[1] Some digital divides between rural, urban, suburban America persist | Pew Research Center

School-based health centers (SBHCs) offer a unique opportunity to provide accessible and comprehensive health care services to children and adolescents in rural communities. SBHCs can help improve overall health care quality and outcomes for rural populations, especially for children with special health care needs. School-based providers are also on the front line of addressing other social and economic factors that affect children and young adults, including food insecurity, depression, bullying, housing instability and more. By incorporating the services provided by SBHCs into managed care, rural providers can be provided additional support from MCOs including the potential for engagement in value-based payment arrangements providing further financial support and stability.

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: We encourage the Division to consider the following recommendations to support the development and investment into a Medicaid Provider Workforce Development Strategy.

Tiered payment structures for high-performing providers. Retaining the current workforce is an important part of a strategy to improving provider workforce capacity in the state. When tied to performance targets, a tiered payment structure may encourage rural participation and identify areas of quality improvement. This structure may also encourage them to improve their care offerings by investing in technology and infrastructure that enhances the member experience and the care delivery model in rural and frontier settings.

Graduate Medical Education (GMWE) residency placements in high-need communities. By working collaboratively with medical schools and educational institutions, the Division can build a stronger provider network with an eye toward physician shortages in underserved areas. An intentional recruitment and placement strategy helps expose graduate medical residents to the unique challenges of rural and frontier Nevada, which in turn may support improved retention rates for providers to continue serving rural and frontier members. Additionally, a rural or frontier placement would expose residents to specialized skills unique to rural and frontier medical practice, such as telehealth, emergency medicine and obstetrics. Beyond a required placement in a rural or frontier setting, many residents may find this work unique and rewarding and choose to continue practicing in a rural or frontier community.

Community reinvestment payments for workforce development strategies. As previously noted, we encourage the Division to re-imagine their community reinvestment program to address Medicaid provider workforce challenges. This may be especially beneficial if tied to quality metrics or other state priorities such as community health needs assessments, population health disparities, health equity goals and others identified by the MRAC. This could also take the form of a scholarship to recruit and retain advanced practice nurses (APNs), physician assistants (PAs), pediatricians and OB/GYNs wherever community need is highest for these clinicians. We encourage the Division to integrate the workforce into the community reinvestment program rather than creating a separate and distinct program to provide the greatest opportunity for significant impact on creating access.

"Grow Your Own" initiatives for high school graduates to gain certification and/or licensure for much-needed clinical and non-clinical capabilities in their own communities. Conceptually, this

pool of available providers. Other states have implemented regulations to allow for out-of-state providers to practice in a state under specific circumstances including the creation of a special telemedicine license for out-of-state physicians interested in serving residents in a state in which they do not physically reside. Examples for the Division to consider include:

- Arizona and West Virginia: Allow providers not licensed in the state to provide telehealth services to in-state members if they register with the applicable in-state licensing or regulatory body.
- New Mexico: Requires the state medical board to issue a licensed physician a telemedicine license who holds a full and unrestricted license to practice medicine in another state or territory.
- Pennsylvania: Issues extraterritorial licenses to physicians residing or practicing with unrestricted licenses in an adjoining state, near the state border, and whose practice extended into the state. Extension of these licenses is based on the availability of medical care in the medical area involved.
- Utah: Allows out-of-state providers to practice without a state license as long as they are licensed in another state with no licensing action and at least 10 years of experience.

In considering implementation of these provider capacity building strategies, we recommend the Division make sure it has the administrative capacity to fully execute on any of these strategies, including the staff available to verify efficient processing of applications.

Not requiring a member to have an established relationship with a provider before utilizing telehealth when clinically necessary is an additional strategy the Division could use to address behavioral health access challenges. Provider-to-provider or interprofessional consultations, including e-consults can play a vital role in addressing behavioral health care needs in rural areas. Through e-consults, providers can share expertise and offer guidance on complex cases, enhancing the quality of care and reducing member wait times. As a result, we recommend the Division verify that its reimbursement processes cover these types of provider engagements. In addition, the Division should consider working with Project ECHO Nevada out of the University of Nevada, Reno School of Medicine to develop ECHOs on behavioral health with a specific focus on telehealth along with one on understanding collaborations within the Systems of Care for children and adolescents to best serve the behavioral health needs of that population.

Finally, the Division and its managed care partners, along with other stakeholders, should work together to offer members accessible and culturally responsive education on telehealth options and best practices for maximizing a telehealth visit. This should include addressing the digital divide, which hinders the successful implementation of telehealth services in rural areas. The Division should consider offering planning grants, technical support and SafeLink phones to make sure members have the necessary resources to engage in telehealth. Developing centralized receiving centers in each of Nevada's counties, offering telehealth and digital offerings, can further support the expansion of these services.

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: Nevada, like most states, faces significant gaps in its behavioral health care system, particularly in rural and remote areas. In addition to the strategies identified in Question 2.A specific to telehealth, some additional best practices that the Division could consider deploying to increase the availability of behavioral health services particularly in the home or community in rural and

remote areas include expanding in-home and site of care services, supporting team-based care value-based payments and investing in workforce/provider capacity and training. We recommend the Division first, however, connect with members in and providers serving rural and remote areas of the state to fully understand the needs, gaps and opportunities to support a "local first" approach to supporting behavioral health care service access.

In-Home and Site of Care Services
Community-based service delivery models such as Assertive Community Treatment (ACT), which can be provided at home or at a clinical site, have been found to be effective at mitigating behavioral health needs while also supporting an individual's social functioning and access to basic needs supports. Streamlining the reimbursement structure for these models will decrease administrative burden and support the establishment of additional teams. As part of its assessment of the current reimbursement model specifically for ACT, it could also consider enhanced rates for ACT teams delivering services in rural and remote areas.

