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To: DHCFP StatewideMCO <StatewideMCO@dhcfp.nv.gov>
Subject: RFI Responses on behalf of Nevada OT Association

Response Template
[Nevada Occupational Therapy Association]

Re: RFI for Nevada Medicaid Managed Care Expansion

The following responses are provided by The Nevada Occupational Therapy Association (NOTA) and are intended to reflect the aims and perspectives of nearly 17,000 occupational therapy professionals (OTPs) in the state. OTPs include occupational therapists (OTs), occupational therapy assistants (OTAs), occupational therapy aides, and OT and OTA students.

Occupational therapy is a healthcare profession that focuses on helping individuals, groups, and populations of all ages and backgrounds improve their ability to perform everyday activities or "occupations." These occupations can include self-care tasks (like bathing and dressing), work-related activities, play, leisure, and social interactions. The primary goal of occupational therapy is to enable individuals to engage in meaningful and purposeful activities, despite physical, cognitive, or emotional challenges.

Occupational therapy interventions often include combinations of: client-centered physical and cognitive rehabilitation, pediatric care, mental health services, adaptive equipment and assistive technology, environmental modifications, sensory integration therapy, & fine motor skill acquisition. These therapists work in a variety of settings from hospitals to outpatient centers, schools to home health, and community-based organizations to telehealth.

Nevada OTPs are a source of valuable knowledge and professional expertise in serving the diverse health needs of our Nevada community. We hope these responses, which are grounded in evidence-based practice, can offer insight, provide clarity, and enhance programming for MCO development across Nevada's rural frontier.

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?

NOTA advocates for the expansion of telehealth services, building on the emergency regulatory changes made in 2020. These changes demonstrated significant benefits, particularly for our rural and frontier communities. Telehealth is an effective delivery-method for occupational therapy (OT) services, especially in holistic pain management, encompassing task and routine modifications, energy conservation techniques, and leisure and mindfulness education. Of note: Congress is currently reviewing multiple bills related to the increased access and use of telemedicine/health options across the nation as, since the pandemic, these services have proven effective. Combining mental health services via telehealth, when in-person options are limited, can reduce the risks associated with adverse coping mechanisms, loneliness, substance abuse, and declining physical and mental health. This comprehensive approach can help mitigate risks such as falls, injuries, (re)hospitalizations, acute/emergent psychological episodes, in short: health provider costs. Therefore, we encourage The Division to consider strategies and requirements that facilitate the integration of telehealth into its procurement and contracts with managed care plans to enhance provider availability and access in rural and frontier areas of the state.

MCOs should also have to submit bid paperwork that proves network adequacy, ability to service specific populations (age, diagnosis, geographical area, etc) ease of access to care (physical locations, telehealth, etc), and access to qualified providers with limited wait times. Denying access results in increased cost to the state and providers by risking complications due to comorbidities, and declining health as a condition progresses while the member is waiting for access to care.
MCOs should not implement value-driven or capitation agreements for cost savings, as this limits accessibility and diversity in the marketplace. By selecting preferred providers, additional strains are put onto the providers to deliver across more members of the state and will result in shortcuts, limitations, and decreased quality; this is something currently being felt in Clark County, where such agreements are presently in place.
NOTA's recent, 2023, Legislative 'Hill Day' Event led to the signing of a licensure compact reciprocity bill to support expanded access for OTPs to practice in Nevada's rural areas. The emphasis of this push for access to OT included educating stakeholders on the role of OT in chronic pain and mental health both of which can be delivered successfully through telehealth.

Occupational therapy's role in these critical areas are outlined here for your reference:

Pain Management: Occupational therapists are skilled at comprehensively assessing pain and its impact on an individual's daily life. They possess the expertise to develop personalized interventions that encompass not only physical aspects but also address emotional and cognitive components of pain. OT practitioners excel in teaching pain coping strategies, energy conservation techniques, and adaptive approaches to tasks and routines. These interventions are invaluable in mitigating pain-related challenges, enhancing functionality, and improving overall quality of life.
Mental Health Services: Occupational therapy uniquely integrates mental health considerations into its interventions. OT practitioners are trained to recognize and address the connections between mental health and an individual's ability to engage in meaningful activities. They facilitate the development of coping skills, emotional regulation, and resilience, which are crucial components of mental health support. In telehealth settings OT can provide vital mental health services and foster emotional well-

being, even at a distance.

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?

