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Department of Health and Human Services
Division of Health Care Financing and Policy
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Re: RFI for Nevada Medicaid Managed Care Expansion

Dear Administrator Weeks,

Select Health appreciates the opportunity to provide comments regarding the state-wide expansion of Nevada's Medicaid managed care program. Select Health is a nonprofit health plan serving over 1,000,000 members in Nevada, Utah, and Idaho, including over 130,000 Medicaid and CHIP members across all of Utah's urban and rural counties. Established in 1983, Select Health is a wholly owned subsidiary of Intermountain Health ("Intermountain"). In Nevada, SelectHealth provides coverage in Nevada Health Link, Medicare, and the Small Employer market contracting with Intermountain and additional community providers to ensure networks meet enrollee access and care needs.

Intermountain is nonprofit health system operating in Utah, Idaho, Colorado, Montana, and Nevada with 33 hospitals (including one virtual hospital), 385 clinics, a Medical Group with almost 3,800 employed physicians and advanced practitioners. Intermountain Nevada, formerly HealthCare Partners Nevada, is a leading network of healthcare providers and clinics with over two decades of experience serving the Nevada community and implementing value-based care for vulnerable and underserved patients. Intermountain Telehealth Services provides primary, urgent, behavioral health, and specialty services across seven states and has experience in Nevada expanding services to rural communities.

Select Health and Intermountain share a mission to help people live the healthiest lives possible and a vision to be a model health system. We are a forever organization in Nevada and seek opportunities to partner with the Division of Health Care Financing and Policy to meet its objective of ensuring that Medicaid enrollees receive high quality accessible care state-wide.

Select Health and Intermountain believe, and our experience has demonstrated, that value-based arrangements provide the greatest opportunity to align the goals of improved cost, population health, and experience among purchasers, payers, and providers. We leverage our integrated enterprise to assume the role of an "integrator," which the Institute for Healthcare Improvement defines as an organization capable of accepting responsibility for all health aims simultaneously and that "will link health organizations (as well as public health and social services organizations) whose missions overlap across the spectrum of delivery." As a result, we have established a culture that drives towards integrated, value-based care, including working upstream with community partners to achieve a collective impact.

Thank you for considering our input. If it would be helpful to discuss our responses or experience, or explore solutions, we would be happy to connect with you. If additional information is needed, please contact Russ Elbel.

Re: RFI for Nevada Managed Care Expansion
Section 1, Provider Networks
Responder: Russ Elbel, Select Health

I. Provider Networks

Improving access to care is essential to ensuring a successful Managed Care Program, especially in hard-to-reach rural and remote communities. All of Nevada's 17 counties are under one or more federal Health Professional Shortage Area (HPSA) designations. Many Nevada providers do not accept Medicaid due to low rates of reimbursement or the administrative burden associated with billing Medicaid. Due to the significant shortage of primary care and behavioral health providers in Nevada, many recipients face long appointment wait and/or travel times for basic health care needs. This is especially true in rural and frontier areas of the state, where people often have no choice but to forgo necessary care or seek services at the nearest local emergency room after a condition has exacerbated.

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

Response:

Rural providers need a greater level of financial and administrative support as compared to their urban counterparts. Permitting sub-capitated payment structures with flexible, supporting encounter requirements is one way to ensure that rural providers have a more stable, prepaid funding source as compared to the traditional FFS structure. A version of sub-capitated and value-based Medicaid ACOs or CINs, can also provide a similar level of funding support, while also helping local providers with administrative and quality metric support. Other ideas that would address these stated concerns include: (1) the use of provider time and distance standards similar to what Medicare uses (see 1.D below); (2) Using provider availability testing processes similar to those that CMS is likely to established under its pending Proposed Rule Making on this subject (https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p); and (3) carefully crafting the Geographic Service Area (GSA) structure and MCO participation requirements (see IV. 1 below.)

