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Response to the Request for Information for Nevada Medicaid Managed Care Expansion

State of Nevada, Department of Health and Human Services
Division of Health Care Financing and Policy
1100 E. William Street. Suite 101, Carson City, NV 89701
RFI#: 40DHHS-S2441
Opening Date: October 17, 2023 | Opening Time: 4:00 PM PT For:
Managed Care Organization

Transforming the health of the community, one person at a time.

Section 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.

SI.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:

Addressing Provider Availability and Access for Individuals Living in Rural and Frontier Nevada

SilverSummit Healthplan (SilverSummit) recommends the Nevada Division of Health Care Financing and Policy (Division) consider encouraging managed care plans (MCPs) to implement strategies that help members living in rural and frontier areas overcome travel as a barrier to accessing providers.

- **Implementing remote patient monitoring (RPM**). Providers can manage members' acute and chronic conditions by pairing telehealth with RPM, which can reduce member travel costs, and prevent health complications when traveling. When providers used RPM in other markets, it reduced emergency department (ED) visits, inpatient admits, average inpatient days, and average monthly claims costs for members enrolled in the program.
- **Developing partnerships and contracts with air ambulance and ground transportation providers**. We recommend the Division consider requirements and capitation reimbursement for MCPs to implement strategies to address transportation that will include supporting members after an emergency air transport with a place to stay and transportation home.
- **Implementing the school-based health center model (SBHC)** to increase availability and access. SBHCs meet the preventive, primary care, and behavioral health (BH) needs of school-aged children due to their convenience and accessibility. Students have consistent access to services without the barriers of transportation, family obligations, or conflicting activities. SBHC providers are an advocate for families across health and education systems and a critical ally for children with chronic conditions and special needs.
- **Improving care delivery through enhanced relationships with bordering states**. By analyzing existing and future patterns of care, MCPs can give members access to the most appropriate and timely services available to them.

SI.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:

Ensuring Sufficient Payment Rates for Rural Providers

SilverSummit recommends the Division develop rural Medicaid fee schedule reimbursement rates that allow MCPs to incentivize providers to participate in Medicaid in rural and frontier areas. When MCPs reimburse providers at a rate that entices them to participate in Medicaid, it expands member access to preventive and other services and can reduce costly ED visits and hospitalizations.

In addition to competitive reimbursement rates, we recommend the Division consider:

- **Reducing the need for prior authorizations.** The Division can reduce administrative burden on providers and prevent delays in member care by encouraging providers to reduce their prior authorization requirements.
- **Implementing pay-for-performance measures.** We recommend the Division encourage pay-for-performance frameworks with quality targets and health outcome metrics that incentivize providers to improve HEDIS outcomes and reduce health disparities that result from less access to care than urban counties. We recommend health equity targets such as, but not limited to, improved infant and maternal health outcomes, Z code capture, and other social determinants of health (SDOH) and health equity services, programs, and measurements, as applicable.
- **Creating a pathway to more sophisticated risk-based arrangements.** We encourage the Division to support providers with resources on effectively delivering covered services to Medicaid recipients and allow grace periods that fit their needs before holding them accountable to value-based payments (VBPs). Please refer to Section V: Value-Based Payment Design for more recommendations on VBPs.
- **Implementing innovative and proactive payment strategies.** We recommend the Division encourage MCPs to evaluate and consider emerging and pilot programs that encompass a rural capitated model to pay participating hospitals a fixed amount upfront. For example, the Pennsylvania Rural Health Model, a Centers for Medicare and Medicaid Services (CMS) Innovation Model, is currently testing whether the predictable nature of global budgets will enable rural hospitals to invest in quality and preventive care, and tailor their services to better meet the needs of their local communities. Another example is the rural emergency hospital (REH) provider designation, established by Congress in 2023, and designed to reinforce access to outpatient medical services and reduce health disparities in areas that may not be able to sustain a full-service hospital. Nevada is one of only 15 states to have enacted laws enabling REH licensure under Assembly Bill 277.

SI.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:

Creating an Effective Workforce Development Strategy and Plan

Nevada, like many states, is facing challenges in ensuring adequate access to health care services in rural and frontier communities. If MCPs invest in a Medicaid Provider Workforce Development Strategy and Plan, they contribute to building a stronger, more equitable health care system that benefits both members and the state. We encourage the Division to consider the following requirements and incentives to ensure effectiveness in increasing workforce capacity.

- **Broadening Physician Assistants' (PA) scope of practice (SOP).** When states require a physician to always be on site when a PA is providing services in a rural primary care setting, it can create an

inefficient use of the physician's time and limits access to care. PAs can safely and effectively provide some of the same health care services as physicians, in addition to providing complementary services. We recommend the Division advocate for the State to consider removing any excessive entry barriers and undue restrictions on SOP for PAs, including:
  - Consider changes tor SOP statutes to allow all health care providers to utilize their full skill set
  - Consider accompanying legislative and administrative proposals to allow non-physician providers to be paid directly for their services
  - Consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians and their care extenders (e.g., PAs) unless there are legitimate health and safety concerns
- **Expanding pharmacists' roles as providers.** In 2022, CMS approved Nevada's Medicaid's State Plan Amendment to include pharmacists as a new provider type. Currently Medicaid reimburses pharmacists for services related to self-administered hormonal contraceptives and HIV prevention. We recommend the Division advocate for the expansion of billable services for pharmacists.
- **Using the Community Reinvestment Fund.** We recommend the Division consider a requirement for MCPs to use a percentage of community reinvestment dollars for workforce development.
- **Providing financial incentives.** We recommend the Division encourage MCPs to implement strategies such as pay-for-performance and capitated payments.

