June 14, 2024

Nevada Division of Health Care Financing and Policy
1100 East William Street Suite 101
Carson City, NV 89701

To Whom It May Concern,

Anthem Blue Cross and Blue Shield (Anthem) is excited to offer our input to the Nevada Division of Health Care Financing and Policy (the Division) regarding their efforts to enhance the Coordination-only Dual Special Needs Plan (CO D-SNP) program.

Anthem has served as a trusted partner for the health of Nevadans for nearly half a century, including 4 years as a D-SNP and 15 years as a Medicaid managed care entity. As an organization with a rich history of serving Nevadans, Anthem welcomes the opportunity to provide our perspective and recommendations through this collaborative public engagement process. We leverage our local knowledge with the best Medicaid and D-SNP practices gleaned through our parent company, Elevance Health, Inc., and its affiliate health plans, who collectively serve more than 9 million Medicaid members across 24 markets as well as more than 585,000 D-SNP members across 21 markets.

We appreciate the opportunity to share our thoughts and look forward to continuing the dialogue about ensuring access to care for dually eligible members across all of Nevada.

Sincerely,

Todd Benson, Regional Vice President, Medicare West Region
Nevada Dual Eligible Special Needs Plan, Anthem Blue Cross and Blue Shield

Nevada Coordination Only Dual Special Needs Plan (CO D-SNP) Program

1. Addition of Federal Requirements

1. Addition of federal requirements such as health risk assessments with mandated screening tools, maintenance of an enrollee advisory committee, tracking of beneficiary cost sharing, and identification of providers that serve both Medicare and Medicaid beneficiaries in the network provider directory.

Nevada's CO D-SNP SMAC will incorporate all Centers for Medicare and Medicaid Services (CMS) federal requirements. To the extent applicable, the Division seeks input on information and data sharing needs to support CO D-SNP compliance with these requirements.

Response

Model of Care Demographic and Agency Contact List

Anthem holds great regard for the collective efforts and acknowledges the paramount importance of adhering to the Model of Care (MOC) coordination requirements stipulated by the Centers for Medicare and Medicaid Services (CMS). This includes the incorporation of health risk assessments, the formulation of Individualized Care Plans, and a specialized care team to ensure efficient Care Coordination. We understand that such coordination leads to improved access to care and fosters substantial cost savings.

Anthem suggests that the Nevada Division of Health Care Financing and Policy (DHCFP) permit Dual Eligible Special Needs Plans (D-SNP) to proceed with their own proprietary health risk assessment tools. This is, however, under the condition that plans comply fully with all CMS and state social determinants of health (SDOH) requirements if applicable. We propose the State require specific questions or insertions but still allow flexibility. To further enhance coordination efforts, plans would benefit from access to comprehensive Nevada Department of Health and Human Services (DHHS) reporting, which would include State enrollee Medicaid data for D-SNP beneficiaries. This report should detail D-SNP member Medicaid programs and services, contact points such as Area Agencies on Aging (AAAs), State waiver service coordinators, demographic information (not limited to race, ethnicity, language, and living status), health condition flags, and other relevant information providing a full scope of Medicaid service engagement. Access to data reporting allows the D-SNP coordination team to mitigate overlap and coordinate with the member and care providers who support and render Medicaid benefits that are not covered by the D-SNP.

As recent as CY2023, Anthem liaised with the DHHS Office of Analytics to gather data to aid the development and renewal of our MOC. We propose this report detail be provided to D-SNPs annually. The data requested and needed is the full Nevada duals information landscape, not specific to a plan. This information will allow D-SNPs to identify similarities and differences in the Nevada duals and allow plans to make appropriate modifications to MOC, plan design, and identify potential chronic condition programs. We also believe that with more expansive and comprehensive data, D-SNP plans can significantly improve coordination with DHHS community agencies, State case management agencies, and waiver service coordinators.

To ensure seamless collaboration and strengthen our relationships with relevant stakeholders, D-SNP plans should also receive an updated list of agencies and Medicaid program contacts twice a year. Having access to this enhanced data and regularly updated contact list will

expedite the management of conditions upon enrollment and allow for swift changes to contact information, broadening outreach efforts.