As an integrated delivery system Intermountain and Select Health have experience leveraging the Enterprise's resources to make a collective impact in rural areas. This includes creating partnerships with rural providers like Federally Qualified Centers to extend specialty care via Telehealth and Hospital at Home programs combining telemonitoring, care management, and home health to allow rural patients to remain in their communities at a lower cost. The Division currently has a profit re-investment requirement. If this is kept in place, this could be modified to create an incentive to reward MCOs who invest in community infrastructure and operations that support rural areas and that aligns with the Division's priorities.

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:

The Division should consider allowing the use Value Based Payment (VBP) models to ensure sufficient payment rates to rural providers and aligning incentives to improve quality and cost and creating incentives and rewards for doing so. The Division should consider using the Health Care Planning and Learning Action Network (LAN) framework to evaluate VBP programs. Other state Medicaid programs, such as Louisiana, have used this framework to stimulate and reward VBP. The Division should also work with MCOs to include VBPs in experience in the Medical Loss Ratio (MLR) and rate setting to ensure there is no unintended disincentive for VBP.

One option is the use of sub-capitated payment structures (see 1.A above) by MCOs, which allows an encounterable value that varies from urban rate structures based on the actual cost structure of the rural provider. (Note: rural provider cost structures tend to vary more widely than their urban counterparts.) Plans can more easily require that providers submit quarterly financial statements in the sub-capitation context, detailing both medical expense and administrative costs. Plans can then use the information to establish rates, monitor the financial stability of the providers, and step in to assist when the information suggests instability. Note: This requirement works best when coupled with a capitated system because the pre-payment inherent in a capitated system give a local rationale for requiring the financial information – the plan needs to know that the provider is stable, because the plan is trusting the provider with payments for services that have not yet been rendered. It's more difficult to insist on such a requirement in a traditional FFS system.

Another option is requiring the use of the FFS payment rate for providers considered Essential Providers in rural areas to create a floor and financial stability. Then, providing an incentive program for MCOs to implement VBPs, such as Pay for Performance, with rural providers.

Select Health has extensive experience implementing VBP including pay for performance programs with providers in urban and rural areas to reward medical and behavioral health homes for improved quality measures, access, and care coordination in primary care for complicated enrollees. We use pay performance to improve quality and access in measures that align with Utah Medicaid's priorities and desired outcomes including improving standard measures for well-child visits, immunizations, and follow-up after a mental health admission. In addition, we reward providers who care for members that are in Utah Medicaid's "lock-in/restricted" program. This has resulted in improved access to primary and specialty care for enrollees since many providers previously would not accept them because of their multiple medical and behavioral health conditions. Providers have used the funds to improve care coordination and wrap-around services leading to greater success managing member care, which, combined with care management support from Select Health, has resulted in greater provider satisfaction. Most important, it changes member's lives with over 50% graduating within twelve months and maintaining new patterns of care with their primary and specialty care providers versus the previous pattern of emergency department use.

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:

The Division might consider building on incentives with MCOs to shape the development of the workforce in rural areas. One process requirement could be a defined workforce development plan. A reward could be further tied to plans with demonstrated outcomes related to their plan, potentially shifting dollars within a defined pool of funds to higher performing plans.

There are several effective and varying approaches that can be applied to address workforce development based on the various positions needed. For physicians, the obvious challenge is finding residency slots in rural locations (physicians are more likely to stay where they complete their residency). A viable alternative is tuition payment/forgiveness programs. Community college scholarship and funding programs – often supported by health plans – are useful for developing allied health positions. Likewise, health plan sponsored peer and family member academies are great for developing candidates for case manager, care navigator, and home care capacity.

As an integrated nonprofit health system that reinvests in the communities we serve, Select Health along with Intermountain is committed to workforce development. In Nevada we fund community agencies that provide

services that impact the social determinants of health such as access to health coverage, food, and housing. This is accomplished through an awards program that provides funding directly to selected agencies as well as donations, sponsorships, and grants, all of which allow for expansion of services including workforce development. We also provide direct educational scholarships for underrepresented individuals in the workforce, such as our Latinx scholarship. In addition, working as an integrated system, we have instituted a program to enhance the Medical Assistant (MA) workforce by providing scholarships to employees in community agencies who earn a degree as an MA. These employees are placed within Intermountain clinical locations upon graduation. We have also had success maintaining the workforce in rural communities through remote jobs available in our various service call centers. Finally, we hire directly from communities to expand our Community Health Worker workforce. The result has been improved access to care, especially telehealth, which is critical to meet access needs in rural communities. In a recent evaluation we found that individuals who engaged with Care Management were likely to adopt telehealth services, but they were 66% more likely to do so when teamed with a CHW.