Value-Based Payments
The Division could consider offering innovative payment arrangements to specific provider types serving rural areas of the state to build capacity. This could include allowing Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Service (IHS) clinics to serve as both origination and distant site providers to further support behavioral health care services access via telehealth.

Workforce Capacity
Training local peer specialists, community health workers and community paramedic programs to support and engage with rural and frontier members to support their behavioral health needs or help them more easily navigate to clinically based behavioral health services can expand the capacity of the entire system. This can be achieved by partnering with local providers, such as FQHCs and RHCs to offer workforce training investments and sponsorships in non-clinical provider capacity. As part of this effort, the Division could also consider the current reimbursement rates for providers such as peer support specialists to verify the rates reflect the variety of services and supports they provide and do not adversely impact access.

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: One way to achieve the goal of supporting increased availability and utilization of behavioral health services in rural communities for children is to allow MCOs the flexibility to innovate and develop customized models for individual practices, leveraging their experience in developing accountable care models. This flexibility enables MCOs to meaningfully engage providers, informed by a provider's experience, resources and sophistication, and will facilitate the development of strategic partnerships that align with practice goals and interests while limiting provider financial exposure.

Another approach is to consider schools as an extension of the home for care delivery, as they can play a crucial role in providing behavioral health services to children. By involving schools in the care process, children can access necessary services without leaving their familiar environment. Additionally, the Division could allow MCOs flexibility to support broadband access or provide

reimbursement pathways to help with virtual care access, particularly in rural communities where access to broadband may be limited.

To further enhance the availability of behavioral health services, we recommend the Division consider increasing peer support specialist reimbursement rates, to include family support specialists. Peer support specialists have been shown to positively impact behavioral health service access and drive better health outcomes for members. Addressing how reimbursement rates may be impacting access will also help attract and retain more qualified specialists to provide necessary support for families and children in need of behavioral health services.

Incentivizing behavioral health programming and provider rates can also contribute to improving access to services in rural communities. As the provisions of the Family First Prevention Services Act (FFPSA) are implemented, the Division could leverage their MCO partners to address coverage of the prevention services identified in the law, including mental health prevention and treatment, substance abuse prevention and treatment and in-home parent skills-based training. Coverage of these services needs to include sufficient reimbursement rates in order to support provider engagement.

Finally, the Division could consider incentivizing mental health and substance use disorder services covered in the FFPSA plan. Nevada submitted its Prevention Services Plan to the Children's Bureau at the end of April 2020, putting structures and processes in place to plan for Family First. By aligning incentives with the goals of the FFPSA, the Division can increase the availability and utilization of behavioral health services for children in rural communities, improving their overall health and well-being.

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: Pregnant women in the United States are increasingly experiencing adverse maternal and birth outcomes. These outcomes are driven by many factors including limited access to needed prenatal and postpartum care due to hospital closures and provider shortages. Rural and frontier areas are particularly impacted by these increasing dynamics. According to the latest maternity care access and equity report from the March of Dimes, 47.1% of the counties in Nevada are defined as maternity care deserts, over 1,200 babies are born in maternity care deserts in the state, and only 2.2% of maternity care providers practice in rural counties in Nevada.[2] These realities are most acutely impacting Black, Indigenous and people of color (BIPOC). Historically, BIPOC have lower rates of adequate early and regular prenatal care, which is important for reducing pregnancy complications and adverse birth outcomes.[3]

With approximately half of births in the United States covered by Medicaid, there are opportunities for the Division and their Medicaid Managed Care Organization (MCO) partners to develop strategies to address prenatal care management and postpartum coverage to improve health outcomes among pregnant members on Medicaid in the new Contract Period. Core to achieving these outcomes are policies and program design features that:

[2] March of Dimes 2023 *Where You Live Matters* Report.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497343/pdf/12037259.pdf.

- Emphasize action to address the disparities that lead to inequities in maternal health outcomes.
- Provide access to a comprehensive array of both clinical and non-clinical services and supports.
- Continue to evolve the care model with enhanced digital modalities.

The tools and strategies we have outlined below for consideration reflect these core program design features and are aimed at continuing to support our collective efforts to improve the maternal and child health outcomes for all Nevadans.

Digital Modalities & Capabilities

- **Cover Broadband as a Social Determinant of Health**: Telehealth is a viable strategy to connect members and providers. Telehealth, tele-medicine and tele-dentistry services should be available and explored as strategies to increase access to care, especially in bridging the divide where disparities and inequities exist. Given that broadband may be limited or unavailable for many Medicaid members, particularly in rural and frontier communities, funding to gain broadband access can help with accessing care in rural areas.
    - The Division could explore pathways to support screening and connection to coverage of broadband as a social determinant of health (SDOH). While the Center for Medicare and Medicaid Services (CMS) has limited coverage options under existing authorities, there may be opportunities to leverage other federal programs. However, if no broadband exists, systemic investments to support infrastructure is needed. This investment likely exceeds Medicaid funding scope and capacity.
- **Support Remote Patient Monitoring, Two-Way Texting**: As member communication preferences continue to shift toward digital platforms, states, providers and MCOs will need to adopt mobile-friendly strategies to encourage engagement. Remote Patient Monitoring (RPM) is one of the best ways to track and measure an individual's progress and identify complications, especially in between in-person visits to a provider.
    - The Division could make sure that policies, rules, regulations, MCO contracts and rates support the use of telehealth, RPM and two-way texting (within HIPAA guidelines) to support monitoring and engagement with pregnant members.
    - Coverage of RPM should be supported for members meeting established clinical criteria without geographic limitations because the member's home would serve as the origination site.