SI.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:

Developing Effective Provider Requirements and Network Adequacy Standards

To ensure MCPs are providing reasonable access to care in rural and frontier communities, SilverSummit recommends the Division consider the following best practices and strategies to meet network adequacy standards.

- **Implementing a provider aggregator model.** When providers collaborate to address regulatory, fiscal, technical and workforce challenges and barriers, they can create access to sustainable, equitable, and high-quality health care for rural and frontier communities. We recommend the Division encourage providers to adopt aggregator models for collaboration between larger provider groups that can accept more risk and have VBPs and smaller rural providers. Providers can reach more members through this collaboration and can improve quality results, reduce costs, and increase access to health care. For more information, please see Section V: Value-Based Payment Design.
- **Establishing reciprocity agreements with providers in bordering states** who have Nevada Medicaid enrollment.
- **Adopting the Department of Insurance guidelines for time and distance standards.** For example, in Counties with Extreme Access Considerations, at least 90% of members must have at least one primary care provider within 60 miles or 70 minutes, one hospital within 100 miles or 110 minutes, and one BH provider within 100 miles or 110 minutes. We recommend the Division consider using telehealth in counties that cannot meet this standard.

SI.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:

Identifying and Removing Barriers to Care Created by Provider and MCP Arrangements

When providers and MCPs establish arrangements, they should not create barriers to care for members. SilverSummit recommends the Division address the following arrangements prior to the next procurement to prevent such limitations.

- **Disallowing limited MCP contracts.** We recommend the Division require that if the same parent company owns an MCP and a medical group, and they choose to contract with one MCP, they must offer a contract to all MCPs at the Medicaid fee schedule (or VBP equivalent). Members will benefit from this requirement because they will not have to change providers if they must change MCPs for any reason.
- **Removing high levels of prior authorizations.** When Medicaid recipients must gain prior authorization for too many services, it can disrupt member care and complicate the health care experience. We recommend the Division encourage MCPs to re-evaluate their prior authorizations and reduce requirements to improve access to care.
- **Removing the single rate structure.** When MCPs implement the same rates for providers in rural and frontier communities and urban communities, they fail to recognize that the cost of rural health care is higher and can contribute to the lack of health care in rural and frontier communities. We recommend the Division develop rural Medicaid fee schedule reimbursement rates that allow MCPs to incentivize providers to participate in Medicaid in rural and frontier communities.

Section 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 Americans with Disabilities Act (ADA) with respect to children with serious behavioral health conditions.

SII.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:

Recommended Strategies for Expanding Behavioral Health (BH) Telehealth Access in Rural Areas

Telehealth bridges the BH care gaps for members in rural and frontier locations by allowing members to access services virtually while remaining active with their family, employment, and community. In addition, telehealth reduces the stigma associated with BH care by providing a private means of accessing care. It also helps prevent BH exacerbations that lead to avoidable emergency department (ED) visits, hospital stays, or justice system involvement. The Nevada Division of Health Care Financing and Policy (Division) can play a strong role in increasing access to BH care in rural communities via telehealth. SilverSummit Healthplan (SilverSummit) recommends the Division:

- **Continue to allow multiple formats for BH telehealth**, including synchronous interactions, asynchronous systems, and audio-only interactions. The Centers for Medicare and Medicaid Services (CMS) encourages states to consider telehealth options as a flexibility to increase access to care. In a 16-month study, participants receiving BH services by telehealth preferred telehealth over in-person treatment and had higher completion rates, attendance rates, and number of treatment visits, suggesting that virtual BH care provides equivalent or better outcomes to in-person treatment.[1]
- **Expand audio-only telehealth for delivery of BH services.** People living in rural and frontier areas have challenges with connecting to the internet to receive BH services via video technology. Studies show the patient satisfaction rate for audio-only was equal to that of video telehealth.[2] Currently, Nevada allows audio-only telehealth for BH targeted case management and crisis intervention services.[3] According to CMS, states have broad flexibility to cover and deliver services via telehealth, and nothing in federal law or policy prevents states from covering or paying for Medicaid services delivered via audio-only technologies.[4] SilverSummit recommends the Division expand audio-only telehealth to include additional BH services, such as individual and family therapy, recovery therapy, recovery supports, and other services that help members remain stable and in their community.
- **Cover Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) via telehealth.** Nevada's Medicaid Service Manual states providers must deliver BH PHP and IOP services in a mental health setting by face-to-face interaction.[5] We recommend the Division consider including