To ensure a fair and equitable healthcare landscape, it is imperative to mitigate the influence of capitation and isolated treatment options within the State of Nevada. Currently, Clark County experiences the adverse effects of capitation, which restricts patient choice and hinders a child or family's ability to access the most suitable care due to coverage barriers. We express concerns that the expansion of Managed Care Organizations (MCOs) to other counties might exacerbate these limitations, particularly in rural areas where choices and options are already significantly constrained in comparison to our more densely populated urban centers.

The division should consider rate reimbursements adjusted per zip code/designated area(s) to increase provider's ability to service rural populations. They should also consider the use of advanced and diverse carve outs in capitation contracts to deliver multiple capitation practices/providers, to cover different needs (peds, adults, mental health, etc). Instead of capitation with 1 provider group, the MCO's could do a flat rate of reimbursement and allow any providers that are willing to accept that rate to be an in network provider.

Providers who offer in-person services to rural populations in Nevada often travel long distances between sites in order to not only serve multiple small communities, but to fulfill a large enough caseload to support a reasonable salary for the provider. Rates should also consider reimbursement of travel costs between sites in various geographic areas throughout the state.

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?

A recent study published by WebPT in 2023 highlighted that an environment that supports collaboration and communicates the value that a provider brings to the health care team improved outcomes for their clients and increased provider retention. Key factors that lead to practitioner resignations according to the same study included a desire for better career growth opportunities, increased compensation, alignment with core values in their workplace, and relocation to new areas (think: cost/standard of living).

To foster workforce growth and capacity, incentives should address these concerns. The Division could consider creating a more competent workforce of members via specific vocational skills training sessions, especially for populations data show would benefit from more robust services. For example, the benefit of early interventions and skill development -either by leaning on, or encouraging continued growth and education of providers, such as OTPs who are already addressing functional deficiencies, can save costs in the future by creating a more skilled rural workforce. This in turn then increases access to care and interventions provided, decreasing the long-term stifling costs of pediatric (among other, e.g.

adult care programs, group homes, respite care programs, vocational skills programs, prison) costs.

Incentives could involve higher reimbursement rates, promoting value-based care models over volume-based ones, supporting private practice and entrepreneurship among the professionals tasked with aiding in these efforts, exploring innovative care provision models, and enhancing quality of benefits for providers. Additionally, addressing the financial burden on health professions students, such as offering loan forgiveness or financial supplements, can further incentivize individuals to join and contribute to Nevada's rehabilitation workforce capacity in MCO's.

On July 25, 2023, Rep. Grace Napolitano (D-CA) and Rep. Annie Kuster (D-NH) introduced the Mental Health Professionals Workforce Shortage Loan Repayment Act in Congress. They've recognized similar barriers and needs, and have leaned on the following idea to help, and support of this bill could help with the expansion as the program grows: the legislation would provide loan forgiveness to mental health professionals, including occupational therapists, who practice in a mental health professional shortage area like rural Nevada. The bill does this by amending an existing loan forgiveness program for professionals who treat substance use disorders which already includes occupational therapists. If the new legislation were to be enacted, occupational therapists who practice in a mental health professional shortage area would also be eligible for student loan forgiveness. Additionally, OT educational programs have been eligible for grants from the Behavioral Health Workforce Education Training (BHWET) Grant program since 2015 (the same legislation also created a new mental health intensive, "outpatient services benefit" in Medicare that includes OT). We hope that legislators in NV will see/consider these considerations, support them, and implement/utilize state-wide. Creative solutions such as this can ensure that providers are able to truly come to the table feeling confident that their participation will be lasting, supported and respected.

It is worth noting that this summer, Governor Lombardo signed an OT-license reciprocity law that streamlines OTP applications of out-of-state providers who have joined the national state licensure compact. While NV is not currently a compact member, having this reciprocity means that there is a simplified process for out-of-state practitioners (this could include telehealth providers) to move to/treat in the state. Leaning on this as an opportunity to increase the number of OTPs (as nationally there is already a national therapy shortage, and as NV infamously is low on OTPs), could strengthen the program expansion that The Division aims to achieve.

Nevada Medicaid's most recent Quadrennial Review highlighted reimbursement deficits for therapy providers in the state. According to its own data, therapy providers (physical therapy, occupational therapy and speech therapy) have dealt with repeated cuts to reimbursement rates when other providers are shown to be overcompensated. This, paired with factors above - such as therapy worker shortages and high-costs of living - do not allow for long- lasting involvement of rehab professionals in Medicaid services, let alone in NV as a whole. We worry that OTPs will not be able to provide their expertise, in an ongoing and lasting way, if such reimbursement cuts make it impossible to live/work within Medicaid systems.

Finally, to increase capacity and support retention of therapy practitioners in rural areas managed by MCO's, a comprehensive support system that emphasizes collaboration and mentorship should be developed. When health care providers work in isolation, this not only reduces the quality of care for patients, but also reduces the satisfaction of the health care workforce.