Comprehensive Array of Services and Supports

- **Maximize Doula Care Benefit**: We applaud the state for its efforts to support doula care access in Medicaid as a critical layer of support for pregnant and postpartum members and their families. This includes the most recent actions by the state to increase the reimbursement for doula care including an incentive payment for doulas serving rural populations. To further provide adequate access and effective utilization, we suggest the Division explore some additional modifications and additions to the current benefit. These suggested program design changes are reflective of the experience of other states' efforts standing up a doula care benefit in their Medicaid program and our experience supporting implementation of that benefit.
    - Non-traditional providers such as doulas typically lack the administrative capacity and resources to navigate the various requirements of becoming and sustaining Medicaid provider enrollment along with the nuances of billing for services.

- Adequate infrastructure provided by the state or through a cross health plan/state-collaborative including trainings and technical assistance could be considered for doulas on topics such as Medicaid enrollment policies, application standards, reimbursement practices, billing guidelines and claims submissions procedures.
- The Division could support doulas in forming cooperatives or umbrella organizations that ease administrative burdens of contracting, member navigation and doula administrative processing.
- To decrease the burden associated with established credentialing requirements, the Division could consider an investment pool to cover required recertification fees.
- A unique doula provider application with simplified language, developed in partnership with doulas, should be considered to further reduce administrative burden.
- Recognizing that many Medicaid members face access barriers – such as restrictive work schedules, childcare challenges and rural isolation – enabling telehealth connection to local, community-based doulas facilitates individualized, person-centered care and expands access to valuable doula services. **Telehealth should be an allowable modality for accessing doula care.**

- **Cover Home Visiting**: The Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) have jointly expressed their support of home visiting and noted its benefits such as improving maternal and child health, preventing child abuse and neglect, encouraging positive parenting and promoting child development and school readiness. Home visiting programs connect new and expectant parents and caregivers to nurses, social workers and other similar professionals to support them in planning and caring for their child through the provision of services and supports such as healthy pregnancy practices, positive parenting skills and connections to services and resources in the community.
  - We recommend the Division evaluate the available pathways to support coverage of home visiting in the Medicaid program.
  - MCOs should be encouraged to coordinate with any established home visiting programs in the state to provide consistent funding and reporting of the program.

Workforce Supports

- **Support Maternal Health Workforce Pathways & Expand Women's Health Care Provider Capacity:** In order to address the shortage of maternal care providers that is driving maternity care access challenges for women across the state, efforts focused on both supporting individuals interested in pursuing maternal health care workforce opportunities along with helping to widen the scope of providers available to support women's health along the care continuum should be considered.
  - The Division could explore joining the Washington, Wyoming, Alaska, Montana and Idaho multi-state medical education compact (WWAMI), as well as the Western Interstate Commission for Higher Education (WICHE). Both provide opportunities for collaboration with neighboring states around education and workforce issues through rotating residency programs, recruitment incentives and other tools.
  - The Division could also consider utilizing its recently legislatively approved loan repayment authority to specifically target funds to maternal health providers with emphasis on those agreeing to serve in rural or frontier areas.

- Federally Qualified Health Centers (FQHCs) are an essential provider of health care for Medicaid members. They can impact maternal health care delivery and outcomes like few provider types. To support their capacity to provide the full range of maternal health services, the Division should assess any current reimbursement regulations specific to FQHCs that may be limiting their ability to fully manage a pregnant individual's maternal health care journey. This assessment should include consideration of increasing reimbursement rates or modifications to the current payment methodology used relevant to maternity care in health center settings.
- The Division should explore or expand community partnerships with local perinatal-focused community-based organizations (CBOs) and/or incentivize MCOs to establish those partnerships, to help expand access to perinatal care workers such as perinatal community health workers, doulas, lactation support specialists, etc.

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: The Center for Medicare and Medicaid Innovation (CMMI) and HRSA are both supporting states as they test various strategies and financial models aimed at provider financial sustainability and improved access to care that could serve as models for Nevada. Specific provider payment approaches the Division could consider supporting to drive improvement in maternal and child health outcomes in Medicaid include:

- **Use value-based payment arrangements to support rural hospital obstetric services.**
- **Ensure current policies and regulations do not unduly prevent FQHCs from providing comprehensive maternal health care**. This should include allowing FQHC coverage and reimbursement for services delivered by doulas, marriage and family therapists, licensed professional counselors and community health workers. Additionally, FQHCs should be allowed to bill for multiple encounters on a single day to allow for medical, dental and/or behavioral health services.
- **Support the utilization of episode of care models.** The episode of care is the preferred alternative payment model/value-based arrangement in maternity care. The episode of care can be designed in such a way to ease providers into risk-based arrangements while incentivizing quality outcomes. The episodes can also be built to foster advancements in maternal care that align with clinical best practices through the establishment of thresholds or programmatic requirements.
- **Require providers to demonstrate adoption of the Alliance for Innovation on Maternal Health Program (AIM) patient safety bundles.** As providers increase in their sophistication, opportunities to take on additional risk or share risk with collaborators in the care team become available and create opportunities to continue to advance care delivery and expand and deepen participation in value-based arrangements.

Section 4.1: Market & Network Stability – 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: We recommend establishing no more than three regional service areas and allowing managed care organizations (MCOs) to bid on all three service areas if they wish to establish a statewide network. The two high-density population centers of the state (Clark and Washoe counties) may have their own individual regional service areas, and the rest of the state, which is predominantly rural and frontier, may serve as the third regional service area.

