***Nancy Bowen, CEO***
***Steven Messinger, Policy Director***

I.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:*** The Division should 1) require local representation in plan governance and service for both members and providers, 2) require strong network adequacy standards and enforce with utilization reports rather than contract rosters, 3) establish a neutral third party or function within the Division to address unresolved contracting issues, and 4) establish a forum for providers to identify challenges that may occur across clinics, plans, or regions.

NVPCA has seen firsthand the value of MCO partners led by people who know the culture of the regions they serve and the challenges that can arise when they do not. Even urban Nevada has a tightly interconnected and small health care community with particular traditions, common history, and personal relationships. Rural Nevada should be expected to express an even stronger and more local sense of culture due to less force of outside influence and even fewer administrators and practitioners delivering care to a less transient population. The Division should require that the plans have input from these communities at the leadership level so that policies are sensitive to the members they serve and the providers delivering services. Provider relations staff should also be local to the extent possible. The Division should incentivize excellent provider relations by including provider satisfaction in performance metrics tied to plan compensation.

The Division should use the opportunity of rural managed care expansion to increase capacity in underserved areas. NVPCA believes that tighter network adequacy distance requirements can contribute to increased contracting with existing providers and plan provision of new providers, while waiving these requirements or setting them to meet the existing scarcity only perpetuates a lack of access. Critically, to the extent that the Division is able to incentivize more access for Medicaid beneficiaries, the entire community can benefit from the increased services. NVPCA has seen in urban managed care the value of a list of contracted providers—it hardly matters how many are on such a list if few are accepting new patients. Network adequacy should be measured by reporting on where and how many members receive care rather than counting miles to hypothetical providers. NVPCA proposes that at least 90% of members should be able to receive primary care services within 50 miles of home.

Because MCOs should be expected to increase provider capacity in rural areas, providers may have the expectation of an upper hand in negotiations. At the same time, a sparse population may make the MCO inclined to move past a provider who is making costly demands. NVPCA believes that distance and provider shortage are enough of a barrier to care in rural areas and no provider should be overlooked when expanding access for the Medicaid population. Thus, a third party mediator will be helpful in

determining the reasonableness of provider contracts as well as interpreting the contractual obligations of the MCO to a given area.

Nevada's FQHCs have benefited greatly from a longstanding quarterly call with the Division and the MCOs. In this forum, common issues can be identified and addressed at the appropriate level of policy. This may be with a single MCO or it may be that the Division needs to clarify a point or implement a process. NVPCA believes that a similar forum will be helpful to empower private providers who may be getting substantially involved with Medicaid for the first time. This could also lead to the identification of opportunities for common action among the MCOs For example, if providers identify where a specialty is in demand in a certain area, it could become clear that group action would be sufficient to bring that service to the region rather than each MCO sending its members a long distance.

I.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:*** See comments on network adequacy above. NVPCA believes that the managed care contract should strongly incentivize the inclusion of available providers in rural Nevada *and promote increased capacity.* This can be done with a strong network adequacy standard that is realistically measured through utilization analysis and tied to plan compensation. If a plan is only delivering 80% of the network they bid for, they should only receive 80% of the bid price. This arrangement ensures that plans are motivated to work with providers and to bring more in where needed, *as they have done in urban areas.*

I.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:*** NVPCA believes that a strong network adequacy requirement with accurate measurement and tied to plan compensation is sufficient to incentivize plan strategy to improve provider workforce capacity without additional policy prescriptions. The plans should be free to innovate and to work with all available resources to meet their obligations to ensure capacity. If plans do not meet the required standards and their compensation is discounted, the Division should use the savings to bolster existing workforce development programs and to create new programs as needed. The Division should include in the RFI the suggestion that MCOs work together to expand workforce supply in order to ensure maximum investment and minimize free riding off the investments of other firms.

I.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:*** Much of NVPCA's thinking on the subject of rural managed care has been informed by "A Close Look at Medi-Cal Managed Care: Quality, Access, and the Provider's Experience Under the Regional Model" published by the California Health Care Foundation in 2019[1]. Acknowledging Nevada's reluctance to take policy cues from our western neighbor, NVPCA found this report compelling because many of the counties in study rely mainly on the health care system in Northern Nevada in the same way that most of the counties proposed for the expansion of managed care do. The report details the experience of Eastern Sierra counties with no easy western access—Mono, Alpine, and Plumas—as well as counties that have western access but where some residents still find more convenient care in Nevada-- El Dorado, Inyo, Lassen, Nevada, Placer, and Sierra.

The report compares managed care expansion in these counties, including through a company operating as an MCO in Nevada, with a separate set of rural counties managed by a regional nonprofit MCO. Specifically, this report recommends local representation at the leadership and provider relations level, strong network adequacy measured by utilization, a third-party contract mediator, and a forum for provider education and problem solving.