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?

Recent research, (Rogers et al., 2016), unveiled a compelling correlation between increased investment in occupational therapy services and a noteworthy reduction in hospital readmission rates. In this study, occupational therapy was the only discipline to reduce hospital readmission on the interdisciplinary team. This underscores the significance of occupational therapy services which address not only clinical but also critical social determinants of health, and allows for greater patient success, health, and safety upon discharge to the community.

For the development of provider requirements and network adequacy standards in managed care, a critical best practice emerges from this evidence: It is imperative that this state integrates occupational therapy into the interdisciplinary healthcare team(s) created by this expansion. By doing so, we can achieve two essential objectives: enhancing the overall quality of healthcare delivery while concurrently managing and minimizing state-wide healthcare costs. This approach, validated by its potential to reduce readmissions, offers a promising strategy that can effectively cater to the unique healthcare needs of rural and frontier communities, as observed in other states and communities.

The benefits of leaning on occupational (and physical and speech) therapy services decrease however, in instances where there is a capitation (or overflow) agreement with a provider/group. Limits in Clark County makes NOTA wary of related expansion, and we puch for provider and patient choice as The Division moves forward. Providers are not able to have the capitation agreement with another MCO insurance, to allow for patients to choose different MCO plans, due to provider options. These factors decrease beneficial outcomes and the longevity of a provider group's capacity to work in rural and Medicaid populations.

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.

Capitation agreements that create preferred providers that are limited in their service delivery model, specialties, age, or diagnosis treatment abilities, etc. limit access to covered services and care for Medicaid recipients. Even with overflow contracts and additional providers being in the network on paper, the member suffers from the time restrictions of the bureaucratic demands and hoops to prove the preferred provider is unable to service the specific need and pass the referral to someone who can and allow for the provider to have time to get the authorization required to initiate care. Across all care providers, (physicians, specialists, therapy practitioners, etc) this is a limitation to the quality, access, and timeliness of care.

Again, there are additional barriers due to the therapist shortage in the state of NV. By limiting the number of providers that are allowed to sign up, The Division risks limiting care options and beneficial outcomes for even more patients. If there are capitation agreements that are limiting therapy providers from signing onto insurances, then they are less likely to relocate to NV, because they will already be excluded from certain insurances. As mentioned, when there is a capitation (or overflow) agreement with a provider/group, they are not able to have the capitation agreement with another MCO insurance,

to allow for patients to choose different MCO plans, due to provider options. Most families on Medicaid are low income, they can have speech therapy (ST) (because that is not in capitation), but even when the practice could do OT and/or PT at the same location, they are not allowed to. This causes added expense for the family to drive to multiple locations, plus the time needed to make it to different locations. These barriers create real limits to outcomes, and on their face - and especially to patients - feel arbitrary and frustrating for families and patients already with limited resources and complex needs.

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?

Among allied and alternative therapies, occupational therapy practitioners possess a unique advantage, characterized by formal medical training combined with specialized expertise in mental health. Ergo, and again: occupational therapy telehealth service availability will play a pivotal role within the interdisciplinary healthcare team/systems created to deliver such care. Unlike our other rehab colleagues (physical therapists, speech therapists), occupational therapists offer a distinct perspective. Our scope of practice addresses the intricate functional and cognitive aspects of acute and chronic mental health disorders, and our NV reimbursement codes allow for this evaluation and treatment in hospitals, schools, outpatient clinics, home-health, and other community-based programs.

We serve a wide spectrum of mental health disorders, whether in a one-on-one capacity or through group interventions, all of which can (again) be effectively administered through telehealth modalities - Intervention includes the comprehensive management of symptoms related to common disorders like depression and anxiety, as well as crucial medication-management technique(s) and training for individuals coping with conditions like borderline personality disorder and schizophrenia. Notably, OT practitioners are equipped to provide care to patients in various states of detox (provided they are medically stable) and those in need of relapse prevention services.

For the Division's consideration regarding strategies to expand telehealth usage and reduce service gaps in addressing behavioral health care needs in rural areas, incorporating occupational therapy into telehealth services emerges as a promising approach. The Division should consider widening their accessibility to telehealth providers by removing physical barriers and limitations on providers. For example, in behavioral health practices, interns must be in a physical building to provide care for telehealth, despite not being under direct supervision of a superior. Their superior is accessible to them for mentorship in an office setting just as they are in a remote setting. This limitation doesn’t increase quality of the care provided but rather puts restricting barriers on companies that support providers in practice by increasing the fixed expenses and increased administrative burden.