If the Division awards three managed care contracts in the next procurement cycle, we also recommend that the two urban regional service areas (Clark and Washoe counties) have all three MCOs available, and two MCOs are made available in the rural and frontier regional service area. Given the state's population and geography, establishing a choice of MCOs is an important approach that should be afforded all Nevadans. This means that, no matter where you are in the Silver State, a Medicaid member will still have the option to choose an MCO that fits their health and wellness goals. With two MCOs specifically in the rural and frontier service area, they will still compete to provide cost-effective care, and offer different solutions that meet the unique health challenges of those areas of the state. This approach also appropriately addresses the population density variance across the state, helps make sure the selected MCOs in all regions are able to reach a sufficient member threshold in order to achieve long-term sustainability, and promotes an MCO's quality and cost-effectiveness through a balanced network, even in rural and frontier parts of Nevada.

We also recommend the Division include all eligible populations in managed care in all three regional service areas, as comprehensive carve-ins into managed care will support the statewide expansion and integration goals that the Division has laid out. Adding the aged, blind and disabled (ABD) population into the statewide managed care program would be a good first step and soliciting stakeholder feedback on the future of children and youth in the care and custody of the state in managed care could be another area for the state to investigate.

Transitioning rural and frontier parts of the state from fee-for-service into managed care will shift the risk and the administrative burden away from the Department of Health Care Financing and Policy (DHCFP). By limiting the state to no more than three MCOs, the Division will be afforded additional capacity to manage the three MCOs for accountability and transparency in meeting their obligations to the state and all Medicaid members.

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: As an MCO with lengthy experience serving in rural and frontier communities across the country, we want to help setup the State of Nevada for successful expansion to statewide managed care. From our experience, in order to balance member choice and healthy market competition, we reiterate our recommendation that the Division not consider any more than three MCOs for award in the next contract cycle. Adding more MCOs into the Medicaid program will have the opposite outcome from what the Division desires, which is overall cost containment and incentives for rural and frontier providers.

We also suggest offering enhanced rates in the single, designated rural and frontier service area. Enhanced rates could be used for primary and behavioral health care, such as addressing a workforce shortage or maintaining or enhancing access in typically underserved areas. Specifically, deploying technological solutions to expand the use of telemedicine in-clinic and at-home would help overcome access challenges, which could be supported by the enhanced rates. The Division could also consider enhanced rates for non-emergency medical transportation (NEMT), including a higher mileage reimbursement rate for rural and frontier providers, higher rates for NEMT drivers who are required to wait for a member during appointments, and capacity-building grants that may help cover the cost of NEMT-related expenses, such as vehicle maintenance.

Section 4.2: Market & Network Stability – 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: We applaud the Division's recent changes to the quality-based auto-assignment algorithm starting on January 1, 2024, especially the decision to focus on the five HEDIS metrics for child and adolescent care and maternal and birthing health. Continuing a focus on quality metrics like these are the predominant driver of competition between and amongst Managed Care Organizations (MCOs) and help MCOs identify areas for improvement and innovation. Additionally, the quality-based "report card" approach incentivizes program and benefit design to include tailored value-added services based on unique regional needs and helps members easily identify MCOs with the history and experience in serving Nevada's Medicaid population.

Expanding managed care across the state is a significant undertaking, and we recognize that an assignment algorithm associated with this expansion will have to be evaluated and refined through the process. As the Division considers an assignment algorithm strategy in the context of expansion of the Medicaid program, we encourage the Division to engage key stakeholders in the process. This engagement would include members, advocates, and MCO partners. MCOs have particularly unique business dynamics relative to any decisions the Division makes to the assignment algorithm including fixed costs, actuarial analyses, and a viable market share threshold (VMST). In addition, we suggest that the Division consider capacity and resource constraints such as enrollment data accessibility for partners and member communication needs, as well as anticipate other outcomes, such as market disruption if an MCO exits the market in its decision-making process.

We believe using performance-based metrics such as HEDIS elevates the entire Medicaid Managed Care program. For the assignment algorithm, we recommend the Division also include the National Committee for Quality Assurance (NCQA) ratings for each MCO. NCQA ratings account for a wide set of standards such as member satisfaction, access to care, and clinical quality. AN MCO's NCQA rating is a strong indicator of performance and is also a strong signal to the member of an MCO's experience in the state, commitment to improving outcomes across the range of health disparities faced by members, and deliberate focus on providing culturally congruent and multicultural care paths, which is a key part of NCQA's health equity accreditation.

The focus on HEDIS metrics and an MCO's NCQA rating are the best ways to maintain a focus on quality while promoting competition and stability in the marketplace.

In order to include an algorithmic shift that accounts for the Division's own priority areas (beyond HEDIS metrics or the NCQA rating), we also suggest the Division establish an increase to the auto-

assignment calculation based on an MCO's alignment, commitment, and eventual changes in outcomes relative to identified Division priorities. As the Division identifies disparities in the Medicaid system, we suggest aligning MCOs to improvement metrics and standards that support both the state's delivery system, and the experience of the members to drive changes in these disparities.

One way to achieve this focus is an alignment to other clinical outcomes, such as a decrease in the total cost of care or a provider network component such as maintaining a member's preferred provider relationship. Another approach is highlighting an MCO's commitment to more equitable practices that support improved engagement, like stakeholder outreach, particularly those with lived experience or persistent challenges and building a network of providers or non-clinical supports with a focus on addressing the social determinants of health (SDOH). The Division may also consider an MCO's value-based payment (VBP) strategy especially if it improves provider relations, and other areas of integration, such as behavioral health and dental coverage.

This proposed alignment to the Division's population health, health equity, and SDOH priorities could be included as a weighted factor in the auto-assignment algorithm alongside the other metrics and ratings.