Also, the Division may consider coordination with the appropriate MCOs based on revenue, to ensure the workforce is distributed to key areas based on need. It may be helpful to coordinate with HRSA grants that can also be applied https://data.hrsa.gov/data/download?data=Grants#Grants. The Division could also consider working with FQHCs for residency slots for physicians and working with community colleges to develop training programs / degrees. The Division might explore partnering with MCOs on these programs to achieve a collective impact.

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:

Obviously, every state is different. However, requiring all health plans to use the same platform to determine network adequacy can be very useful. For example, Arizona's Medicaid department uses a software program, Quest Analytics, to determine network adequacy, using metrics that are analogous to those used by Medicare. The Arizona health plans have all slowly aligned with this, and now principally rely on Quest as well. One advantage of Quest Analytics is that it also suggests providers that may be available in each region to close provider network gaps. This way both the Division and health plans know what providers are theoretically available and can have an informed discussion about how best to resolve the gaps.

Also, consider expanding the types of providers / scope of services to increase access to care for Rural / Frontier beneficiaries such as expansion of Nurse Practitioner Scope of Services.

E. Nevada Medicaid seeks to identify and remove any unnecessary barriers to care for recipients in the Managed Care Program through the next procurement. Are there certain arrangements between providers and managed care plans that directly or indirectly limit access to covered services and care for Medicaid recipients? If so, please identify and explain. Please also explain any value to these arrangements that should be prioritized by the Division over the State's duty to ensure sufficient access to care for recipients.

Response:

A barrier to care (presuming the existence of an adequate network), is the lack of convenient transportation. The barrier is exacerbated by the extreme distances in rural areas and lack of mass transportation. Ensuring the non-emergent medical transportation benefit has a sufficient reimbursement rate to fund maintenance of vehicles and staff is important to maintain this program. Rural providers will generally be open to expanding services in rural areas because it gives them some assurance that appointments are not missed. Managed care can help facilitate proper use of the benefit.

Re: RFI for Nevada Managed Care Expansion
Section 2, Behavioral Health Care
Responder: Russ Elbel, Select Health

II. Behavioral Health Care

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

A. Are there strategies that the Division should use to expand the use of telehealth modalities to address behavioral health care needs in rural areas of the state?

Response:

The state could, either directly or indirectly through contracted health plans, support the technology needed for providing telehealth services. For example, several plans in Colorado, New Mexico, and Arizona have offered free or subsidized access to secured telehealth platforms and even provided telehealth enabled computer equipment and office space to providers who were willing to use the platforms to provide services to members. As opposed to contracting with some of the large commercial telehealth behavioral health firms, this approach has the advantage of using local providers which helps them with financial stability and facilitates continuity of care.

Also, the Division may consider expanding credentialing or establishing a "compact" like the nursing compact that would expand the number of providers that may provide care to Nevadans. Compact nursing states refer to the Nursing Licensure Compact (NLC), which is an agreement between states that allows nurses to have one compact state nursing license that gives them the ability to practice in other states that are part of the agreement.

There is also a need for consistent policies regarding telehealth services at the state level including the services that will be covered. There is also a need for clarification on the mode of service. Phone services excluding video remove the barrier that a face-to-face requirement can create.

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:

The initial creation of rural, community based, behavioral health providers was funded through the Mental Health block grant program in the mid-60s under the Johnson administration. This was successful because it provided not only a funding source that reimbursed for services provided, but additional funding to support the creation of the infrastructure and administration to create new providers. While this funding model is not favored by CMS any longer, some of the same goals could be achieved through state grant programs, or even using CMS capitation using the kind of sub-cap models referenced in 1.A above.

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:

The Division should consider creating an incentive in the managed care contract for the implementation of innovative solutions that combine telehealth with remote monitoring and in home services.

