Nevada Rural Hospital Partners

NEVADA RURAL HOSPITAL PARTNERS

An alliance of rural hospitals

4600 Kietzke Lane
Suite I-209
Reno, Nevada 89502
P: (775) 827-4770
F: (775) 827-0939
www.nrhp.org

Blayne Osborn
President

NRHP & Foundation Members

Banner Churchill Comm. Hospital
Fallon, Nevada

Battle Mountain General Hospital
Battle Mountain, Nevada

Boulder City Hospital
Boulder City, Nevada

Carson Valley Health
Gardnerville, Nevada

Grover C. Dils Medical Center
Caliente, Nevada

Humboldt General Hospital
Winnemucca, Nevada

Incline Village Comm. Hospital
Incline Village, Nevada

Mt. Grant General Hospital
Hawthorne, Nevada

Pershing General Hospital
Lovelock, Nevada

South Lyon Medical Center
Yerington, Nevada

William Bee Ririe Hospital
Ely, Nevada

NRHP Foundation Associate Members

Desert View Hospital
Pahrump, Nevada

Mesa View Regional Hospital
Mesquite, Nevada

October 17, 2023

Purchasing Division, State of Nevada
515 E Musser St Ste 300
Carson City, NV 89701

Re: RFI for Nevada Medicaid Managed Care Expansion 40DHHS-S2441

Dear Mr. Vradenburg,

Nevada Rural Hospital Partners is a consortium of the 13 Critical Access Hospitals in Nevada. Throughout the month of September, we have engaged the Department of Health and Human Services in conversations with our member hospitals on the possibility of expanding managed care services throughout the State. Our response to the RFI is a collection of the discussion points we had in these meetings. On behalf of the Critical Access Hospitals listed below, please find our attached response to the Request for Information for the Nevada Medicaid Managed Care Expansion.

Banner Churchill Community Hospital
Battle Mountain General Hospital
Boulder City Hospital
Carson Valley Health
Desert View Hospital
Grover C. Dils Medical Center
Humboldt General Hospital
Incline Village Community Hospital
Mesa View Regional Hospital
Mt. Grant General Hospital
Pershing General Hospital
South Lyon Medical Center
William Bee Ririe Hospital

Sincerely,

Blayne Osborn, President
Nevada Rural Hospital Partners

Respondent: Blayne Osborn
Organization: Nevada Rural Hospital Partners
Re: RFI for Nevada Medicaid Medical Managed Care Expansion

Section I: 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: *In the 15 rural counties that do not yet have Medicaid managed care for residents currently, there are only 10 Critical Access Hospitals (CAH) and 14 affiliated Rural Health Clinics (RHC). In the 2 urban counties (Clark and Washoe) where Medicaid Managed care for residents is already available, there are only 3 Critical Access Hospitals and 4 affiliated Rural Health Clinics. All Critical Access Hospitals and Rural Health Clinics must be deemed Essential Community Providers (ECP) and for the Managed Care Organization (MCO) networks to be considered adequate, they must be required to contract with all of the CAHs and RHCs in their service area.*

It should be noted that during the 82nd Legislative Session, legislation passed recognizing a new model for hospitals, the Rural Emergency Hospital (REH). Although regulations governing REHs are still being promulgated in Nevada, future REHs should be considered ECPs as well.

NRS422.373 requires that "To the extent that money is available, a Medicaid managed care program must include, without limitation, a state-directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally-qualified health center or rural health clinic affiliated with a critical access hospital for covered services at a rate that is equal to or greater than the rate received by the critical access hospital, federally-qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee-for-service basis." As part of this procurement, the money must be made available to ensure that NRS422.373 is the minimum for any state directed payment.

We request that each MCO provide specific billing representatives to the CAHs not just 'provider outreach' contacts. Additionally, CAHs need timely access to the CRS Reports from the MCOs. Requiring this data to be provided timely would alleviate some of the burden in year-end closings and cost reporting. In developing the timeline for the rollout, we request the Division to give rural hospitals enough time (6-9 months) to contract with the awarded managed care companies prior to January 1, 2026.

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?

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Response: *There are some services that are simply not available in many rural communities in Nevada. That makes it difficult to come up with uniform requirements for managed care plans but all the more important to protect the services that do exist. The following are critical services that need to be given additional thought:*

- *Enhanced rates for Emergency Medical Services*
- *Covering the cost of surgical implants*
- *Obstetrics and Delivery Services*
- *Protections for the 340B program*
- *Coverage for mobile units such as MRI and Mammography*
- *Home Health Services*

With respect to outpatient imaging and laboratory services, the division must mandate a maximum geographic limitation of 50 miles. It is critical that beneficiaries not be expected to commute more than 50 miles in one direction to receive services offered in their own community.