[1] Waite MR, Diab S, Adefisoye J. Virtual Behavioral Health Treatment Satisfaction and Outcomes Across Time. J Patient Cent Res Rev. 2022 Jul 18;9(3):158-165. doi: 10.17294/2330-0698.1918. PMID: 35935523; PMCID: PMC9302910.
[2] Danila, M. I., Sun, D., Jackson, L. E., Cutter, G., Jackson, E. A., Ford, E. W., DeLaney, E., Mudano, A. S., Foster, P. P., Rosas, G., Melnick, J., Curtis, J. R., & Saag, K. G. (2022). Satisfaction with modes of telemedicine delivery during COVID-19: A randomized, single-blind, parallel group, noninferiority trial. The American Journal of the Medical Sciences, 364(5), 538–546. https://doi.org/10.1016/j.amjms.2022.06.021
[3] Medicaid Service Manual Changes Chapter 3400 Telehealth Services. (2022, June 1). Division of Health Care Financing and Policy.
[4] Centers for Medicare and Medicaid Services. (2023, July). State Medicaid and CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth. https://www.medicaid.gov/sites/default/files/2023-07/medicaid-chip-telehealth-toolkit.pdf.
[5] Medicaid Service Manual Changes Chapter 400 Mental Health and Alcohol and Substance Use Services. (2023, July 25). Division of Health Care Financing and Policy.
https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_23_08_01_ADA.pdf.

BH IOP and PHP via synchronous telehealth as a covered benefit under the member's health care insurance. By leveraging telehealth technology, members living in rural and frontier areas will have access to needed BH services and increased attendance and completion rates of BH PHP and IOP programs.[6]

- **Prioritize broadband expansion in rural areas with the greatest disparity and BH needs.** As Nevada develops its Broadband Action Plan, we recommend the State prioritize installing internet access in rural and frontier areas with the greatest health care disparities. We also suggest the Division regularly communicate the State's Broadband Action Plan with Managed Care Plans (MCPs) to ensure their providers and members receive the support needed to increase access to BH services via telehealth.

SII.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:

Increasing Availability of BH Services in Rural and Remote Home and Community Settings

SilverSummit recommends the Division develop a BH Rural Community Coalition comprised of MCPs, providers, and other stakeholders to share data and identify causal variables and associated strategies for supporting in-home and community based BH services. Several states have organized coalitions to address critical BH issues in rural and frontier areas through in-depth data review, focus groups, interviews with stakeholders, and research.[7] These coalitions have been successful in developing state strategies to address BH services in rural and frontier areas. The Division could then encourage MCPs serving rural members to work together to address the State's priorities for increasing BH services.

We also recommend the Division consider:

- **Expanding who can bill for Community Health Worker (CHW) services.** CHWs meet with members in the community or in their homes to connect them to health care services and services addressing social determinants of health (SDOH). We recommend the Division expand reimbursement for CHWs to include those who are employed and supervised by community-based organizations and BH licensed clinicians. Currently, only physicians, advanced practice registered nurses, and physician assistants can bill for CHW services. Expanding this coverage would augment support services through our current provider network and increase member access to in-home and community SDOH services that can support their BH and physical health needs.
- **Improving access in rural areas by allowing medical necessity to drive limits on BH therapeutic sessions.** SilverSummit recommends the Division remove the level of intensity restrictions for outpatient mental health services and allow BH licensed providers beyond psychologists and psychiatrists to determine service needs without prior authorization.[8] We also suggest removing the one therapeutic session per day provider billing limitation to maximize the benefits of BH therapy. Our Medicaid affiliate in Texas worked with the Texas Health and Human Services Commission to change limits to allow a provider to bill two sessions in one day for a member. As an example, a child could participate in a family session and then have an individual session on the same day. This allows

[6] Waite MR, Diab S, Adefisoye J. Virtual Behavioral Health Treatment Satisfaction and Outcomes Across Time. J Patient Cent Res Rev. 2022 Jul 18;9(3):158-165. doi: 10.17294/2330-0698.1918. PMID: 35935523; PMCID: PMC9302910.
[7] National Academy for State Health Policy. (2023, April). The State Perspective on Rural Behavioral Health Crisis Services. https://nashp.org/the-state-perspective-on-rural-behavioral-health-crisis-services/.
[8] Medicaid Service Manual Changes Chapter 400 Mental Health and Alcohol and Substance Use Services. (2023, July 25). Division of Health Care Financing and Policy. https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_23_08_01_ADA.pdf

families to participate more fully in therapy and reduces transportation and childcare barriers. Offering BH therapy when medically necessary, on par with physical health visits, could reduce avoidable hospital and ED utilization and costs[9]

- **Expediting Medicaid licensure process.** To increase the BH provider network, we propose the Division assign a single reviewer for each Medicaid BH provider application and implement timelines for approving applications. This would encourage BH providers to accept Medicaid, as they can contract with MCPs and can start seeing Medicaid members without prolonged delays.
- **Allowing license reciprocity and increasing recruitment activities.** To address members' immediate BH needs, we recommend the State support reciprocity for mental health professionals licensed in other states who are moving to Nevada to avoid delays in serving members in Nevada. We also suggest the State join interstate compacts to improve BH provider recruitment from other states to increase access to BH telehealth for members living in rural and frontier communities.[10]
- **Supporting integrated care services by reimbursing for Collaborative Care Model (CoCM) CPT codes** in rural primary care practices. Rural primary care providers with collaborative care services can increase access to BH care by offering CoCM as an integrated, co-located, or asynchronous psychiatric consult service. We suggest the Division reimburse CoCM CPT codes 99492, 99493, 99494, and G2214, especially for members who live in rural and frontier areas, to encourage primary care providers collaborating with BH providers to support a member's BH needs in a community setting and close to home.

