October 16, 2023

Stacie Weeks, JD, MPH
Administrator
Division of Health Care Financing and Policy
Department of Health and Human Services
1100 E William Street, Suite 101
Carson City, NV 89701

Dear Administrator Weeks:

UCare is pleased to submit the enclosed response to the request for information, titled "Request for Information for the Nevada Medicaid Managed Care Expansion" published by the Nevada Division of Health Care Financing and Policy (the Division) of the Nevada Department of Health and Human Services.

As the nation's third largest 501(c)(3) nonprofit government health plan, UCare welcomes the opportunity to provide input to this Request for Information, bringing more than 40 years of experience in Medicaid managed care. Recognizing that health care is local, we look forward to sharing our experiences in partnering with state Medicaid, communities, and providers and describe how to apply those capabilities and expertise to meet the particular needs of Nevada members.

As a home-grown nonprofit health plan, UCare excels at developing a keen understanding of the communities we serve. UCare's reach extends to urban, suburban, rural communities, and we work to ensure our members in all areas have access to the full range of covered health care services while recognizing the unique needs of each community. We appreciate that Nevada, includes a wide mix of populations with diverse needs that requires tailored and flexible approach. Our contributions to this RFI will reflect our attention to those needs and populations and our commitment to be member-first and provider-focused in our approach.

Thank you for the opportunity to share our input. Please contact Stephanie Minor, UCare State Government Relations Manager, at 612-889-6921 or sminor@ucare.org if you have any questions or follow up about the submission.

Sincerely,

Jay Stave
Vice President, Business Development
UCare

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October 16, 2023

Stephanie Minor, Government Relations
UCare
500 Stinson Blvd. NE
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Re: RFI for Nevada Medicaid Managed Care Expansion

Section 1: Provider Networks

1.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: We understand that although Nevada is home to a richly diverse population and landscape, it is challenged in both urban and rural areas with health professional shortages areas (HPSAs), including challenges of geographic challenges of the Northeastern counties to Clark County where providers may be unwilling to contract for Medicaid or may limit which Medicaid MCO they will contract.[1,2] Two potential ways to address access and availability of providers in rural areas is to increase the number of providers or to enable greater efficiencies for providers serving those rural and frontier areas.

To increase the number of providers, the Division could designate providers in rural or frontier area (and referring providers) as essential community providers and require managed care organizations (MCOs) to contract with these providers, including offering good faith contracts. This could further extend to Federally Qualified Health Centers and Rural Health Clinics, critical access hospitals, behavioral health providers such as CCBHCs, and potentially even certain specialties where the state is experiencing shortages. Further, as part of contracting with providers in rural and frontier designated areas, the MCOs could be required to provide a rate of up to 5 percent above the fee schedule, which would allow these providers to invest more into the recruiting and retention of providers.

[1] Health Resources & Services Administration, U.S. Department of Health & Human Services. (2022). HPSA Find. Available, here.
[2] Nevada Division of Public and Behavioral Health, Department of Health and Human Services. Health Professional Shortage Area Designations. Available, here.

Additionally, MCOs could also provide reinvest through community benefit to assist with recruitment and retention; this could include incentive payments, stipends for students in training, funding for supervision time, or funding no-load miles to allow greater transportation access to existing providers.

To support provider efficiency, the Division could contractually require fewer prior authorizations or provide uniform standards and criteria, reducing administrative burdens on providers in designated rural and frontier areas. This enables current providers to spend more time on providing care and less time pursuing prior authorizations or completing post payment reviews, where providers are often asked to retrieve medical charts and consult with MCOs after the service is provided and payment is made. This also encourages greater recruitment and retention of clinical staff.

Another suggestion for the Division not directly tied to procurement or contracting with MCOs would be for the Division to consider implementing a Delivery System Reform Incentive Payment (DSRIP) or Alternative Payment Model (APM) program to pay rural and frontier providers additional funding based on Division-defined quality metrics. Looking at the most recent Medicaid and CHIP Payment and Access Commission (MACPAC) report on supplemental payments, Nevada could look to states of comparable size, like Kansas or New Mexico, which have DSRIP programs that bring in $33.6 million and $12 million respectively of additional funding for hospitals.[3]

1.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: Additional requirements the Division should consider related to rural health clinics (RHCs) and federally qualified health centers (FQHCs) includes requiring MCOs to pay RHCs and FQHCs the higher global, prospective payment rate, or the highest rate given to participating primary care clinics in urban areas, unless an alternative payment arrangement is agreed upon between the clinic and the MCO. Similarly, the Division could require payment for certain hospital admissions to rural hospitals and a percentage of urban hospitals, if the rate is higher. This could be prioritized for services such as maternity or behavioral health admissions. This could work similarly in urban areas where certain admissions could be paid at a higher rate compared to other admission to ensure access.

