCFP.*
    - *The DHCFP will define the time period and frequency of the directed payment reconciliation in consultation with the NHA.*
    - *MCO participation is required in claims payment reconciliation with individual providers.*
    - *MCOs cannot prohibit the DHCFP from providing claims level data and summaries to the NHA and NHA's consultants. (All hospitals are subject to anti-trust regulations prohibiting the share of pricing/rates).*
    - *MCOs cannot use directed payment PMPM amounts to supplant current or future payment rates to hospitals. MCOs must refund any unused directed payment dollars (PMPM add-on) to DHCFP for refund to hospitals.*

Please contact me at Pat@nvha.net with additional questions. Thank you.