Finally, when a new MCO enters the market, we suggest that the Division immediately help support and stabilize the new MCO in order to decrease market disruption as much as possible. We recommend that the Division identify a reasonable and credible VMST and immediately assign members to the new MCO, considering member acuity levels, regional service area distinctions, and existing dual special needs plan (D-SNP) alignment. The VMST should be developed with state dynamics, including product types carved into managed care and membership density taken into consideration and we recommend engaging your MCOs partners in calculating the standard. Once the new entrant has reached the identified member threshold, use of the quality-based assignment algorithm should be reestablished for all MCOs.

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: The Division's prioritization of value-based payment (VBP) design in its expanded managed care program demonstrates its commitment to addressing health disparities and the rising cost of health care. Along with the current one-year bonus payment arrangement based on performance, there are additional incentives and strategies that the Division can consider implementing in its upcoming procurement and contracts to further promote the expansion of VBP with providers in the Nevada Medicaid program.

In considering any new VBP design, we recommend the Division focus on the following core aims:

- Articulate the specific goals the Division hopes to achieve through implementation of VBP arrangements.
- Verify that any executed VBP arrangement is simple and lacks ambiguity as to its purpose.
- Allow for flexibility in the design of VBP arrangements by Managed Care Organizations (MCOs) to include avoiding a required percentage of providers to operate under a VBP. Benchmarks based on penetration of Medicaid members as opposed to volume of providers creates a more meaningful incentive for practice transformation driving better health outcomes.

- Support providers in engaging in VBP arrangements by directly providing technical assistance or incentivizing MCOs to provide training and technical assistance.
- Align with existing federal efforts (e.g., Center for Medicare and Medicaid Innovation State Innovation Model, etc.), where appropriate and applicable, to promote efficiency and leverage available tools and resources.

In addition to these core aims, a strategy the Division could deploy to support providers in developing their expertise and experience engaging in VBP arrangements is to use a tiered approach similar to the Making Care Primary model. In this model, providers in Tier 1 receive Fee-for-Service (FFS) payment with performance incentives, plus an infrastructure payment. Tier 2 providers receive partial Prospective Payment System (PPS) plus performance and infrastructure, while Tier 3 providers receive full PPS plus performance incentive, with no infrastructure. This approach can help address the challenges faced by many providers, particularly rural providers, which may lack experience engaging with managed care processes and VBPs.

Performance incentives within the managed care contract should be structured to acknowledge a wide range of VBP arrangements. This flexibility maximizes the likelihood of provider participation by aligning VBP to the unique characteristics of the practice (e.g., skills, practice capacity, transformation goals, sophistication with valued-based models, etc.). In addition, a higher reimbursement could be considered for value-based activities.

Lastly, we recommend the Division focus on maximizing the number of Medicaid members in VBP arrangements to incentivize the shift of the delivery system away from fee-for-service and encourage providers to engage in practice transformation. This approach aligns state VBP models with federal initiatives, promoting provider and payer administrative efficiencies.

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: To further facilitate the success of current and future VBP arrangements, we encourage the state to consider developing and improving upon certain tools and information sharing practices. Specific areas of opportunity include data interoperability, provider readiness assessments, training and technical assistance (T/TA), and data sharing with a focus on encounter and demographic data for all members, current utilization of FFS Medicaid in rural and frontier areas, and FFS network details.

Data interoperability allows for seamless communication between different health care information systems. The state could develop a universal portal accessible by caseworkers, MCOs, caregivers, providers, and others, tying into the state's electronic Health Information Exchange (HIE). This would improve care coordination and provide real-time updates. Investments in rural health care providers to use member engagement technologies, such as automated workflows, secure text messaging, electronic medication refills, and appointment alerts would also be helpful. These tools would help reduce unique rural and frontier access barriers.

Provider readiness assessments are essential for identifying areas where providers may need additional support. The Division can assist MCOs in providing devices and technical support/education to members and providers for digital/virtual visits. Recognizing the limited broadband availability in rural and frontier areas, the Division could allow MCOs flexibility to support broadband access or provide reimbursement pathways to help with virtual care access.

Training and technical assistance (T/TA) can be invaluable in helping providers navigate the VBP landscape. The Division can work with stakeholders to remove barriers and deploy pilot initiatives, continuously monitoring and improving the pilot process.

Data sharing of all Medicaid encounters, including all currently carved out encounters, enables a comprehensive understanding of service utilization and member needs. We recommend the Division work towards full transparency in this regard, fostering better care coordination and resource allocation. In addition, sharing all available member demographic information, including system engagement with MCOs can provide valuable insights into a member's social needs. This information can be used to tailor interventions and programs and align VBP arrangements and associated outcomes.

The current utilization of FFS Medicaid and the dynamics of the current health care provider network in rural and frontier areas are crucial for understanding the unique challenges and gaps in these areas of the state. With this information, tailored VBP arrangements can be developed to target the unique care access preferences and challenges in these regions of the state.

Lastly, when considering VBP arrangements specific to rural and frontier providers, careful consideration needs to be given to the unique differences between costs directly attributable to member care (variable costs), costs of infrastructure required to support member care regardless of volume (fixed costs), and costs necessary for readiness to delivery care anytime (standby costs).

5.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 requires careful consideration and planning. We recommend the Division consider the following aspects when implementing these arrangements with rural providers.

- **System protections/safeguards.** The safety and well-being of rural providers and members is paramount. We suggest the Division consider implementing model flexibility, system protections, and governance structures to support the movement of risk to the health care delivery system. Specific examples of strategies the Division could deploy include:
  - Aligning all MCOs within the same VBP arrangement design to make sure that rural providers are not required to manage different and sometimes misaligned care and payment systems.
  - Minimizing competing demands of the various stakeholders engaged in VBP arrangements by creating consistency in expected outcomes. This could include taking steps so that regulatory change in one model does not conflict with existing regulations or regulatory change in another model.
  - Mitigating financial risk to essential local services, including primary care, public health, and EMS in the design of VBP arrangements. Financial risk should only be applied to aspects of performance controlled by providers.
- **Phased implementation.** Consider a gradual implementation process that allows rural providers to adapt and transition to VBP arrangements over time. This can include leveraging MCO experience and expertise, as well as aligning with other VBP initiatives.
- **Strong stakeholder engagement.** Effective collaboration and transparency among all stakeholders, including MCOs, providers, and members, are essential for the success of VBP arrangements. The Division could engage local providers, community partners and members to

identify existing health care needs, disparities, and service gaps, as well as opportunities for state-level rural health collaborative organizations and initiatives.