[3] Medicaid and CHIP Payment and Access Commission. (2023, March). Medicaid Base and Supplemental Payments to Hospitals Issue Brief. Available, here.

The Division could also utilize the essential community provider designation and set the rates for rural and frontier providers at a higher level than for those in urban areas and require MCOs to contract with essential community providers assuming they have appropriate qualifications and credentials. Some states that offer managed care statewide develop rates that include a regional consideration within the fee schedule so that rural and frontier providers get higher rates than their urban and semi-urban counterparts. Requiring MCOs to contract with these providers also ensures that MCOs are not developing narrow networks that limit access for members and prohibit providers from participating in the Medicaid program. Several states have similar concepts, requiring MCOs to contract with specific providers and 35 states have any willing provider laws.[4]

Another challenge we that may be present in the current Nevada market includes MCOs who exclusively contract with a provider and prohibits the provider from contracting with other MCOs. This scenario restricts access and member choice because members are only able to go to a provider if they are with one specific managed care plan. This effectively takes away the members' choice of health plan because of the exclusive relationship between MCOs and certain providers. The Division could protect against this by prohibiting MCOs from exclusive contracts with providers and set state policy that if a provider organization exclusively contracts with one MCO, they are not eligible for supplemental payments. On the provider side, and similar to the statute related to Nevada's public option, the Division could require provider participation if the provider participates in the state employee health plan or worker's compensation.

1.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: While MCOs are partners in the efforts to improve the workforce, many investments that demonstrate improvements are completed with funds in collaboration with state agencies and other community organizations, as strategies for workforce development should be explored across all insurance products. With that said, MCOs can, and should, contribute in several ways.

[4] Amalot, T. (2023, February 13). Amid NV's Health Provider Shortage, Insurance Companies Denying Specialists Entry in Networks: Systemic Barrier May Be Especially Troublesome for those Seeking Behavioral, Mental Health Services. The Nevada Current. Available, here.

At a recent, National Academy for State Health Policy (NASHP) conference, a panel of state staff and organizations focused on workforce shared: [5]

- Coordinating across various health and human services agencies and offices and with the labor agency is important to strategically approach shortages.
- Investing in education, including stipends, scholarships, and loan repayments in addition to investment in education and training programs themselves, remains a common approach.
- Pursuing a diverse workforce with connections to the communities and individuals they serve is a growing priority.
- Building pathways through employers and the state for entering priority jobs. Some begin with high school students, while others identify individuals in adjacent fields who may be looking to make a change.
- Supporting growth of community-based workforce such as doulas, peers, and direct care workers. Since the COVID-19 pandemic, there has been a major growth in community health worker jobs and other community-based workforces. States and employers are considering how to define these workforce sectors, what certification and training requirements might look like, and how to collect data on a workforce that traditionally is not licensed.[6]
- Seeking new opportunities through the recent Medicaid Section 1115 Demonstration Waivers to investments in workforce and infrastructure, related to supporting health-related social needs and community-based organizations. This provides an opportunity to bolster data collection and sharing.

Using this information, MCOs can play the most impactful role through:

- Investing in education and training programs, such as providing grants for completion of the GED or partnering with local high school and higher education programs to allow for internships or shadowing opportunities.
- Creating partnerships, including investment in staffing of local providers, and value-based programs focused on community health workers and community-based workforces, such as doulas.
- Working with the state once Medicaid Section 1115 Demonstration Waivers are approved by CMS to operationalize investments by the state.

UCare recognizes the importance and prioritizes workforce development and has successfully implemented the following initiatives in Minnesota:

- Over 30 years of funding to the University of Minnesota Department of Family Medicine for the purpose of training primary care physicians

[5] Chhean, E. (2023, October). Keeping Pace with the Labor Market and the Health Care Workforce. National Academy for State Health Policy (NASHP). Available, here.
[6] *See* NASHP's work on community health workers, doulas and midwives, and direct care workers for additional information.