Of note: in 2023 NOTA advocated for the expansion of telehealth services, and OTPs playing a role in that service delivery, specifically targeting mental health needs across the state. Ergo, the current

legislative body should already be primed to recognize OTP's role in mental health services, including through a telehealth medium, aiding any related efforts in the future.

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?

There are programs and initiatives supported by AOTA (The American Occupational Therapy Association) that are prime examples of efforts that can foster significant benefits and positive outcomes for both communities and healthcare providers.

Given the inherent nature and scope of the occupational therapy profession (as outlined above/throughout), contributions within these programs extend to addressing mental health concerns of clients and families.

1. CAPABLE (https://www.ncoa.org/article/evidence-based-program-capable): allows for a hybrid in-person/virtual team of professionals working to have community-based aging in place efforts improve within a partnership of service delivery from a nursing team and occupational therapy practitioners.
2. C.O.P.E. -Care for Persons with Dementia in their Environment (https://drexel.edu/cnhp/research/centers/agewell/Research-Studies/COPE/): works to provide dementia education and training to patients and their caregivers, again, leaning on the expertise of nurses and OTPs.

There is (ironically) a COPE Program (same acronym, different service) in Nevada, as well: (https://adsd.nv.gov/Programs/Seniors/COPE/COPE_Prog/): This COPE program works to increase the reach of Medicaid programs for seniors across the state, by allowing formal skilled assessment and intervention as part of working to increase safety and independence in the home for participants. This is another angle that occupational therapy practitioners see as an opportunity within the bounds of something that already exists.

Of note, OT plays a pivotal and distinct role in the delivery of mental health care in pediatric settings, as well. As a profession deeply rooted in understanding the interplay between an individual's physical, emotional, and cognitive well-being and their daily activities and routines, occupational therapists bring a unique perspective to the field of pediatric health. Specifically, OT pediatric mental health services - be it in schools, outpatient clinics, inpatient capacities or telehealth (1:1 or group/didactical intervention) - can play a crucial role in meeting NV's mental healthcare objectives, across the lifespan, especially when it comes to: collaboration with mental health specialists who provide early intervention and support, helping children and their families manage and cope with mental health challenges and providing interventions tailored to each child's unique needs, focusing on building essential life skills, coping strategies, promoting emotional regulation, sensory processing, social skills, and self-esteem.

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?

Yes. By adding a modifier that indicates use of telehealth, vs in-home, vs in community, vs in-office, there should be additional incentives/monetary reimbursements made to providers that are spending

the additional time, money and resources to service clients and children in their natural environment. The outcomes by doing care in this model are more positive in life-long future changes and costly. By removing the financial burden, more practitioners can meet clients where they are and influence substantial functional changes.

Additionally, we've observed that when families and children have a range of options and improved access to care, their likelihood of achieving successful outcomes increases. This perspective challenges the current limitations in Clark County, which stem from a capitation-based system where Medicaid is closely tied to just one or two clinics that may not fully align with the diverse needs of those seeking treatment. NOTA strongly urges any expansion efforts to prioritize provider choice and eliminate restrictions on preferred choices within the system. Such changes would benefit patients and their families by ensuring they receive the care they truly need.

It is also important to note that the gold-standard for pediatric and adult mental health (occupational) therapy services is group (didactical) intervention and service. It'd be vital to ensure that expansions and programs would indeed cover and promote group-based intervention strategies, whether in person, or via telehealth to allow for adequate and appropriate options for consumers looking to improve their mental health.

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?

Last month, Medicaid & CHIP released their Post-partum Toolkit. It promoted pregnancy health homes and emphasized the importance of behavioral health and management of chronic conditions for postpartum people. If the state is going to use managed care contracting authority to hold managed care plans accountable for meeting maternal health quality metrics, we think it makes sense to again promote how increased access to OT could help them achieve these goals. OTPs working with pregnant and postpartum people around psychological well-being and/or chronic disease management would indeed help the state in its aims.

The Division should consider implementing a comprehensive early intervention (EI) program that incorporates occupational therapy services, particularly in these targeted rural and frontier areas of the state. This program should also encompass mental health services tailored to support mothers,

specifically addressing postpartum and other common mental health challenges associated with childbirth.

OTPs, with their unique qualifications and expertise, can play a pivotal role in improving maternal and child health outcomes through the Managed Care Program, be it in inpatient, outpatient or home-based settings. Consider the offered vignette (from an interested party assisting in the creation of our RFI proposal) of this OT, as she helped a new mother with MS: she instructed her on strategies for safely holding, feeding, and bathing her infant while managing the mother's own fatigue and balance. Mom and baby both met goals, in the home, and were able to thrive in the development of new offered routines and strategies created from 1:1 OT intervention (see: answer to portion III-B, below).