- **Continuum of arrangements**. Support a full continuum of VBP arrangements to meet providers where they are — from lower-risk models like pay for quality to higher alignment models like accountable care. This can help maximize the number of Medicaid members in VBP arrangements, incentivizing the shift away from FFS and encouraging providers to engage in practice transformation.
- **Simplified approach**. To address health disparities and the rising cost of health care, we recommend the Division consider implementing simplified VBP arrangements that focus on improving health outcomes and closing gaps in care. This can be achieved by developing landscape analyses, identifying barriers, and deploying pilot initiatives to support rural health administrative model goals.
- **Sufficient volume**. Provide a viable market share threshold (VMST) to adequately balance risk. Total cost of care and utilization-based arrangements are best administered in practices with large membership, so we recommend the Division consider strategies to increase enrollment in rural VBP arrangements with VMST in mind.

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

Response: Many Medicaid members face social needs challenges that can impact their health, such as access to healthy food, safe and affordable housing, reliable transportation, strong social connections, and opportunities for employment. The Centers for Medicare and Medicaid Services (CMS) recently issued guidance on leveraging both In Lieu of Services (ILOS) and 1115 waivers to address social determinants of health (SDOH) making it clear that addressing SDOH are core to health equity work and the delivery of Medicaid services. As a result, we support the Division's interest in considering ways to cover optional services through its managed care organization (MCO) partners to better meet the individual social needs that impact the health outcomes of Medicaid members.

Optional service pathways, such as the ILOS option, can be used to cover services or settings of care determined to be acceptable substitutes for covered state plan services. In Lieu of Services are typically provided in alternative settings and/or by non-traditional providers and are developed with the intention of promoting greater access to services in culturally responsive ways. In alignment with the recent CMS guidance, we encourage the Division to consider ILOS that advance the objectives of the Medicaid program, are cost effective, medically appropriate and uphold member rights.

In addition to the specific service ideas detailed below, we recommend the Division to consider the following when exploring the addition of optional services in its Medicaid Managed Care Program.

- Develop optional services that support individualized member supports and achievement of program goals.
- Target non-covered services to meet the unique needs of specific populations.
- Consider the sustainability and accessibility of services when developing optional benefits.
- Allow programmatic flexibility to account for the costs of optional services in the numerator of the Medical Loss Ratio (MLR). We recommend the Division also ensure that innovative in lieu of

benefits are reported to the Division through encounter data and appropriately financed in the capitation rates.

- Monitor and trend the use of optional benefit coverage requests to determine if the collective needs of Medicaid members and the anticipated cost savings achieved for providing coverage warrant defining specific services as Medicaid covered benefits (either as an entitlement or for a subset of the Medicaid population).

Specific Services for Consideration

Social Isolation Supports: Social connection is essential to health and well-being. There is a wide range of risk factors that leave people vulnerable to loneliness and social isolation. Addressing barriers to social connection is central to effective action in reducing social isolation and loneliness, which in turn can: 1) Improve overall health and health outcomes, 2) Reduce health care costs and ER expenditures, and 3) Reduce disease morbidity and mortality.

- Explore adding certain clinical interventions or group clinical approaches that can be an effective substitute for existing behavioral health services covered under a managed care plan contract.
- Allow coverage of home-and community-based service options that are specifically targeted to address social isolation and loneliness.
- Consider coverage of screening, assessment, and treatment of health issues that trigger social isolation. Explore if screening and assessment may be possible through existing mechanisms already deployed through managed care operations and community engagement.

Broadband: Given that broadband may be limited or unavailable for many Medicaid members, particularly in rural and frontier communities, gaining broadband access can help with accessing care in rural areas.

- Consider pathways to support coverage of broadband as a social determinant of health.

Home Modifications and Supports: The accessibility and safety of a member's home can have a direct impact on their health care challenges. As a result, the coverage of modifications or resources to address issues in a member's home can help support individuals who are older or that have a chronic illness with living independently. Those services and supports can also help to ameliorate the environmental factors of a member's home that might be causing or exacerbating their health care concerns.

- Support coverage of physical home modifications or services to address environmental triggers like mold. Modifications can include filtered vacuums, air filters, ventilation improvement, pest control services, and hoarding cleanup services.
- Cover supports that allow members to function with greater independence. Examples include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.
- Consider coverage of minor home repairs that are necessary to maintain housing to prevent eviction and homelessness.

Caregiver Support/Respite: With the burgeoning caregiver shortage coinciding with an increase in the number of individuals wanting to live at home/independently, caregiver supports are becoming

more essential. Respite care is important for the well-being of caregivers because it can help them reduce their stress levels and prevent burnout.

- Provide respite services to member caregivers when useful and necessary to maintain a member in their own home or preempt caregiver burnout to avoid institutional services.
- Consider the requirements around caregivers and personal care attendants and the impact on accessibility and availability of services to those in need in both urban and rural areas.

Sobering Centers: We applaud the Division for already providing coverage of these centers that provide important short-term, supportive settings for individuals during acute intoxication (or sobering) and throughout the alcohol withdrawal and early treatment phases (or detoxification). We offer the following suggested enhancements to the benefit.