Enrollee Advisory Committees

D-SNP Enrollee Advisory Committees (EACs) meetings are a critical component of member service experience in the D-SNP space. Anthem has had success with an approach that relies on Town Hall calls, which are facilitated by our marketing team and include a representative sample of D-SNP members and their representatives. EACs are used to solicit and collect member insights on a variety of topics, but with a primary focus on members' experience with understanding, accessing, and using benefits. Focusing on traditionally underrepresented member communities and including partially eligible members would also provide valuable clarity through the EACs.

EACs do not have to focus on members exclusively. Expansion into providers and other community representatives such as family supports for D-SNP members would open the opportunity to better identify and meet member needs, implement person-centered care, and identify gaps in services including health-related services. An updated and expanded EAC approach would better support plans' ability to collect direct feedback from members and generate actionable recommendations that represent the diverse perspectives of a health plan's membership.

Beneficiary Cost-Share Tracking

From the D-SNP member perspective, correct management and reporting of the cost-share calculation is an important indicator of the value of a D-SNP program. Transparency in the Explanation of Benefits (EOB) that members receive also allows for a better comparison of D-SNP to standard Medicare Advantage programs and demonstrates the utility of Medicaid benefits as applied to the service. For Medicare Part A and Part B services, D-SNP members benefit where copays are eliminated through the application of the Nevada Medicaid benefit.

CMS has offered valuable best practices that could be adapted to the D-SNP program, including specific recommendations for reporting of payments of cost sharing and the data elements necessary to effectively oversee plan payments. Adapting from the State's fee-for-service systems would ensure alignment between the Medicaid and Medicare Advantage systems serving D-SNP members and has the potential to eliminate confusion, especially at the point of inquiry by a member.

Assuming the continued enrollment of most Nevada D-SNP members in the fee-for-service Medicaid program, precision in the coordination of benefits as it relates to cost-sharing offers the state the value of a more accurate calculation of the cost of Medicaid expenditures to cover Medicare copayments and, at a program level, additional predictability of D-SNP cost of care.

However, the tracking of cost share involves additional analysis. Since 2017, Medicare has required the designation of qualifying plans as Zero-Dollar Cost Share plans. However, the determination of whether a plan qualifies implicates provider contracts, State Medicaid benefits at the service level, and the member's health plan type. Health plans have the responsibility to ensure proper designation at the plan level and correct descriptions of a given

plan in marketing materials. In cases where an out-of-network provider could still trigger a cost-share, for example, a plan would not be designated as Zero-Dollar Cost Share. This requirement benefits the member and moves the administrative burden to the plan. Anthem views this as an appropriate compliance responsibility for plans.

Identification of Providers Serving Medicare and Medicaid in Provider Directory

Finding suitable, accessible providers, such as the behavioral health (BH) providers who are so critical to the management of Nevada members, can be challenging and overwhelming for individuals, particularly for those who need to sort through separate Medicare and Medicaid providers. Because maintenance of the relationship with an existing provider is frequently cited as a driver of plan selection for D-SNP members, it is essential members have access to timely, accurate information about a plan's provider network.

To address this issue, states can ask D-SNP plans to develop a single directory encompassing both Medicaid and Medicare providers. A unified directory, such as the one implemented in Tennessee, can simplify the provider search process and make it easier for individuals to find the right provider.

A unified directory also promotes a robust Medicare Advantage network and may improve member access, especially in rural areas, as Nevada plans a statewide expansion of its Medicaid managed care program. The policy also promotes further D-SNP alignment, in which members experience less administrative burden and more efficiencies because both Medicare and Medicaid providers are sending claims to the same entity.

The combined strategies of integrating provider directories and aligning provider networks could significantly enhance the accessibility and coordination of health care services for members and increase provider satisfaction.

2. Covered Populations

2. Currently, health carriers offering CO D-SNPs must enroll the following dual eligible populations: Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary (QMBs), and Qualified Medicare Beneficiary Plus (QMB+). The Division seeks input on the scope of dual eligibles that may enroll in the CO D-SNP.