Furthermore, and especially, sensory-based approaches, a core aspect of occupational therapy, can be particularly beneficial in addressing the developmental needs of children. These approaches are well-suited to promote healthy development in children, as they often involve creative and adaptable techniques that can be tailored to the specific needs of individual children.

Moreover, as Teena - an EI therapist, and another supporter of these efforts - aptly points out, "It is hard to provide services for children who do not have the tools for therapy, it would be ideal if we could provide them these items."

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?

We do not have an official position to share with respect to improving payment models, per se. Again, we know maternal and child health outcomes can be sooner met with participation in OT services, which inherently decreases costs and repeat hospitalizations/need for services throughout the lifespan of parents and children. Consider this example, provided to us by our national association, to help us highlight for The Division how having access to OT services can help meet these outcomes:

"Ann, a 32-year-old new mother with multiple sclerosis, was referred to occupational therapy for baby care skills and management of falls risk, balance, and fatigue. She reported having difficulty with household chores, specifically cleaning and ironing. She also reported becoming easily fatigued during the day. An occupational therapy practitioner instructed her on strategies for safely holding, feeding, and bathing her infant while managing fatigue and balance. The occupational therapy practitioner focused on identifying adaptive and compensatory strategies for completing household chores and taught her how to self-pace daily routines between demanding and undemanding activities to conserve energy. She also worked with Ann to identify, modify, or eliminate environmental hazards that could pose a risk for falls. Ann reported increased confidence in her ability to safely care for her child and was able to continue her daily routines with improved energy and effectiveness."

IV. Market & Network Stability

1. Service Area:

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.

Exploring the possibility of establishing multiple regional or county-based service areas within Nevada Medicaid holds the promise of several advantages. Firstly, it would promote better choice(s) for patients and their families. A diverse array of providers and healthcare facilities within these regional or county-based service areas would empower individuals to select the care that best aligns with their unique needs and preferences. This increased competition would foster an environment where healthcare providers strive to deliver high-quality care, continuously improving services to meet the evolving demands of their respective regions.

That said, secondly, regional or county-based service areas recognize the distinctive characteristics and healthcare requirements of each area. Nevada is known for its geographic diversity, with urban centers like Las Vegas, rural communities, and frontier regions each presenting their distinct challenges and opportunities. An arbitrary, one-size-fits-all approach, as exemplified by treating the entire state as one service area, may not effectively cater to these unique considerations. Tailoring healthcare delivery to the specific needs of each region ensures a more meaningful and targeted approach to improving health outcomes and access to care. Just the example of broadband access alone is one distinct consideration of the geographical nuance/capabilities of different regions of the state.

A limiting factor, the concept of Managed Care Capitation, as it currently stands, has raised critical questions regarding the delivery of healthcare services within the state of Nevada, in the greater Las Vegas area. Presently, a limited number of providers offer services that may not fully meet the robust and diverse needs of the community, and further expansion of this would limit services provided, and also impact the area-specific needs/capabilities of service access of patients.

We deduce that the establishment of multiple regional or county-based service areas within Nevada Medicaid holds the potential to provide better choices, foster competition, and address the unique healthcare requirements of diverse regions.

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.

2. Algorithm for Assignment

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?

As a person-centered profession, OT practitioners, while acknowledging potential benefits, time-saving features, etc. of algorithmic assessments and decision-making, nuance and patient-first decision-making can be at risk when one-size-fits-all models of service delivery are applied. We find this especially true as it concerns under-served and vulnerable populations, who tend to have a higher likelihood or risk historically falling through the cracks of our systems’ pattern-based thinking. On the whole, using algorithms in healthcare raises several concerns that are currently being grappled with - especially as algorithm use continues to expand and related technologies continue to advance. The aim should always be to ensure the safety, effectiveness, and ethical use of these technologies in mind, and have a human-based review system in place as a check. Here are some of the key concerns, commonly cited, associated with using algorithms in healthcare:
Bias and Fairness: Algorithms can inherit biases from the data they are trained on. If the training data is not representative or contains biases, the algorithms can produce biased results that disproportionately affect certain demographic groups, that can lead or add to disparities in healthcare outcomes.
Transparency and Interpretability: Many healthcare algorithms, particularly deep learning models, are often considered "black boxes" because it can be challenging to understand how they arrive at their decisions. Lack of transparency can make it difficult for healthcare professionals – and the public - to trust algorithmic recommendations, without concerted efforts in clarity and communication.
Accountability and Liability: Establishing clear lines of accountability and liability is essential to ensure that patients are not harmed by algorithmic errors.
Data Quality and Integration: Algorithms heavily rely on data, and the quality of data used can significantly impact their performance. Integrating data from various sources and ensuring its accuracy and completeness is a significant challenge in healthcare – especially when (if not) taking into account many state-specific or patient-specific factors when arriving at decisions.
Regulatory and Ethical Challenges, including Patient Autonomy: Ethical considerations, such as patient consent, data ownership, and the potential for unintended consequences, need to be carefully addressed. The healthcare industry is subject to strict regulations, and introducing algorithmic systems can pose regulatory challenges. For instance: would patients be aware that algorithmic decision-making is aiding in decisions regarding the care/coverage they receive? Patients should have a say in their healthcare decisions. Algorithms should not override a patient's autonomy or reduce their involvement in the decision-making process.
Dependency on Technology: Overreliance on algorithms can lead to reduced human clinical judgment and decision-making skills. Healthcare professionals should use algorithms as tools to support their decisions rather than replacing their expertise.
Algorithmic Drift: Algorithms may become less effective or outdated over time as medical knowledge evolves. Regular updates and maintenance are necessary to keep algorithms relevant and accurate.