- Three decades of support to the University of Minnesota School of Dentistry training and outreach program.
- Participation in professional associations, such as the Community Health Workers (CHW) Alliance.
- Grants to providers serving a large Medicaid population, such as Critical Access Dental practices and doulas.
- Partnership with the Minnesota Hospital Association to develop and roadmap and toolkit for workforce development.

Should Nevada explore adding a workforce development and plan requirement to MCOs, it is suggested that MCOs be allowed flexibility as to what is incorporated into the plan, as well as what any investment should look like, unless funding is structured into the rates and contract. In addition, UCare highly encourages the Division to partner with the Nevada Departments of Labor and Insurance to provide incentives across all insurance products in the state. The more funding and focus on this topic by all stakeholders interested in workforce development, the stronger implementation of initiatives will be.

1.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: No response.

1.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 members.

Response: No response.

Section 2: Behavioral Health Care

2.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: No response.

2.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: Providing school-based behavioral health services has helped expand availability and access to behavioral health services for children. The Division already covers school-based behavioral health services and has included schools as an eligible site for telehealth services, which is a crucial step. Further, the Division implemented 988, mobile crisis response teams, and crisis stabilizations services, all of which are critical for members in behavioral health crisis and help to avoid hospitalizations, institutionalization, and negative health outcomes. Lastly, the Division also reimburses for community paramedicine, which allows for paramedics to participate and get reimbursed for delivering services.

One suggestion for the Division to consider, if it has not already done so, is setting up a series of conversations to engage MCOs, the local community, and faith-based organizations to understand the behavioral health needs of the diverse racial, cultural, and ethnic groups more fully in Nevada. Through this engagement, community-based organizations can serve as resources for their members and help support community-level interventions. This can also help drive financial and non-financial contributions to address members living in their community and gives MCOs ideas on where the MCO can make meaningful investments. These types of investments could include support to build provider capacity by implementing project Extension for Community Healthcare Outcome (ECHO), creating more workforce opportunities for peer support specialist, and exploring funding for services as in lieu of service or value add that provide respite care for families or similar wrap around supports.

2.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: No response.

Section 3: Maternal & Child Health

3.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: Over the past decade, childbirth in the United States has become increasingly risky, particularly for rural residents and people of color, especially for Black and Native Americans.[7] Additionally, people covered by Medicaid face almost double the risk of severe maternal morbidity and mortality during childbirth hospitalizations, compared with people that are privately insured.[8]

According to the Nevada Department of Health and Human Services report on Maternal Mortality and Severe Maternal Morbidity, Black, non-Hispanic Nevadans are 4.3 times higher to experience maternal mortality than their white, non-Hispanic counterparts. Additionally, Native American, non-Hispanic Nevadans, have the highest death rate at 19.8 per 100,000 women, compared to 5.3 per 100,000 women for white, non-Hispanic women.

To better support maternal and infant health outcomes in Nevada (44 percent of which are paid by Medicaid), the Division could consider requiring all contracted MCOs participate in a performance improvement project focused on improving services provided to pregnant and infant members, particularly in areas of the state that experience significant disparities.[9] With a program like this, each participating MCO could work toward a unified goal for pregnant populations to reduce disparities and improve pregnancy and birth-related health factors, such as access to and utilization of prenatal care, postpartum care, well-child visits, and/or childhood immunization status-combination 10 (COMBO-10) rates.

Nevada has a substantial number of counties (47.1 percent) defined as maternity care deserts.[10] With several counties lacking access to hospitals and birth centers that offer obstetric care, MCO's can leverage telehealth and transportation exceptions for pregnant members living in rural areas, with support from MCO case managers to help troubleshoot solutions and engage with pregnant members throughout their care.

Additionally, UCare has been successful by engaging with communities and systems, including Tribal and County governments and public health staff, collaborating with providers across counties to find ways we can better support members who have limited access to prenatal care or a birthing facility. Providers on the ground often have innovative solutions to provide care for their communities and MCOs can support providers through value-based payment (VBP) initiatives that improve health outcomes and allow providers to put resources where needed in their communities to achieve shared goals.