Re: RFI for Nevada Managed Care Expansion
Section 3, Maternal & Child Health
Responder: Russ Elbel, Select 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?

Response:
The incentives proposed above are consistent with other state's programs. Testing the performance of these programs may be warranted before considering additional programs. The Division might also consider beneficiary incentives to promote EPSDT, pre-natal visits, or telehealth visits, as examples. Other strategies that should be considered include incentives to MCOs to adopt the use of technology that expands access to care, such as teaming care management with telemonitoring and telehealth. It will be important for incentives and encounter policies to support these programs so MCOs are not required to absorb all costs within administrative rates.

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:
Nevada might consider expanding the bonus program for MCOs that implement pay for performance for providers that close gaps in care in HEDIS measures, both incentivizing value-based care and quality. This can be done for maternal and child health homes or primary care for physical health measures, such as well-child visits, as well as maternal depression or substance use screening, as examples.

Other payment programs, such as bundled, and quality-based payment approaches may increase provider capacity and promote long term effects. For example, pre-natal visits plus a delivery bonus have been applied in other States.

Re: RFI for Nevada Managed Care Expansion
Section 4, Market & Network Stability
Responder: Russ Elbel, Select Health

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.

Response:
The state should have multiple Geographic Service Areas (GSAs). The primary reason is to allow MCOs to address the unique circumstances of regions more easily. While there are many ways to accomplish this, having three GSAs may make the most sense for Nevada. The 3 GSAs that address the unique need of the Reno MSA (North), Las Vegas MSA (South), and the largely rural remaining areas of the state (Central). There should be at least two MCOs in every GSA to allow for member choice. Although CMS will allow a single MCO to hold a statewide contract, it generally makes sense to limit MCOs to two out of the three GSAs. This has the benefit of creating inherent redundancy in the system so that if an MCO loses a contract for any reason, an experienced MCO from another GSA can step in temporarily to fill the void.

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:
Several multi-GSA states mandate that if an MCO holds a contract for an urban GSA, it must also hold a contract for a rural GSA. (For example, using the three GSA structure described in IV.1.A, each contractor that holds a North or South GSA contract must also serve the Rural.) This strategy has the positive effect of ensuring that the MCO has enough revenue from the urban membership to offset the added administrative cost of serving the rural membership. However, it has the potentially negative effect of diluting the MCOs attention from the unique needs of the rural GSA. (Note: Arizona is using this strategy for the currently pending ALTCS RFP.)

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?

Response:

It is important that new MCOs continue to get prioritized enrollment in the first year to ensure market stability and sufficient enrollment to measure performance on standardized measures. When those objectives are achieved, then performance-based auto assignment should be considered. A recent trend is for states to auto-assign membership based on performance metrics that reflect components of the Institute for Healthcare Improvement's "Quintuple Aim": (1) member satisfaction (e.g., CAHPS scores); (2) provider satisfaction; (3) quality performance (usually an aggregate score across 5-10 key HEDIS/NCQA metrics); (4) cost containment using a combination of actuarially-normalized encounter submissions, along-side administrative cost reports; and (5) health equity performance (using HEDIS/NCQA metrics). This drives a balance of performance across all five of the primary areas of each MCOs operations. This reallocation does not have to be performed annually, but it should be performed every 1-3 years to provide a sufficient incentive for improvement. Most of the above work best if all contracted MCOs are required to be NCQA accredited, thus ensuring that the metrics above are being collected and analyzed using standardized methods.

Re: RFI for Nevada Managed Care Expansion
Section 5, Value Based Payment Design
Responder: Russ Elbel, Select Health

V. Value-Based Payment Design

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

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

Response:
As noted in Section I., the state should consider adopting the LAN Alternative Payment Model approach to – over time – guiding MCOs and providers to a VBP system that encourages providers to accept risk. (E.g., LAN categories 3 and 4). This will better align payors and providers to encourage expenditures on needed services to improve quality outcomes but restrict the use of duplicative or unnecessary services. This process may take several years to implement (i.e., 5-10 years). Other States such as Louisiana have required a percentage of Medical Expense payments to be under a Value Based Contract (VBC) which may be an approach that is gradually increased year over year.