SII.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:

Implementing Incentives and Provider Payment Models for BH Services in Rural Communities

SilverSummit recommends the Division consider the following incentives and payment models to increase the availability and utilization of BH services for members in rural and frontier communities.

- **Acknowledging the need to customize the Medicaid fee schedule** for services delivered by BH providers practicing in rural counties. Increasing reimbursement rates for BH providers practicing and serving children in rural counties will motivate providers to contract with MCPs. An attractive reimbursement rate will support MCPs in maintaining an adequate BH provider network and enhance member choice of BH providers.
- **Encouraging MCPs to offer at least one value-based payment (VBP) model rewarding practices providing integrated primary health and BH services** and maintaining performance against defined quality and cost containment thresholds, such as reducing ED visits.
- **Working with MCPs and providers to develop standard criteria for participation in BH VBP programs** (e.g., maintain open panels, HEDIS measures) consistent across MCPs. Standardized expectations will make it easier for rural providers to work with MCPs and maximize rural providers' success in VBP arrangements.

[9] Rapfogel, N. (2022, May 26). The Behavioral Health Care Affordability Problem. American Progress. https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/

[10] Guinn Center for Public Policies. (2014, October). Nevada's Mental Health Workforce: Shortages and Opportunities. Http https://guinncenter.org/wp-content/uploads/2014/10/Guinn-Center-Policy-Brief_Mental-Health-Workforce-Final.pdfs://www.medicaid.gov/sites/default/files/2023-07/medicaid-chip-telehealth-toolkit.pdf.

Section 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.

SIII.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:

Improving Maternal and Child Health (MCH) Outcomes in Rural and Frontier Areas of Nevada

SilverSummit Healthplan (SilverSummit) recommends the Nevada Division of Health Care Financing and Policy (Division) encourage Managed Care Plans (MCPs) to develop provider partnerships in urban and rural counties that advance MCH through established quality targets, telehealth services, care coordination, and expansion of OB/GYN services in federally qualified health centers (FQHCs).

- **Consider these quality targets:**
  - Improving health equity through increased prenatal and postpartum visits for women of color
  - Increasing Notification of Pregnancy rates
  - Increasing prenatal and postpartum care rates
  - Increasing prenatal and postpartum depression screening and follow up
  - Increasing prenatal immunization status
  - Increasing Screening, Brief Intervention, and Referral to Treatment completion rates
  - Reducing elective Cesarean section rates
  - Reducing neonatal intensive care unit admissions and lengths of stay
  - Reducing the incidence of very low birth weight deliveries
- **Offer telehealth services in medical deserts.** When providers use telehealth, they create greater accessibility to health care for all populations, especially those living in rural communities. We encourage the Division to recommend MCPs implement telehealth services in rural and frontier communities of the state. See Section VI: Coverage of Social Determinants of Health for suggestions on expanding high-speed internet connections to give all Nevadans access to telehealth.
- **Expand care teams.** We recommend that the Division support any legislation and/or policies that expand reimbursement for services by Community Health Workers (CHWs) and Peer Support Specialists, particularly for behavioral health services, which are currently not reimbursable. These individuals understand the unique challenges members in rural and frontier communities may face versus those residing in urban areas, and their lived experience can help them build trust with members. For example, SilverSummit supports Senate Bill 117, expanding the type of providers who can supervise CHWs. See Section VI: Coverage of Social Determinants of Health for more information.
- **Support rate increases for doulas.** We support the recent reimbursement rate increase for doulas and support continuous review of rates to ensure they remain competitive. Research indicates formal

doula support throughout the prenatal, perinatal, and postnatal periods of pregnancy is associated with positive delivery and postpartum outcomes. The usage of doulas through the labor process decreases the use of Cesarean section deliveries and reduces the length of labor. Doula-based interventions throughout labor can alleviate the burden of maternal and infant health disparities for people with low incomes and people of color. Doula support improves breastfeeding success, especially for women with low incomes, and reduces postpartum depression and anxiety.

- **Expand OB/GYN services in FQHCs.** We recommend the Division support rural and urban FQHCs in adding OB/GYN services with the appropriate liability protection and adequate reimbursement.

SIII.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:

Implementing Provider Payment Models to Improve MCH Outcomes

SilverSummit recommends the Division encourage all MCPs to operate a value-based payment (VBP) design focused on improving MCH outcomes using a specific set of MCH quality measures. When MCPs implement VBP models, they support more timely access to perinatal care, improve birth outcomes, and lower costs. We recommend the Division allow MCPs the flexibility to design VBPs most effective for their respective memberships. For example, if an MCP's membership exhibits high rates of substance use disorder (SUD), a VBP that includes bundled payments for evidence-based programs addressing SUD in pregnancy would be most beneficial for their membership.

SilverSummit also recommends that the Division develop actuarily sound Medicaid fee schedule reimbursement rates that allow MCPs to appropriately reimburse and incentivize providers to participate in Medicaid in rural and frontier communities.

Section IV: Market & Network Stability

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.