- Incentivize direct coordination with local behavioral health agencies so referrals and linkages are made to additional needed health and social services (such as follow-up behavioral health treatment and housing options).
- Make sure sobering center protocols and programming are centered in best practices for those who are experiencing complex medical and behavioral health needs, as well as those who may be experiencing homelessness, such as: trauma-informed care, harm reduction, and Housing First.

Utilities: Energy access, including access to propane particularly in rural and frontier areas, is an increasingly important social and public health concern. Heating, cooling, and other household energy needs continue to increase in cost and yet are essential to meeting basic needs. Lack of energy access or interrupted access due to a natural disaster, referred to as energy insecurity, has been associated with negative health outcomes.

- Explore coverage of utility set-up fees/deposits along with limited monthly utility bills
- Consider efforts to streamline the application and eligibility process to provide a single point of entry for economic assistance programs including Medicaid and the Energy Assistance Program (EAP) to decrease application time and support quicker access to benefits.

Education and Workforce Supports: Social need impacts on health outcomes include an individual's economic stability. Supporting members in achieving their educational goals and finding work that brings them greater economic security can have a positive impact on their overall health and well-being.

- Support connections to GED test preparation classes, workforce training programs, and provide coverage of any testing or program fees.
- Consider coverage of required items necessary for purchase in order to enter a workforce training program or to begin employment.

Domestic Violence/Interpersonal Violence Supports: The growing understanding of the nonmedical factors impacting health outcomes has come to include the specific impacts of exposure to domestic or interpersonal violence. Survivors of violence are more likely to need mental and behavioral health services, to be living with chronic pain and chronic health conditions, and to need reproductive health care in addition to specific supports to help transition out of a traumatic situation. While evidence-based home visiting programs screen for and address domestic violence, additional services and supports can have a significant impact and should be considered for those who are not eligible for home visiting.

- Explore supports specific for individuals experiencing domestic or interpersonal violence such as case management and violence intervention services, system navigation support, legal assistance, and child-parent support programs.
- Consider reimbursement of or incentivize support for the creation of low-barrier, crisis-based service options specifically for survivors of domestic or interpersonal violence.

Childcare: Finding and accessing affordable childcare can impact an individual's ability to address their own health care needs serving as a nonmedical impact on health outcomes.

- Help members with linking to high quality childcare and after-school programs.

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: In addition to utilizing the optional services pathway to advance benefits to help address the social determinants of health, there are other strategies the Division should consider that are more permanent options and will help to both improve health outcomes for Medicaid members and drive cost efficiencies in the Medicaid program.

- **Transportation:** There is opportunity for the state to reconsider the scope of its current non-emergency medical transportation (NEMT) benefit to best meet the health care access needs of members. **The Division could specifically consider extending the benefit to allow for rides to social needs appointments including for example job interviews, food bank pick up, and housing appointments.** In addition, consideration could be given to the current limited geographic scope of the benefit and resources allocated to support a broader allowable footprint to better support rural and frontier members.
- **Reentry Services:** Many people are leaving jails and prisons with complex health and social needs and many states are designing and implementing strategies to connect these individuals to health care and other supports to help stabilize and successfully re-integrate them into the community. We are supportive of the Division's current efforts to pursue a Medicaid Reentry Section1115 Demonstration Waiver to cover a package of pre-release services for individuals who are incarcerated, eligible for Medicaid, and returning home to their communities for at least 60 days prior to their expected release date. As part of this effort, we recommend the Division assess its ability to include information about new incarcerations and pending releases on a member's eligibility file.
- **Medical Loss Ratio**: **We recommend the Division account for SDOH service investments as part of the MLR calculation for MCOs.** The establishment of a clear MLR definition sets program investment and rate development standards, and when adjusted appropriately, helps to encourage expenditures at the individual and sub-group levels focused on health improvement. Any discussion about rate setting or financial incentives should include the consideration for MLR adjustments that factor in optional benefits and other social investments for SDOH screenings, referrals, and programs, as these are core efforts to decrease other highly utilized health care services.
- **Medical Respite or Recuperative Care:** Hospital discharge is a significant event for anyone, but even more so for homeless individuals as safe, affordable, and appropriate places to recover are often unavailable or unattainable. Medical respite care programs help to fill this gap and provide

a comprehensive care site for homeless individuals being discharged from emergency rooms or inpatient hospitals. Medical respite care programs not only help improve health outcomes, but also provide a care setting based on dignity and respect. **We recommend the Division explore the use of either the 1115 Demonstration Waiver or 1915 Home and Community-Based Services Waiver option to authorize funding for medical respite/recuperative care programs.**