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[7] Young, A. (2021, March 22). Deadly Deliveries: A USA TODAY Investigation. USA TODAY. Available, here.
[8] Heberlein, M. (2020, January 24). Maternal Morbidity among Women in Medicaid. MACPAC. Available, here.
[9] Fontenot, J., et al. (2023) Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity in Nevada. March of Dimes. Available, here.
[10] *Id.*

The Division could work with MCOs to support the perinatal workforce and deepen collaboration efforts with community-based organizations to support outcomes including doula agencies, County partnerships, birthing centers, WIC agencies, and more. The Division could consider asking MCOs to participate in Pregnancy Notification Program with providers, where MCOs and providers share information to stratify low-, moderate-, or high-risk pregnancies for appropriate intervention. And to accomplish this goal, MCOs would need to contract with all types of perinatal care providers, OBGYN, maternal health and ancillary providers in the state – including hospitals, birthing centers, midwives, doulas, and CHWs.

Nevada has provided Medicaid reimbursement for CHWs to support disease prevention and chronic disease management since 2022. Building on this achievement, the Division could consider utilizing CHWs to support maternal health outcomes for members. This could include supporting members with setting up prenatal and postpartum visits and following up with members to keep their appointments. CHWs can monitor and assist members throughout their pregnancy (e.g., assess the baby's birth weight) and refer pregnant members to other resources, including substance use treatment, food, and housing. Outreach provided by CHWs who speak the same language may gain a stronger understanding of the challenges members may be facing and support members with getting connected with other disease management, population health and value-added benefits offered.

3.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: No response.

Section 4: Market & Network Stability

4.1. Service Area

4.1.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: The benefits of a statewide service area include providing consistency and clarity regarding which health plans are available to members. This approach allows for a balanced cost and enrollee mix to allow for financial viability and sustainability for MCOs. A statewide service area can also be beneficial to members, allowing for continuity of care and seamless transitions when MCOs have other products. As members transition in and out of Medicaid, they can transition to

another product within the same plan, such as Medicare Advantage or Marketplace coverage.

A statewide service area approach can lead to less local focus as MCOs may choose to provide services/models on a statewide level that does not account for the unique differences in geographic areas. It is important that MCOs develop models based on the demographics specific to a geographic area. Population-specific models can result in greater outcomes with a focus on localized programs and partnerships if the Division continues to ensure a balanced cost and enrollee mix, including balance of rural and urban county service areas for each health plan.

Should a regional or county-based service area contract model be established, the Division should consider issuing only one RFP that allows responders to identify the service area(s) for which they are applying versus separate RFP responses for each service area, that could lead to fragmentation within the program. The Division could consider providing some differences in questions and scoring for different regions of the state to ensure the specific local needs and priorities area being met.

Finally, evaluation of outcomes by the health plans awarded contracts should be conducted to understand the success of the model chosen.

4.1.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: Regardless of the service areas determined, it is important that the Division review outcomes of the MCOs to determine if and what types of changes should be considered. Parts of this evaluation include member experience, cost, quality metrics, community engagement, and provider experience and network.

Since managed care will be available statewide, developing capitation payments and fee-schedules based on rate cells and geography will be critical. Most states offering managed care statewide have broken up the state into regions allowing them to pay providers in rural and frontier areas more than other areas where there are more members and resources.

4.2. Algorithm for Assignment

4.2.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: There are a few ways to approach an assignment algorithm that promotes market stability; one for plans new to the market and another for existing plans as new members receive Medicaid coverage.

When an RFP results in a new entrant it is important to ensure healthy competition among new entrants versus incumbents. States like Iowa and Kansas are examples where even distribution of membership is maintained, not allowing one MCO is get too big and ensuring a new entrant is viable. This includes a rotating enrollment for the annual selection period, so that current and new members are spread across the MCOs. However, enrollee choice always comes first, and members should be able to choose which plan they remain in for the next 12 months regardless of any passive, default, rotating enrollment that is used.