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:
Some areas for consideration include providing three years of claims history when a beneficiary changes MCOs and ensuring quality benchmark data from all Nevada MCOs and providers. The State could also work to improve beneficiary information including demographics such as race, ethnicity, preferred language, sexual orientation, and gender identity to help identify disparities leading to more precise data for VBP programs. The State could also advocate that the FCC make its interpretation of Medicaid's consent process permanent and continue to authorize and direct MCOs to provide outreach to members via text messaging and explore expanding the use cases beyond enrollment assistance. Keeping Medicaid enrollees who are eligible continuously enrolled is a basis for improving health, and outreach via text messaging has proved to be effective in engaging members in care.

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

Response:
Rural providers are inherently more focused on maintaining economic stability than urban providers. Additional tools and resources may be needed through an external resource (e.g., MCO, ACO, or CIN) to ensure proper coding and collection of utilization data to support various quality metrics. The Division might consider incentives to MCOs to provide practice management support to help rural clinics develop value-based care capabilities. Select Health provides practice management transformation support to providers today, which may include coaching on items such as closing gaps in care and implementation of tools and workflows to identify and address SDOH.

Re: RFI for Nevada Managed Care Expansion
Section 6, Coverage of Social Determinants of Health
Responder: Russ Elbel, Select Health

VI. Coverage of Social Determinants of Health

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

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

Response:

In addition to supporting housing and food security, another major factor is supporting employment. Having a peer and family member "academy" program where members receive training and employment support can help members gain employment with providers as peers, case managers, community navigators or assistors, and eventually as community health workers. It turns members into a potential (albeit partial) solution to the staffing challenges that providers are facing.

Access to care is another major SDOH and the Division should examine how to ensure MCOs are supported to address churn that existed prior to and will return after the unwinding period ends in 2024. As noted in Section V.B the Division could ensure that consent processes at the time of enrollment include all partners, including MCOs, as part of the outreach team.

The Division should consider allowing MCOs the flexibility to implement programs that address the SDOH and how to create incentives to stimulate innovation and reward higher performing plans who implement a core set of services. Select Health aids in a variety of ways as examples of services that could be part of a core incentive program, including:

- Screening and electronic referrals
- Community Health Workers
- Discretionary funds to assist with member needs not covered through benefits, like rental applications
- Utilities assistance
- Transportation assistance
- Application assistance

B. Are there other innovative strategies in other states that the Division should build into its Managed Care Program to address social determinants of health outside of adding optional benefits?

Response:

Requiring all MCOs to participate in a single SDOH referral system helps to ensure that members are receiving SDOH services and provides data on the performance of SDOH providers to permit actions that optimize the SDOH system over time. The Division might consider an incentivize to providers to complete SDOH screening and utilize Z codes or build that into a MCO incentive program as noted in VI.A above. The Division might also consider working with ACOs and providers to create incentives to drive healthy food options, such as food prescriptions and delivery.

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:

Medicaid beneficiaries encounter various and unique challenges. Each beneficiary may experience vast differences, however, housing, utility, rental assistance (i.e., housing first principles) appears to be a fundamental consistency for most beneficiaries. Focusing and expanding housing first should be strongly considered.

Also, the Division should consider allowing and incentivizing the use of funds to expand capacity in rural areas for SDOH services through grants to community agencies, and providers for non-traditional health worker programs or other wrap-around services investments. The Division could consider directing a portion of funds to be used to address key SDOH, such as food, and potentially making this a Performance Improvement Project (PIP) for all MCOs.

Re: RFI for Nevada Managed Care Expansion
Section 7, Other innovations
Responder: Russ Elbel, Select Health

VII. Other Innovations

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

Response:

The Division should consider performing a provider fee schedule and pay increase study with the objectives of identifying providers who disproportionately serve Medicaid enrollees, their payment compared to the Medicare equivalent fee schedule, and when their last increase took place. This can be utilized to work proactively with providers and legislative appropriations to manage workforce needs.