SIV.1.A. *Should Nevada Medicaid continue to treat the State as one service area under the Managed Care Contracts or establish multiple regional- or county-based service areas? Please explain.*

Response:

Providing Greater Market Stability, Sufficient Access to Care, and Quality Managed Care Plan (MCP) Choice for Medicaid Recipients

SilverSummit Healthplan (SilverSummit) recommends the Nevada Division of Health Care Financing and Policy (Division) contract with three MCPs in urban Washoe and Clark Counties and no more than two existing MCPs currently serving Marketplace members statewide to serve the expansion counties for the upcoming procurement. Our recommended approach would contribute to achieving market stability, sufficient access to care, and quality MCP choice for recipients by:

- **Increasing access and continuity of care** by offering members the ability to stay enrolled with their current MCP if they move within the state or need to seek care across the state, thereby reducing potential disruptions in care. Limiting the number of contracted MCPs also reduces confusion regarding benefits and value-added services as these may differ among multiple MCPs. In addition, MCPs currently serving members in rural counties through Marketplace coverage maintain an existing statewide provider network, including in Nevada's catchment areas, thereby eliminating the need to allow for an MCP without statewide experience the additional time needed to develop an adequate statewide provider network prior to implementation.
- **Reducing provider administrative burden** by limiting the array of claims processing systems, prior authorization requirements, value-based payment (VBP) models, and other items providers must be familiar with among an unmanageable number of MCPs.
- **Reducing the Division's administrative burden** since the Division would likely have fewer MCPs to monitor. Additionally, our recommended approach would allow the Division to continue to evaluate and compare MCP performance on an even playing field.
- **Allowing for more consistency among MCPs**, thereby improving the ability to more easily collaborate and align goals to maximize collective impact. For example, our recommended approach would allow for MCPs to continue to collaborate with the Division on initiatives that impact the entire State such as maternal and child health, while still allowing for region-specific initiatives based on the needs of individual communities.
- **Effectively scaling programs, partnerships, and initiatives** across the entire State to support providers and maximize members' access to care in both urban and rural areas of Nevada.
- **Investing in the communities** MCPs serve through innovative partnerships, clinical programs, VBP models, infrastructure, workforce development, and the hiring of local field-based staff (e.g., Community Health Workers (CHWs) and care managers).
- **Maintaining market viability, analyzing statistically significant data sets,** and distributing actionable analytics to providers and community partners to support population health management, VBP

models, and SDOH programs.
- **Investing in solutions and strategies to effectively address provider capacity, access, and availability of services** in underserved and rural areas of the state versus only in urban areas where a large portion of the Nevada Medicaid population resides.

Selecting MCPs with Established Statewide Provider Networks

SilverSummit recommends the Division give preference to MCPs that submit a statewide application and currently meet network adequacy as defined by the Department of Insurance for Marketplace through established relationships with providers in every county through Marketplace contracts. Awarding contracts for serving the expansion counties to MCPs that have proven statewide relationships with providers offers multiple benefits to the state, Medicaid recipients, and the provider community, such as:

- **Established contracts and relationships with providers in the expansion counties** to meet network adequacy standards quickly and efficiently.
- **Reduced administrative burden for providers**. Providers already contracted with an MCP to serve Marketplace members in the expansion counties would have a more seamless contracting experience through an addendum to their existing Marketplace contract compared to contracting from scratch with a new, unfamiliar MCP.
- **Seamless access to care for individuals who move between Marketplace and Medicaid enrollment.** Members would continue to receive care with their current provider(s) without the need to change MCPs and with no disruption of services.
- **Strong network foundation** in the event the Division elects to carve in any new populations or services to managed care in the future.

SIV.1.B. *Please describe any other best practices used in other states that the Division should consider when establishing its service area(s) for managed care plans that have balanced the goal of ensuring recipient choice and market competition (price control) with market stability and sufficient provider reimbursement.*

Response:

Ensuring Recipient Choice, Market Competition, Market Stability, and Sufficient Provider Reimbursement Statewide Based on Best Practices

SilverSummit recommends the Division account for the following considerations when establishing service areas for MCPs that have balanced the goal of ensuring recipient choice and market competition with market stability and sufficient provider reimbursement:

- Acknowledging the need to customize Medicaid fee schedule reimbursement rates for services delivered by providers practicing in rural counties of the state. MCPs can only maintain an adequate provider network and maximize member choice of providers if reimbursement rates are enticing enough to motivate providers in the expansion counties to contract with MCPs.
- Recognizing the value of MCPs that currently operate statewide provider networks and whose existing networks include providers practicing in catchment areas and across state borders.
- Carefully analyzing trends in membership volume, utilization, and patterns of care, especially in rural regions of the state.
- Continuously monitoring the volume of Medicaid-enrolled providers and trends in provider shortages throughout the state.

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.