Response

Anthem acknowledges the unique needs of dual eligibles in Nevada and fully comprehends the potential opportunities to align seamlessly with the State's mission to maximize the performance of the D-SNP program. We propose this can be achieved by including partial duals and expanding the integration model. This approach would not only ensure enhanced service provision but also contribute significantly to cost savings. Further, this will promote the transition to a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) program.

We suggest that DHCFP consider broadening its D-SNP eligibility categories beyond Qualified Medicare Beneficiary (QMB), Full Benefit Dual Eligible (FBDE), and Qualified Medicare Beneficiary Plus (QMB+). This would include partial categories but only if a full dual plan is accessible to serve as a potential transition pathway. The inclusion of partial duals enables D-SNPs to preempt beneficiary health condition decline while ensuring maximum efficiency, thereby converging with DHCFP's mission to provide quality health care to low-income Nevadans and constrain health care cost growth.

With Anthem's D-SNP leveraging its deep understanding of Medicaid's benefits and services and collaborating with essential community resources – such as Certified Community Behavioral Health Centers and home and community-based services (HCBS) waiver coordinators – there is an immense opportunity to streamline care for dual eligible beneficiaries. Currently, Medicare MCOs coordinate all duals' care, transitioning beneficiaries to Medicaid fee-for-service (FFS).

Anthem's recommendation for the D-SNP program to have discretion in eligibility expansion comes from our extensive experience with our current D-SNP enrollees and our familiarity with other D-SNP states that have similar demographic profiles and conditions. We believe that D-SNPs can effectively enhance the Care Coordination efforts specific to dual subpopulations, especially those requiring BH and Substance Use Disorder (SUD) treatment. Many Nevadans in need of BH and SUD services fall into this category and continue to require these services after enrolling in Medicare. A more integrated D-SNP model, inclusive of partial dual eligibles, could enhance Care Coordination efforts with state and community partners.

One additional recommendation is passive enrollment into the Medicaid-aligned D-SNP for Medicare age-ins, with an option to opt out. This could promote a smoother transition that mitigates any potential gaps in care and enhance collaboration with specialized clinics and agencies. Through improved Care Coordination, we can help stabilize enrollees, offer necessary follow-ups and debriefings, and identify suitable referral sources for ongoing community BH Services.

This approach could also support cost reduction while continuing care under the MOC, offering a more seamless continuation of services between Medicaid and Medicare eligibility stages. A focus on critical services such as out-of-home placement, specialized mental health services,

and therapies can further enhance this model, providing necessary support from community resources and social service programs.

Another reason for this approach is that it would align with CMS' final rule requiring exclusive alignment between Medicare and Medicaid plans, potentially minimizing future transition abrasion for enrollees and reducing impact on providers. This constructive collaboration underlines our shared commitment to quality care for Nevada's dual eligible population.

3. Covered Populations

3. Currently, all health carriers offering CO D-SNPs in Nevada must make such plans available to eligible Nevadans in Clark and Washoe Counties as authorized per CMS with rural counties as optional service areas. Nevada intends to expand the mandatory service areas for CO D-SNPs statewide over the term of the contract. Bearing in mind various network adequacy standards and CMS' approval of service areas, what factors or options should the Division consider with respect to a phased-in timeframe for achieving a statewide expansion of CO D-SNP operations?

Response

Expanding the service area for CO D-SNPs statewide to cover all Nevada counties, including those encompassing the most rural areas, will bring consistent, coordinated care as well as expanded access to some benefits and services to the most rural Nevada residents.

The following factors should be considered with respect to a phased-in timeframe for achieving statewide D-SNP expansion while remaining compliant with current CMS and State adequacy standards and requirements:

Minimizing Provider Abrasion. Expanding Medicaid managed care to Nevada's rural counties may require a phased-in implementation approach to minimize provider abrasion as the selected MCOs collaborate with rural providers on credentialing, contracting, education, and training. It will be critical for the State to partner with selected MCOs and key stakeholder groups, such as the Nevada Hospital Association and Nevada Rural Hospital Partners, on rate structures, policies and procedures related to prior authorizations, claims processing and denials, and payment innovations.