I.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.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 Division should use network adequacy requirements and utilization analysis to incentivize minimization of the distance members travel to receive services. Under such a policy, an MCO might find it helpful to pay for broadband where available for a patient with high needs. The MCOs might collectively contract for an originating site where broadband is scarce but needs are high.

[1] https://www.chcf.org/wp-content/uploads/2019/10/CloseLookMediCalManagedCareRegionalModel.pdf

Additionally, the Division should make it easier for non-provider entities to bill as an originating site. A community center, library, fire station, or school may be able to spare some room and some bandwidth with minimal incentive.

II.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:*** NVPCA is not aware of any state that feels they are providing enough behavioral health services to meet the need. However, one critical best practice is to grow providers from the areas of need. The most culturally competent care comes from a provider who shares a common culture with their patients. Bringing in providers from urban Nevada or from out of state will never be as effective as training up someone who is already a member of the community and has some level of trust.

II.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:*** NVPCA is not expert on higher levels of behavioral health care, and it is not clear if that is what this question is addressing. For more primary behavioral health care—therapy and minor medication—we suggest that the emphasis be placed on school and clinical settings. Many minors requiring these services will have issues they want to address stemming from their parents, and some of them will fear abuse. It is safest to have these sorts of conversations outside of the home. As to incentives, NVPCA suggests managing these through a primary care provider and MCO contract. Incentivize screening, referral, loop closure, and results and ensure it is integrated with high quality medical care.

III.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:*** In both urban and rural parts of Nevada, there should be recognition that FQHCs bring a valuable skillset to maternal patients that is being underutilized due to payment bundling. NVPCA hopes that the incentives for the MCOs to facilitate better outcomes can lead to opportunities to partner more closely with hospitals to engage patients from pre-natal care through delivery to post-partem care. The RFP should explicitly identify coordinating with FQHCs and hospitals as an example tactic for MCOs to meet the proposed objectives.

IV.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:*** NVPCA is agnostic on this question. We have seen both arrangements work well or not, and both have advantages and tradeoffs. Having more MCOs does increase the complexity of administration,

particularly of credentialing and clinical quality measures. However, we expect the credentialing burden to ease with the Division's implementation of the CVO, and NVPCA is working to align quality measures. More MCOs also means a diversity of interests and funding that can open opportunity for FQHCs. Based on the way the FQHCs are currently arranged, any change to managed care geography and density is likely to be similar in complexity to the status quo. The main principle that concerns our members is ease of access to provider relation staff who understand the health center and hopefully have some longevity in the position.

IV.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.

***No response***

IV.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?

***No response***

V.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:*** Advancing in value-based care is important to Nevada's FQHCs. In the current contract period, the MCOs are offering (though not requiring) more advanced payment models than NVPCA's members are ready to embrace. The state could devote resources outside of managed care contracting to ensure that FQHCs are able to predictably update their cost-based reimbursement base. An encounter rate that accurately captures current cost is considered essential to advancing in any value-based payment model that is based on a FFS baseline.

V.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 should invest in a Health Information Exchange that requires providers to share robust information while also allowing affordable or cost-free access. As the state makes health data available, cost barriers to advanced value-based care and payment are lowered. A more expensive and less effective strategy, though perhaps more feasible, would be for the state to invest in custom data management systems for various providers, including and especially FQHCs. An ideal system would share data between primary care providers, hospitals, specialists, and insurers and present analysis at

the point of care to help drive decision-making. Quality gaps could be identified and addressed, and utilization could be managed with such a system.

The State could also define and incentivize an accountable care model featuring partnership between hospitals, primary care providers, and specialists and collective payment models both capitated and sub-capitated. One way to do this would be to include the basic parameters in the RFP and require MCOs to specify the details. Any such model should require invitation to the FQHCs in order to better integrate them with the hospitals and take advantage of the comprehensive primary care that they offer to the most at-risk patients.

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

***Response:*** In many ways, rural settings are ideal for value-based payment models. There are fewer health care partners and opportunities for members to slip outside of a network for routine, urgent, or emergency care. Where specialty care is needed and members must travel, there is opportunity to direct them within a well-defined network.

IV.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:*** NVPCA has partnered with Project ECHO to promote specialty consultation services to Nevada's FQHCs. However, this innovative program is underutilized because of the lack of a payment incentive. The Division should include interprofessional case consultation as an optional service. This would reduce the need for patients to travel for specialty care and build capacity in primary care providers. Reimbursing these consultation services should also lower expenditures as more care is delivered at the primary care level and less at specialty care prices.

IV.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***

IV.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:*** NVPCA and Nevada's FQHCs have been beneficiaries of this program in the past, as MCOs have invested in establishing a data warehouse and analytics platform in the health centers. NVPCA believes this is an excellent use of this program and requests that the Division include language in the

reinvestment policy making explicit that investment in FQHC capacity is an appropriate way to fulfill the requirement.

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

***No response***