SIV.2.A. *Are there other innovative strategies that the Division could use in its Medicaid programs with respect to the assignment algorithm that promotes market stability while allowing for a "healthy" level of competition amongst plans?*

Response:

Promoting Market Stability and Healthy Competition Amongst Plans

Maintaining an equitable share of a state's Medicaid membership allows MCPs to invest in innovation and infrastructure (e.g., specialized staff, data and analytical capabilities, care management systems, VBP models, and robust specialty provider networks) necessary to improve member health outcomes. This allows an MCP to:

- Maintain member continuity and member choice while reducing provider disruption
- Invest in data and technology platforms that support innovation and continue to drive quality outcomes at both the member and population level
- Scale technology platforms and innovative programs effectively to ensure successful VBP programs, higher quality care, and improved member health outcomes
- Invest in the communities MCPs serve through innovative partnerships, clinical programs, infrastructure, and the hiring of local field-based staff (e.g., care managers and CHWs)
- Scale programs, partnerships, and initiatives across the state to support providers and maximize members' access to care in both urban and rural areas of Nevada
- Support population health management and social determinants of health programs

Balancing market share equally among MCPs mitigates the risk of market and network instability while reducing "unhealthy" competition, thereby increasing the willingness of MCPs to collaborate on innovative initiatives. For members who do not voluntarily select an MCP, SilverSummit recommends the Division consider the following considerations that promote market stability:

- **Leverage the Division's auto-assignment algorithm to even out market share among MCPs over time.** SilverSummit encourages the Division to limit the market share differential among MCPs to a maximum of 3% at any time and design a process for systematically, continuously monitoring MCP market share and rebalancing market share every 30 days as necessary. If an MCP's market share exceeds the maximum differential, the MCP would be systematically blocked from receiving new members through auto-assignment until the MCP falls below the threshold.
- **Ensure network stability by establishing equitable market share.** Following open enrollment, an enrollment broker may equitably assign enrollees who do not select a specific MCP. Consistent with best practices in other states, auto-assignment methodology seeks to preserve existing provider-recipient relationships and keep family members in the same MCP. MCPs must accept recipients in the order in which they are assigned without restriction, up to market share limits. Once market parity is established, dollars that have historically been spent on MCP's marketing efforts can be reallocated to the Community Reinvestment Fund.
- **Expand recipients' access to care and preserve continuity of care** by prohibiting MCP-owned provider practices from removing recipients from their panels in the event the recipients' enrollment changes

to an MCP unaffiliated with the provider.

- **Annually rotate the order of available MCPs** on the MCO change form and Medicaid application (e.g., instead of an alphabetical list) to reduce primacy bias. Primacy bias is the tendency for respondents to pick one of the first options presented to them, particularly if they are reading quickly through a document.

Section 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.

SV.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:

Expanding Value-Based Payment (VBP) Design with Providers in Nevada Medicaid

SilverSummit Healthplan (SilverSummit) recommends the following strategies for supporting provider advancement along the VBP continuum, aligning VBP models with the Nevada Division of Health Care Financing and Policy (Division) priorities, and facilitating provider engagement in a meaningful way across all managed care plans (MCPs):

- **Continue to allow MCPs the discretion to operate a variety of VBP models**, offering all providers an opportunity to participate in VBP and a pathway to advance along the VBP continuum to more sophisticated risk-based arrangements.
- **Encourage MCPs to offer at least one VBP model specific to improving maternal and birth outcomes.**
- **Encourage MCPs to offer at least one VBP model rewarding practices that provide integrated primary health and behavioral health services** and maintain performance against defined quality and cost containment thresholds, such as emergency department reducing recidivism.
- **Continue to encourage MCPs to align VBP quality measures with the Division's quality performance measures**. To reduce provider administrative burden, we recommend the Division prescribe six quality measures against which all MCPs would assess provider VBP performance and allow MCPs the flexibility to self-select three quality measures based on the needs of an individual MCP's membership. This would align all MCP VBP programs with the Division's highest priority quality goals while simultaneously reducing provider administrative burden, since providers would be managing against a more uniform set of quality measures in all MCP VBP models versus a more burdensome array of disparate quality goals.
- **Work with MCPs and providers to develop standard criteria** for participation in VBP programs (e.g., maintain open panels, HEDIS measures) consistent across MCPs.
- **Work with MCPs to offer the same VBP models and standard criteria for Medicaid and Marketplace providers,** reducing administrative burden and the impact of members enrolling and disenrolling between the different forms of health care coverage.
- **Organize a joint workshop with the Division, MCPs, federally qualified health centers, primary care providers (PCPs), hospitals, independent rural health clinics, and hospital-owned rural health clinics** to discuss progress, identify barriers, develop strategies, discuss quality metrics, and share best practices supporting value-based care in rural counties.

SV.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:

Tools and Information to Help MCPs and Providers Succeed in VBP Arrangements

SilverSummit recommends the following tools and information to assist MCPs and providers succeed in VBP arrangements:

- **Encourage providers to submit data to health information exchanges** to facilitate access to timely and actionable data
- **Encourage MCPs to systematically provide actionable and timely data,** such as care gaps, to VBP participating providers
- **Provide up-to-date contact information for Medicaid recipients** at time of enrollment to help providers and MCPs engage members in care and coordinate care
- **Allow MCPs to utilize the national change of address database and third-party companies** to access up-to-date contact information
- **Provide increased flexibility for MCPs to update PCP assignments** based on claims history to help Medicaid recipients stay connected to the providers from whom they routinely receive care today
- **Encourage MCPs to simplify the prior authorization process** for rural providers to maximize their success in VBP models

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

Response:

Promoting the Use of VBP Design with Rural Providers

SilverSummit recommends the Division consider the following to promote the use of VBP design with rural providers:

- **Engage provider associations** in educating and encouraging provider participation in VBP programs.
- **Create mechanisms to encourage and support providers to move along the VBP continuum** (e.g., developing a statewide VBP roadmap, subsidizing investments in infrastructure to help prepare providers for assuming risk).
- **Encourage MCPs to use Aggregators.** Individual rural providers may not have a sufficient panel size necessary to succeed in VBP arrangements themselves. Recognizing this, multiple states have encouraged MCPs to use Aggregators to pool rural providers into aggregate networks that allow MCPs to measure and reward the collective performance of rural providers participating in VBP arrangements.

