**From:** Deanna Yates <billing@tiltonstherapy.com>
**Sent:** Tuesday, October 17, 2023 3:57 PM
**To:** DHCFP StatewideMCO <StatewideMCO@dhcfp.nv.gov>
**Subject:** Re: RFI for Nevada Medicaid Managed Care Expansion




**Casey Walker**
**CEO, Tilton's Therapy**

**RFI Questions:**

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:***

- MCOs should submit bid paperwork proving network adequacy, ability to service specific populations (age, diagnosis, geographical area, etc), ease of care access (locations, telehealth, etc), and service with qualified providers with limited wait times. Denying access results in increased cost to the State and providers by comorbidities, worsening situations, declining health as the conditions progress and escalating in their functional impedance while the member is stuck waiting for care.
- The MCOs should not implement value-driven or capitation agreements for cost savings, as this limits accessibility and diversity in the marketplace. By selecting preferred providers,

additional strains are put onto the providers to deliver across more members of the State and will result in shortcuts, limitations, and decreased quality.

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:***

- Proposed consideration of rate reimbursements adjusted per zip code/areas to increase provider's ability to service rural populations.
- Consider use of advanced and diverse carve outs in capitation contracts to deliver multiple capitation practices/providers, to cover different needs (peds, adults, mental health, etc).
- Instead of capitation with 1 provider group, the MCO's could do a flat rate of reimbursement and allow any providers that are willing to accept that rate to be an in network provider.
- Allowing all providers who see pediatric patients to be reimbursed with the Pediatric Enhancement Rate will encourage them to treat pediatrics and not just adults. Currently, only certain provider types receive the additional reimbursement.

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 should consider the benefit of early interventions and skill development by addressing functional deficiencies that can save costs in the future by creating more competent workforce members before vocational skills training sessions. By increasing access to care and interventions provided, Nevada providers can cultivate a more skilled workforce for the future while simultaneously decreasing the long-term stifling costs of adult care programs, group homes, respite care programs, vocational skills programs, prison costs, etc.

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:***

- Therapists should not be limited, because their specialties can vary and limiting providers then limits the possible care to patients.
- If there is a capitation (or overflow) agreement with a provider/group, they are not able to have the capitation agreement with another MCO insurance, to allow for patients to choose different MCO plan, due to provider options.

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:***

- One of the most significant barriers to care would be capitation agreements that create/reduce preferred providers that are limited in their service model, specialties, age or diagnosis treatment abilities, etc. Even with overflow contracts and additional providers being in the network on paper, the member suffers from the time restrictions of the bureaucratic demands and hoops to prove the preferred provider is unable to service the specific need and pass the referral to someone who can and allow for the provider to have time to get the authorization required to initiate care. Across all care provider types (physicians, specialists, therapy practitioners, etc.) this limits care quality, access, and timeliness.
- There is a therapist shortage in the State of NV, and by limiting the number of providers allowed to sign up, you are limiting even more care.
- If capitation agreements limit therapy providers from signing onto insurances, they are less likely to relocate to NV, because they will already be excluded from specific Medicaid insurance plans.
- If there is a capitation (or overflow) agreement with a provider/group, they are not able to have the capitation agreement with another MCO insurance, to allow for patients to choose different MCO plan, due to provider options.
- Most families on Medicaid, are low income, they can have ST (because that is not in capitation), but even when the practice could do OT and/or PT at the same location, they are not allowed to. This causes added expense for the family to drive to multiple locations, plus the time needed to make it to different locations.

## 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 Division should consider widening its accessibility to telehealth providers by removing physical barriers and limitations on providers. For example, in behavioral health practices, interns must be in a physical building to provide care for telehealth, despite not being under the direct supervision of a superior. Their superior is accessible to them for mentorship in an office setting just as they are in a remote setting. This limitation does not increase the quality of the care provided but rather puts restricting barriers on companies that support providers in practice by increasing the fixed expenses and administrative burden.

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 use of telehealth and increasing reimbursement for in-home and community-based services will increase the provider's ability to provide increased effective 1:1 care and generalization of trained skills for increased independence by completion in the community.

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:***

- Yes. By utilizing the modifier that indicates the use of telehealth, vs in-home, vs in community, vs in-office, there should be additional incentives/monetary reimbursements made to providers that are spending the additional time, money and resources to service clients and children in their natural environment. The outcomes of doing care in this model are more costly and more positive in life-long future changes. By removing the financial burden on practitioners, we can meet clients where they are and influence substantial functional changes.
- Allowing all providers who see pediatric patients to be reimbursed with the Pediatric Enhancement Rate. Offering additional funds will encourage them to treat pediatrics and not just adults, which may be less demanding.

## 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:***

- Allowing all providers who see pediatric patients to be reimbursed with the Pediatric Enhancement Rate will encourage them to treat pediatrics and not just adults. Currently, only certain provider types receive the additional reimbursement.

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:***

- Allowing all providers who see pediatric patients to be reimbursed with the Pediatric Enhancement Rate will encourage them to treat pediatrics and not just adults. Currently, only certain provider types receive the additional reimbursement.

## 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: no response***

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

***Response: no response***

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: no response***

## 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:***

- Currently we are seeing where the "incentives" are causing a decrease in quality care. Authorizations from the MCO's are being issued for 1x a week even when more is medically appropriate.

B. Are there certain tools or information that the State could share, develop, or improve upon, to help plans and providers succeed in these arrangements?

***Response:***

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

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

***Response: no response***

## 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: no response***

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: no response***

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: no response***

## 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.