Another area where the Division could help to streamline processes is the credentialing of providers. A centralized credentialing whereby providers credentialed by DHCFP would have to be accepted by the MCOs would save a great deal of time and provide quicker access to beneficiaries.

Lastly, considering that four Critical Access Hospitals are closer geographically to tertiary hospitals out-of-state than those in-state, the costs of transferring those patients to a higher level of care must be covered.

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: *Utilizing community reinvestment dollars to support existing workforce development programs such as those for Certified Nursing Assistants, Medical Assistants, Nurse Apprentices, Radiology Technicians, Nurses, Physician Assistants, and Physicians could be very beneficial in rural Nevada. Currently, there is only one residency program in rural Nevada. Support for and investment into these programs is desperately needed.*

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: *No Response*

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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: *Unnecessary requirements regarding Prior Authorizations (PA) create burdens to care. Standardization and streamlining of PA forms, and submission and approval deadlines, is necessary to limit the burden on the rural providers.*

Section II: 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: *Ensure that all services provided via telehealth are covered in the same amount as services provided in-person including 'audio-only' in accordance with SB119 of the 82nd Legislative Session.*

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: *Community paramedicine is relied upon heavily in Minnesota and has been put into practice in Nevada. Supporting community paramedicine programs or like-programs for behavioral health visits in the home would be beneficial in rural Nevada.*

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: *Designing programs for Non-Emergency Behavioral Health Transportation would be significant to ensuring behavioral health needs are met. Costs to transfer a patient to inpatient psychiatric care must be covered. Currently, these services are often provided by local EMS in ambulances traveling out-of-county, which puts at risk the response times to emergency situations in-county.*

Section III: 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: *Prioritizing prenatal care in rural communities is a must. With only three Critical Access Hospitals in the state that are still able to provide routine labor and delivery services, they must be paid adequately so as not to lose the ability to provide those services.*

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: *No Response*

Section IV: Market & Network Stability

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: *Awarding managed care contracts to four health insurance carriers will be difficult with comparatively low volumes of Medicaid beneficiaries in rural counties. It might make sense to have two regions: urban and rural. And in so doing, it is our preference to limit the number of MCO plans in the rural counties to two.*

However, regardless of whether the plans are limited to certain counties or regions, all hospitals throughout the state will eventually see a patient from each plan, and not just for emergency care. This is occurring now as MCO beneficiaries travel and vacation throughout our state. We also see this in a number of divorced families where children on one parent's managed care plan are splitting time with the other parent residing in a rural county for different parts of the year (i.e., summer vacation). When this occurs, and the rural hospitals are not in-network with that plan, there is unnecessary and costly burden in payment denials, and appeals processes. In these instances, we believe that the managed care plan should be required to pay the provider as if they were in-network.

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: *No Response*

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?

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Response: *Providing beneficiary education is particularly important. The beneficiary needs to know what plan they are in and should have distinct ID cards indicating their plan selection. Beneficiaries need assistance in managing their care. Investments need to be made in health literacy, helping beneficiaries to understand when to use the emergency room vs. urgent or primary care.*

Section V: 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: *Value-Based Payment (VBP) programs often fail to recognize the critical importance of maintaining essential community providers in rural areas. Without access to care, there is no quality of care. Placing an emphasis on access to care is essential.*

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: *Critical Access Hospitals are required to submit MBQIP measures to CMS. Aligning VBP programs with the quality reporting requirements already in place for the CAHs is critical.*

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

Response: *CAHs do not have dedicated staff for quality reporting purposes. Easing the burden of reporting quality measures and relying on the data that the Division already receives is important to us.*

Section VI: 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: *Transportation coverage for primary care appointments. Transportation upon discharge from a hospital stay.*

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?

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Response: *In previous years, Nevada Medicaid funded a Care Management Organization, "the Healthcare Guidance Program" under an 1115 waiver. This model included community health workers providing beneficiary education, patient navigation, and more. The successes of the HCGP should be expanded upon. Help in locating and scheduling appointments, and reducing no-shows to appointments, scheduling transportation assistance to medical appointments, annual check-ups, flu shots, and other preventative health care.*

Providing coverage for adult dental care is also extremely important in rural Nevada.

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: *There needs to be a requirement that those dollars be reinvested in each rural community that the MCO is covering. Perhaps there should be minimum thresholds in place by county.*

Another area where community reinvestment dollars could be utilized is to support Project ECHO. Although not a direct investment in specific counties, this support for rural providers is important and has been successful in other states.

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

Response: *Currently, state Medicaid programs are required to have a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency director about health and medical care services. Currently, the Nevada MCAC reviews managed care health plan marketing materials. NRHP would like to see more accountability for managed care built either into the MCAC or a like-committee with both urban and rural hospital representation.*