To address these concerns, it is crucial to develop and implement algorithms in healthcare with a focus on fairness, transparency, privacy, and accountability. If it’s use - as the question states - is in the introductory phase (only?), it may be of benefit to share with stakeholders results, recommendations for continued use - or not, and adding additional avenues of transparency as time marches on, as well, to keep communication and clarity open and maintain trust. Involving healthcare professionals, patients, ethicists, and regulators in the development and deployment of healthcare algorithms can help strike a

balance between the benefits and risks of algorithmic technologies in healthcare. OTPs in the state encourage these considerations and more, carefully, before implementation and a full reliance on such technologies.

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 incentivized 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?

Where we see such incentives currently, the "incentives'' are actually causing a decrease in quality care, when rehab is concerned. This is in part due to the fact that authorizations from the MCO's are being issued, for example, only 1x a week even when more visits are medically appropriate. If such strategies will be employed, we want to request that The Division really takes into account patient interaction with such contract procurements. We hope that The Division considers looking outside the state for other beneficial strategies that may be working better in states like ours.

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?

In the behavioral health realm, AOTA touts two Nevada Medicaid policies to other states: (1) the agency's 2022 web announcement and (2) clarifying the coverage parameters for OT in behavioral health and their investment in Certified Community Behavioral Health Clinics (CCBHCs) (Attention…Providers in a Behavioral Health Setting, 2022).

In the last term of Congress, our national Federal Affairs team promoted legislation that would have required the federal Medicaid agency to issue a similar bulletin to the states. Specifically, AOTA wanted a State Medicaid Directors (SMD) Letter explaining the coverage of occupational therapy mental health care. We believe these kinds of clarifications can expand access to behavioral health services by showing states how to use tools they already have, without adding a new benefit. In Indiana, they also clarify that behavioral health is in OT's scope of practice by supporting the inclusion of OT in the treatment plan of members receiving behavioral health services. We think adding such language could build on an already well-serving/intentioned 2022 web announcement.

Nevada was one of the states that piloted the CCBHC model, first under a demonstration grant and now under state waiver authority, with OT on the suggested staffing list. The Bipartisan Safer Communities Act of 2022 provided authority to expand this model nationwide, in 10-state batches every two years. We urge that through this RFI / managed care procurement, that OT is advanced as a core part of the program.

With the capitation agreements in place for HPN Medicaid and Silver Summit for all ages and

Anthem for over the age of 18, OT and PT providers are not allowed to be in contract with the MCO's. Therefore, any discussions about care, payment, etc. do not apply to them. If the MCO's are going to have capitation with a single therapy group they should not be able to select the same provider for multiple MCO's. By only selecting 1 group, they are limiting the care for patients. Currently, HPN Medicaid and Silver Summit Medicaid have the same capitation provider, and the overflow providers read almost exactly the same, as well.

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

One of the limits of the growth and expanse of any related venture that we see as providers is the fact that NV is a 'Purple' state, meaning that on a rather consistent 2-year interval, we see program development and funding, and then the inverse and such efforts rolled back. A cyclical pattern of the 'having' and then 'not' of resources really decreases the impacts of attempted programs. It creates a burnout and cynicism amongst those working in the psychosocial and community-based arenas, and has detrimental outcomes for residents of NV.

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?

NOTA has actively participated in discussions related to data gathering and the assessment of the relevance and necessity of implementing a PACE Program in the state. This involvement allowed us to provide occupational therapy-specific recommendations and perspectives.