Section 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.

SVI.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**:*

Improve Member Access to Care by Enhancing the Non-Emergent Transportation (NEMT) Benefit

NEMT is a cost-effective way to improve member use of timely preventive services. For households without access to a vehicle or reliable transportation, NEMT can also serve as a resource to address non-medical needs in support of overall health and wellness. The Centers for Disease Control and Prevention reported in 2018 that 11.3% of Lander County residents did not own a car. This is higher than in Clark and Washoe counties and demonstrates a need for transportation within expansion counties.

SilverSummit Healthplan (SilverSummit) recommends the Nevada Division of Health Care Finance and Policy (Division) enhance their NEMT contract statewide so members may access community services to address social determinants of health (SDOH). For example, members experiencing food insecurity can access nutritious food with an enhanced NEMT benefit. The United States Department of Agriculture Food Access Research Atlas reported in 2019 over 190,000 Nevadans (6.5% of the population) lived in food deserts where access to affordable, healthy foods are limited. Forty percent of the population lived in low-access tracts, requiring they travel more than one mile in urban areas or ten miles in rural areas to the nearest grocery store. SilverSummit recommends including rides to grocery stores, WIC offices, and food pantries to improve access to food. We also recommend rides to the Department of Motor Vehicles, job training, literacy services, and social services.

Finally, we recommend the Division expand the NEMT benefit to provide safe transportation back home for members transferred to a different county or catchment area for inpatient services.

SVI.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:

Improve Member Outcomes by Providing Housing and Meal Supports as a Standardized Covered Benefit Across Managed Care Plans (MCPs)

SilverSummit supports the Division's goal to increase the availability of housing supports and services and meal supports for members. According to the U.S. Department of Housing and Urban Development, from 2020 to 2022 Nevada experienced the fourth largest increase in the number of individuals experiencing homelessness in the United States. Providing coverage of these services will improve outcomes for members experiencing homelessness and allow SilverSummit and other MCPs to enhance the support we provide.

We recommend the Division go one step further than offering housing supports and services and meal supports as an optional benefit, and instead create a standardized covered benefit across all MCPs to ensure every Medicaid member may access the same benefit. We recommend the Division define eligibility criteria and reimbursement for these services. With all MCPs providing the same benefit, the Division can identify quality measures and compare outcomes for these members across MCPs. We also recommend the Division assist MCPs with identifying individuals without housing. With this information, MCPs can connect members to appropriate services and supports in a timely manner.

Enhance Member Support by Expanding Coverage for Community Health Workers (CHWs)

CHWs meet members at their points of need in the community and provide culturally and linguistically appropriate health education and connect members to services and supports to address SDOH needs. CHWs encourage members to make healthy choices and engage in preventive care, improving health and wellness for members with the greatest risks. Many CHWs work within community-based organizations (CBOs) and CBOs do not have a state-level Medicaid enrollment pathway to receive reimbursement. SilverSummit recommends the Division allow MCPs to contract directly with CBOs, such as food pantries, that employ CHWs. We recommend MCPs establish a process to evaluate these providers, which may extend to CHWs employed by or delivering services on behalf of the CBO. The MCP will verify appropriate licenses, conduct background checks, and ensure these providers meet the required capabilities and standards. This expands coverage to CHWs in other provider settings, offering an additional funding source to sustain the community network of CHWs. Refer to Section III: Maternal Health for additional recommendations to support CHWs.

Expand Internet Access and Promote Digital Equity

SilverSummit recognizes the Governor's Office of Science, Innovation, and Technology for their focus on expanding high-speed internet connection, so that every Nevadan may access affordable, reliable, and scalable internet service. According to the U.S. Census American Community Survey, 16% of Nevada households did not have an internet subscription in 2020. Most counties outside of Clark and Washoe have a higher percentage of households without an internet subscription. More equitable broadband supports more equitable access to health care services and supports, including telehealth, and the availability of programs and services to address SDOH needs, such as work training.

We recommend the Division allow telehealth providers to count toward MCP network adequacy requirements. Telehealth expands member options for care and reduces the barriers sometimes associated with in-person visits, especially for recipients in rural areas. Refer to Section II: Behavioral Health Care for additional telehealth recommendations that improve access to care.

SVI.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:

SilverSummit supports the Division's Community Reinvestment Fund. The Division offers MCPs the flexibility to invest in community programs that support urgent or emerging member needs. We are

proud of our approach and the investments we make to transform the health of the community. We look forward to the opportunity for further discussions with the Division to shape the program.