- **Peer Recovery Support Specialists (PRSS) and Community Health Workers (CHWs):** Access to non-clinical supports with lived experience, including PRSSs and CHWs, serves as an important resource for members. These roles specifically provide critical support in helping members navigate to social supports that can help them address the social needs that are impacting their health outcomes. We encourage the Division to review the current scope of both of these provider types, along with the current reimbursement rates, to make sure both accurately reflect the wide variety of services and supports they provide, the value they bring to members, and the impact on availability driven by limited definition scopes and low reimbursement rates.
- **Integrated Information Systems and Data Sharing:** To support appropriate, accessible, and cost-effective care for individuals with complex social needs, **we recommend the Division explore how to better leverage local HMIS or Healthcare Information Exchange systems to monitor progress and the impact of services.** Additionally, these systems could be used to pre-identify potentially eligible populations to help providers (Federally Qualified Health Centers, hospital staff, PCPs, etc.) connect eligible individuals to community providers contracted to deliver housing related supports. In addition, where possible, **the Division could execute data sharing agreements with local Continuum of Care (COC) HMIS administrators.** Creating standard requirements and protocols with coordination across MCOs for monitoring and oversight of providers will prevent confusion for providers contracted with multiple MCOs. **The Division could also explore sharing lists of members identified in the HMIS as homeless with MCOs.** By sharing this data, MCOs can leverage claims systems to target unsheltered members with the highest vulnerabilities for identification and connection to housing supports. Furthermore, MCOs can further assist these members through enhanced, ongoing physical and behavioral care management. **Lastly, linking the Eligibility Verification System (EVS) to HMIS to display eligibility information to service providers would allow for greater community collaboration and improved referral processes to the MCOs for SDOH support.**
- **Community Information Exchange and Community-Level Screenings**: Standardized screenings and data sharing can help quickly identify a member's social needs, as well as other risk factors and trends across the population. In turn, both providers and MCOs are able to increase their care coordination activities to include a focus on the information gleaned from the social risk screenings and the associated needed referrals, including establishing new relationships with community clinics and flagging population health trends before they become greater risks. In addition, given clinic providers' and social service providers' common goal of addressing SDOH to improve overall health, integrating siloed screening and referral processes and establishing communication between the two groups, could aid in better addressing whole person care. **As a result, we recommend the Division explore ways to directly resource or incentivize MCOs to establish standardized screening and data sharing capabilities along with establishing a community-wide data sharing system that brings together providers and data from the health and social services sector.**

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: Community reinvestment requirements can be a useful strategy to not only address SDOH but can also be leveraged to increase provider capacity, bolster infrastructure, and expand the scope and quality of services provided through the Medicaid program. As the Division considers changes to its community reinvestment program, we offer the following ideas that reflect and help support the needs and goals outlined by the Division in improving health outcomes and also effectively serving the rural and frontier areas of the state.

- Allow MCOs to allocate a percentage of the 3% required investment to support provider network investments including technical assistance and capacity building activities targeted specifically for primary care providers.
- Support or incentivize MCOs to work collaboratively in a region to maximize the collective impact of the community reinvestment funding.

Section 7: Other Innovations

7.A. 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: Nevada has a strong Medicaid Managed Care Program today that brings value to members served. That value will only be enhanced as the program is expanded into new regions of the state and a larger part of the population gains access to managed care. As the Division enters the next phase of its program development, we encourage efforts to seek MCOs that can demonstrate performance, expertise and an ability to bring innovation to members within the Nevada Medicaid program. Strong collaboration and engagement between the Division and its MCO partners is required to administer and advance the Medicaid program effectively and efficiently. We encourage the Division to seek MCOs that can demonstrate partnership at all levels of the program from day-to-day operation to strategic program evolution design and implementation. In addition, we offer the following innovations and best practices for consideration to continue to offer a high value Medicaid Managed Care program for all Nevadans.

As the Division implements expansion of its Medicaid Managed Care Program, clear and regular communication to new members will be critical. We recommend the Division prioritize developing accessible and consistent messaging, in conjunction with its MCO partners, to support the transition. In addition, making sure the Division's data collection practices will support capture of verifiable, current contact information for future members, and expressly allowing MCOs to contact members before the transition into managed care, is strongly recommended.

In addition to the geographic expansion of the Medicaid Managed Care Program, strong consideration should be given to supporting expansion to populations and services currently carved out of managed care. Medicaid managed care drives a more integrated and person-centered care model with positive implications for a member's health outcomes, and also helps to improve stability and predictability in budgets, shifts risk and administrative burden away from the state, and promotes transparency, accountability, innovation, and competition. To achieve these system benefits, a comprehensive managed care program inclusive of all populations and services is recommended. A comprehensive program also creates more stability for MCOs, decreases

administrative burden for providers, and supports the statewide expansion and integration goals that the Division has laid out.

Specifically, the Division should include all eligible populations in the managed care program in all three regional service areas. Adding the aged, blind and disabled (ABD) population into the statewide managed care program would be a good first step and soliciting stakeholder feedback on the future of integrating children and youth in the care and custody of the state in managed care is another area for the Division to investigate.

We also recommend that the Division consider all of the flexibilities afforded through the Medicaid waiver process inclusive of the ability to serve new or broader populations, extend or add new services, and test new ways to pay for services. We specifically applaud the Division for actively pursuing the Medicaid Reentry Section1115 Demonstration Waiver Opportunity to cover a package of pre-release services for individuals who are incarcerated, eligible for Medicaid, and returning home to their communities for at least 60 days prior to an individual's expected release date. As part of that application, we recommend the Division consider how it can be leveraged to address the unique transition of care needs for justice-involved youth and create a pathway for a whole person approach to care for this population using the flexibility of the waiver authority.

We also recommend working with Native and Tribal leaders to establish a native and traditional healing benefit through an 1115 demonstration project. While the Centers for Medicare and Medicaid Services (CMS) has signaled the need to further study this practice, many other western states have been working deliberately with their native and tribal communities to incorporate a Medicaid benefit for programs such as native dance rituals, plant treatments, and traditional massage. This is a culturally responsive approach to establishing new benefits in the Medicaid program, and by working in partnership with native and tribal leaders, the Division can develop a unique but historically valued well-being benefit.

Lastly, to effectively support the health and well-being of all members, it is important that there are data sharing practices between the state, providers and MCOs that support the sharing of critical health information. Specific to children and youth in the care and custody of the state and native and tribal members, there are currently gaps in data sharing processes that impact the ability to support a whole person approach to care for these populations. As the Division expands the Medicaid Managed Care Program, we encourage consideration of ways to support cross system sharing of information. This includes establishing practices that support information sharing when children and youth served by the child welfare system are transitioning from the fee-for-service system to managed care and reconsidering the current practice of having Indian Health Service clinics bill the state directly versus having those claims submitted to the MCOs.