The Division is likely well-informed about the concept of the Medicaid Program of All-Inclusive Care for the Elderly (PACE), which is designed to provide comprehensive medical and social services to eligible older adults covered by Medicaid. The primary aim of the program is to enable older adults to access necessary services while remaining within their communities, thereby avoiding the need for extended stays in healthcare institutions.

We recognize the potential benefits of implementing the Medicaid PACE program as a valuable service that can significantly enhance health outcomes, particularly (as voiced during their listening sessions) when leveraging the expertise of Occupational Therapy Practitioners across the state. Collaborative efforts such as the PACE program, in conjunction with initiatives like COPE (mentioned and the other programs mentioned above) with those proposed here by The Division, could synergistically strengthen overall healthcare outcomes.

By embracing these comprehensive strategies and leveraging the unique contributions of these

programs, and with aid from practitioners like occupational therapy practitioners, our state could be poised to improve health outcomes with enhanced community-based care for older adults in our state. These collaborative efforts reflect the commitment of these advancing healthcare services and the overall quality of life of all Nevadans. It'd also help decrease the risk of growing concern of 'lonliness' as an again crisis - as noted by this most recent national presidential administration. Early work to mitigate the growing epidemic of loneliness-especially for our aging and rural population - will well serve the state, and NV OTs hope to be a part of this growing effort.

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?

We think it important to mention/remind the division that part of the concern here has been the gradual, but near complete closure of rural hospitals in Nevada (and across the entirety of The United States), and remains a significant problem. It compounds all our barriers mentioned, and adversely affects access to healthcare services in these underserved areas, plus, is exacerbated by the limited availability of urgent care facilities in rural regions. The closure of rural hospitals creates several challenges, such as reduced emergency care, primary care, preventative care services, and has an economic impact that ironically increases health disparities.

However, there is an opportunity for creative solutions and investment in this time of MCO expansion. Telemedicine has been a theme of our responses, and remains a ready-today option that we support, and hope to collaborate with the state and its partners in those efforts.

Additionally, expanding partnerships with those rural clinics/urgent cares that are out there is going to be crucial for the success of any endeavor proposed here. OTPs hope to allow for the growth of services to allow for perhaps outpatient rehab services that can aid in meeting the needs of these communities. Such ideas within the bounds of these partnerships: preventative care and screening (fall risk assessment, home evaluation sign-ups), education (telehealth education/sign up). There is even cross-industry partnership opportunity (bringing in rural broadband providers to these clinics to ensure telehealth services at time of sign up.

Until the time we as a state can rely on rural hospital systems, these options will help meet the needs, and improve the lives of those impacted by social determinants that right now remain barriers to access to care.

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?

Numerous challenges confront healthcare systems in Nevada - they're big challenges - echoed across the nation. We do not face these concerns alone. As far as beneficial changes, increasing from a 3% profit system would of course serve the community more. Inter-state programs and collaborations to raise the boats of all citizens may be a worthwhile venture/consideration when seeking out Medicaid(-/care) legislation and program development, and improve overall continuity. For the specific question and task at hand, posed by this prompt, we advocate for a concerted focus on three pivotal areas, recognizing their potential to mitigate the multifaceted issues that burden our communities. Recall:

according to June 2020 statistics, ~22% of Nevadans were enrolled in CHIP/Medicaid programs. There is a significant need within the broader population for such ongoing healthcare/community support(s).

Affordable Housing Support: The provision of affordable housing support stands as a cornerstone in addressing the intricate web of social determinants of health. By prioritizing affordable housing initiatives, we can significantly impact the prevalence of risk factors that undermine the well-being of our residents.

Mental Health Services: The expansion of mental health services is of paramount importance, as this RFI itself recognizes. This expanded resource base has the power to alleviate not only mental health concerns but also issues that reverberate through our communities, such as substance abuse, cycles of addiction, gun violence, suicide and the pervasive challenges of loneliness and social isolation.

Poverty Alleviation: A steadfast commitment to alleviating poverty is imperative. Those experiencing homelessness and living in poverty are susceptible to a multitude of social factors that exacerbate health disparities, from increased obesity to heightened domestic violence risks.

NOTA holds unwavering values rooted in reaching and serving all Nevadans, with particular emphasis on underserved populations. It is essential to recognize that mental health factors often intersect with housing instability and poverty, compounding the complexities of addressing healthcare disparities.