Section 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:

SilverSummit Healthplan (SilverSummit) appreciates the opportunity to share our thoughts and ideas. We look forward to learning about the innovations and best practices shared across stakeholders to enhance the Nevada Medicaid program and achieve Nevada's policy objectives. We recommend the Nevada Division of Health Care Finance and Policy (Division) consider the following strategies to support the successful expansion of the Nevada Medicaid Managed Care Program.

Award Contracts to Managed Care Plans (MCPs) with Experience Serving Expansion Counties

For the upcoming procurement, we recommend the Division only accept RFP responses from and award contracts for the expansion counties to MCPs who serve Nevada's rural communities through statewide Marketplace plans. MCPs that serve expansion counties understand member patterns of care and rural provider challenges that would be challenging, at best, for non-incumbent health plans to replicate and plan to address prior to implementation. MCPs who already operate in rural and frontier communities of Nevada are better positioned to:

- Reduce rural provider administrative burden of learning non-incumbents' MCP systems and processes
- Invest in solutions to address provider capacity, access, and availability of services in rural communities
- Effectively scale programs, partnerships, and initiatives across the entire state
- Increase access and continuity of care by ensuring members have the same choice of health plans if they move within the state
- Invest in the communities they serve through innovative partnerships, clinical programs, value-based payment designs, infrastructure, workforce development, and the hiring of local field-based staff
- Share actionable metrics with providers and community partners to support population health management, value-based payment designs, and social determinant of health programs

We describe these benefits in more detail in Section IV: Market & Network Stability.

Enhance Provider Experience through Centralized Provider Credentialing Processes

SilverSummit supports the Division's efforts to centralize provider credentialing and re-credentialing through a single state-wide vendor to simplify the credentialing process. Centralized credentialing is consistent with the vision of Medicaid transformation, and responsive to concerns providers have raised regarding administrative burdens with the credentialing process. To support a standardized, streamlined approach to centralized credentialing for providers, we offer the following recommendations to the Division when implementing centralized credentialing:

- Align with National Committee for Quality Assurance (NCQA) credentialing requirements, including oversight and routine monitoring requirements. We also recommend applying NCQA credentialing requirements to a potential Division-led credentialing committee.
- Submit documentation and track the status of provider applications through a single provider portal. Additionally, we recommend offering MCPs the ability to track/view the status of provider applications to effectively share this information with provider partners.
- Provide MCPs with timely notice of changes in credentialing status that result from ongoing sanctions.
- Integrate the credentialing process with the Medicaid provider enrollment process.

- Allow each MCP to independently manage their provider network. This is crucial to the success of value-based contracts. MCPs are well-positioned to manage and monitor their network within established network access guidelines outlined in the Division's provider agreement.
- Capture data related to providers' cultural competency and racial and ethnic identification during the provider credentialing process and share this data with MCPs. This allows MCPs to assist members with locating a provider who best meets their needs and preferences.
- Select a Centralized Credentialing Vendor that has the capacity and capabilities to be delegated credentialing from MCPs for other lines of business.

Optimize Medicare-Medicaid Integration by Carving in Long-term Services and Supports (LTSS) and Aged, Blind, and Disabled (ABD) Populations to Managed Care

SilverSummit commends the Division for its efforts toward enhancing coordinated care among dually eligible members in Nevada, including the recent Nevada Medicaid needs assessment on current delivery models for Nevada's ABD population. Before requiring MCPs to operate a Highly Integrated Dual-Eligible Special Needs Plan (HIDE-SNP), as we propose in the following narrative, we recommend the Division carve in the LTSS and ABD populations to managed care following the successful implementation of managed care expansion into Nevada's rural communities. This will maximize the number of members benefitting from an integrated Medicare-Medicaid care model.

Improve Member Experience and Quality Outcomes through a HIDE-SNPs with Exclusive Alignment

After successful implementation of ABD and LTSS managed care, SilverSummit recommends the Division's focus on advancing Medicaid and Medicare integration for individuals with dual eligibility. Integrated care models improve member outcomes and experience, reduce provider administrative burden, and reduce Federal and State spending. Our parent company, Centene Corporation (Centene), has coordinated member care across products and payors since 1984. We serve over a million dually eligible recipients, including 404,000 members through D-SNPs in 32 states. Based on this expertise and the needs of the Nevada Medicaid and Medicare populations, SilverSummit recommends the Division require MCPs offer a HIDE-SNP with exclusive alignment among the MCPs dually eligible members.

Establish HIDE-SNP Default Enrollment

SilverSummit supports default enrollment, a policy under which State Medicaid agencies enroll individuals who are newly Medicare-eligible into an aligned D-SNP if they are already enrolled in an affiliated Medicaid managed care plan through the same parent company. Default enrollment provides a seamless transition from Medicaid-only coverage to an aligned arrangement with additional care coordination and supplemental benefits that are not available in Medicare FFS. Default enrollment also supports member choice. Beneficiaries may opt-out of the plan 60 days prior to enrollment and within the 90-day Special Enrollment Period after their coverage begins. If they choose, members can easily opt-out by contacting the health plan.

SilverSummit looks forward to the opportunity to offer further insight and recommendations as the Division develops and refines the approaches to integrating care for this population.