After MCOs are introduced into the Medicaid market, in non-RFP years for new Medicaid members and ongoing annual selection periods, quality metrics could be used to determine passive/default enrollment to create healthy competition. There is potential for difficulty in determining incentives based on quality measures, as there could be a lack of agreement regarding the story the metric tells or if the metrics are limited to a specific population. For example, using metrics based on prenatal and postpartum care utilization will only show impact on pregnant members, while the majority of enrollment may be children. The Division could also broaden the definition of quality, so it is not solely quality metric-based. It could also include the percentage of value-based agreements, MCO payments that encourage/support workforce development, provider experience with the MCOs, or utilization and performance of value-add or in lieu of services.

If the Division decides to implement a quality-based algorithm, whatever measures are used, the MCO contracts should explicitly state the Division has the final decision on any assignments.

Section 5: Value-Based Payment Design

5.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: Effective financial incentives are central to the adoption of and engagement with VBP design. While VBP models often include financial rewards for achieving or exceeding certain quality, cost, or equity targets, emerging evidence suggests they are often ineffective and that two-sided models, which include both upside and downside risk, may lead to better outcomes and stronger motivation

from providers.[11] As such, the Division could consider requiring two-sided value-based payment arrangements between MCOs and providers with a member assignment that is sufficient to support such a model.

Providers are also more motivated to focus on improving outcomes in care delivery when a greater portion of their revenue is tied to VBP.[12] This can also lower the administrative burden on providers that often receive payment from a variety of sources. The Division should consider requiring MCOs to have a VBP contract with a specific percentage of providers across the service area and/or deliver a specific percentage of provider payments, set to increase over time, through approved VBP arrangements. VBP participation tends to be more likely among larger health systems, specific considerations for rural VBP participation could include a population based payment on a per-member per month (PMPM) basis that allows flexible funding that is tied to performance without the large financial risk of a two-sided arrangement. [13]

Another strategy the Division could consider promoting value-based payment design is tying a portion of the bonus payment to provider satisfaction in MCO contracting. If MCOs are not directly incentivized to focus on provider satisfaction, they may default to using their national models and/or models from other lines of business. Incentives tied directly to provider satisfaction may better motivate MCOs to align contracting with local provider objectives and needs.

5.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: No response.

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

Response: No response.

Section 6: Coverage of Social Determinants of Health

6.A. Besides housing and meal supports, are there other services the Division should consider adding to its Managed Care Program as optional services in

[11] Gondi, S., et al. (2022). Analysis of Value-Based Payment and Acute Care Use Among Medicare Advantage Beneficiaries. JAMA network open, 5(3), e222916. Available, here.
[12] Lewis, C., et al. (2023, February 23). Value-Based Care: What It Is, and Why It's Needed. Commonwealth Fund, Available, here.
[13] Horstman, C., Lewis, C. (2023, April 13) Engaging Primary Care in Value-Based Payment: New Findings from the 2022 Commonwealth Fund Survey of Primary Care Physicians. To the Point *(blog),* Commonwealth Fund. Available, here.

managed care that improve health outcomes and are cost effective as required by federal law?

Response: No response.

6.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.

6.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: Building on the Division's work and the current requirement of MCOs to invest 3 percent of their pre-tax profit in community organizations that support addressing social determinants of health, the state may want to consider naming broad priorities for investments. This could encourage MCOs to achieve targeted goals and require them to gather data on the impact of specific innovations achieved through established partnerships and investments.

For example, the state could consider engaging the community to develop the areas of focus by naming goals that allow for enough flexibility in partnerships and investments. These priority areas determined in collaboration with community, could include specific goals of connecting people with services, grounding in health and racial equity, ensuring access to care and coverage, and/or supporting alternative payment arrangements. Specifically, the state and its community partners could consider naming maternal health, housing services, and/or workforce development as priorities for consideration in MCOs reinvestments.

The state could also add amendments each contract year that update and/or change these priorities based on reported outcomes and community/public feedback.

Finally, the state could also consider asking MCOs to provide an annual report on the amount of pre-tax profits, beyond the required 3 percent for reinvestment, which could be compiled in a public report.

Section 7: 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 prohibiting MCOs from sub-delegating key health plan functions, including behavioral health and network development. This will help ensure that decisions are community-focused as corporate staff external to the local health plan are not making decisions to potentially restrict enrollee access to necessary care, such as utilization management or contracting decisions. This also helps providers because in a sub-delegated model, they have to collaborate with corporate staff instead of local staff on various aspects of care and contracting.