Recent reports have unveiled troubling statistics, that one-third of teenage girls in the US surveyed from 2016 - 2020 reported contemplating suicide. Vulnerable groups, including Indigenous, queer, and Black and Brown youth, have witnessed a surge in related sentiments. These young individuals have candidly cited their experiences of loneliness, paired feelings of hopelessness in relation to societal stressors with unclear solutions: the mounting pressures of climate change, racial tensions, and health insecurity (the enduring effects of the pandemic) (Affairs (ASPA), 2022).

Moreover, our rural and frontier youth, grappling with various states of poverty and precarious living conditions, warrant utmost attention in all healthcare endeavors. The Division has an opportunity to expand these programs with the dignity and well-being of Nevadas in mind. NOTA ardently hopes that Nevada's managed care plans will channel their investments into initiatives that support our communities in these vital areas. We implore them to consider harnessing the profound expertise of occupational therapists and occupational therapy assistants to fortify their endeavors. By doing so, we can collectively advance the cause of healthcare equity, enhance health outcomes, and foster the well-being of Medicaid recipients throughout the state.

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.

We think it apt to call attention to a valuable resource provided by the American Occupational Therapy Association (AOTA) that highlights the significant impact of home health occupational therapy (OT) intervention in helping seniors avoid costly healthcare interventions, ultimately resulting in substantial cost savings for the state. Accessible at the following site: https://www.aota.org/-/media/corporate/files/advocacy/federal/fact-sheets/medicarehomehealthaccessibilityactfactsheet2023.pdf

Key highlights from AOTA Home Health Intervention Fact Sheet (in-depth, below) underscore the cost-effectiveness and positive outcomes associated with OT-led interventions in home health:
Fall Prevention through Home Modifications: OT-led home modifications for fall prevention have not only reduced hospital readmissions but have also demonstrated the potential to save a remarkable $22,120 per patient over a two-year period. These interventions have proven to be both cost-effective and successful in reducing falls by 40% among high-risk seniors.
Chronic Condition Management: Seniors with multiple chronic conditions who have participated in OT-led self-management programs have realized substantial savings, amounting to an average of $2,548 in healthcare costs over just six months.
Dementia Care and Cost Savings: OT-led home support programs designed for seniors with dementia have consistently yielded significant annual medical cost savings, estimated at $6,667.
In summary, the evidence strongly supports improved performance in activities of daily living (ADLs) and overall health outcomes for individuals who participate in OT-led programs. Therefore, we find it imperative to include these services in the expansion of Medicaid managed care initiatives within the state. These recommendations are grounded in the distinctive value that OT brings to the table. We request that OTPs remain on the forefront of decision-maker's minds when creating state-wide solutions, as we would promote both the well-being of its diverse populations and the fiscal health of its healthcare system, yielding long-term benefits for all stakeholders.

Please reference the following attachments to support this stance against the rate reductions, as well as other related considerations:

Effects of Evidence-Based Fall Reduction Programming on the Functional Wellness of Older Adults in a Senior Living Community: A Clinical Case Study
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5177607/#:~:text=Conclusion,amount%20of%20physical%20therapy%20intervention.

New UnitedHealthcare Benefit for Low Back Pain Helps Reduce Invasive Procedures and Address the Opioid Epidemic
https://www.unitedhealthgroup.com/newsroom/2019/2019-10-29-uhc-benefit-low-back-pain.html#:~:text=2019-,New%20UnitedHealthcare%20Benefit%20for%20Low%20Back%20Pain%20Helps%20Reduce,and%20Address%20the%20Opioid%20Epidemic&text=Share%3A,tests%2C%20spinal%20surgeries%20and%20opioid

AJOT Teletherapy Findings
https://research.aota.org/ajot/article-abstract/76/6/7606205090/23960/Telehealth-Interventions-Within-the-Scope-of?redirectedFrom=fulltext

Mental Health Professionals Workforce Shortage Loan Repayment Act
https://www.aota.org/advocacy/advocacy-news/2023/bill-would-provide-loan-forgiveness-for-ots-in-mental-health#:~:text=Grace%20Napolitano%20(D%2DCA),mental%20health%20professions%20shortage%20area.

Behavioral Health Workforce Education Training (BHWET) Grant Program, 2015
https://www.aota.org/advocacy/advocacy-news/2022/end-of-year-legislation-new-mental-health-

benefit-advances-ot
CDC/CMS Chronic Pain Management Map
https://www.cms.gov/files/document/cms-chronic-pain-journey-map.pdf
AOTA Post-Dobbs Task Force Report
https://www.aota.org/about/for-the-media/aota-releases-post-dobbs-task-force-report

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Sisolak, S., & Whitley, R. (2022). Quadrennial Rate Review Division of Health Care Financing and Policy Rate Analysis and Development October 2022.
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