Contracting with Out-of-State Providers and Distance Access to Care. To accomplish a successful statewide rollout of the CO D-SNP, it is essential to highlight the significance of engaging with out-of-state providers, specifically for the benefit of residents in the State's rural communities. The approach to cater to the medical needs of members who reside in rural Nevada will hinge on a collaborative strategy with out-of-state providers while bearing in mind the potential extended commuting distances that might be required by some members for specialty care**.** Network adequacy requirements, including specifics related to provider type as well as time and distance standards, may necessitate a phased-in implementation in the rural expansion counties.

Data Integration. The ability to maximize data integration and data sharing capabilities is critical to a successful expansion of D-SNP service areas, particularly in rural areas. Ensuring access to timely, accurate, and complete data in all counties may require a phased-in implementation approach. Minimal data integration and sharing capabilities should be established for rural providers to ensure all members receive appropriate preventive and follow-up care. Establishing the minimum standards, facilitating access to appropriate systems, and coordinating with providers in contiguous counties may require additional implementation time.

Additional Considerations

In addition to the factors outlined above, there are additional options and best practices that the Division should consider in achieving statewide expansion of D-SNP:

- Leverage telemedicine providers, both in-state and out-of-state, to address needs in rural areas.
- Consider rural member patterns of care when evaluating networks to recognize out-of-state providers who members rely on.
- Influence CMS to maintain the Medicare fee schedule and not make further cuts (as primary D-SNP payer).
- Ensure policies and future contracts allow plans the flexibility and capacity for innovation required to successfully implement the Value Based Insurance Design model as applied to rural populations facing access challenges.

4. Change of Supplemental Benefits

4. There are eight core Supplemental Benefits currently offered by CO D-SNPs as outlined here. Are there other supplemental benefits the Division should consider to best serve and enhance member experience as well as to improve access to services?

Response

Anthem acknowledges and appreciates that the eight core D-SNP supplemental benefits offered by Nevada's CO D-SNPs are valuable and do well in supporting the needs of dual eligible members. In addition to these supplemental benefits, Anthem suggests the Division permit more flexibility in the supplemental benefits D-SNPs may offer, with the goals of improving health outcomes, enhancing member experience, increasing access to services, and addressing health-related social needs. Through a collaborative process that is data-informed, we suggest tracking utilization of these benefits and the flexibility for plans to alter benefits in prescribed intervals to achieve the outcomes the Division is seeking.

Enhancing Member Experience

To enhance the member experience in the upcoming Contract period, Anthem would suggest application of the following guiding principles for supplemental benefits:

- Flexibility – As indicated above, member preference for flexibility in program design is reflected in member feedback and increasingly built into program design across markets.
- Adaptability – Member needs are constantly evolving. The need for technology-infused services or tech-enabled providers is an example of a changed environment for member services that plans need the freedom to explore if they are to best serve the often high-need members who make up our dual membership.
- Individuality – No service can be standardized in its application because all members are not the same and an individual's needs change over time. Benefits must contain the capacity to be tailored to the individual.

Anthem would strongly encourage the State to offer D-SNPs greater flexibility in deploying these supplemental benefits, so that they may more individually tailor D-SNP plans with these additional benefits to enhance the overall well-being of their members.

Improving Access to Services

Anthem would recommend and support the inclusion of a broader Health Related Social Needs (HRSN) supplemental benefit category to further expand access to services. Through this category, D-SNPs could deploy additional supports that reduce HRSN through strategies such as access to nutritious food, over-the-counter supports for health and wellness, personal care needs, and housing supports such as rent-mortgage flex funds and utility assistance.

Introducing mandatory selection from an approved list of supplementary health benefit choices can enhance members' plan experience as SDOH interventions continue to evolve and expand. This could further personalize individuals' access to health improvement benefits, leading to enhanced overall health and well-being. For example, the State could require D-SNP plans to cover any four to six supplemental benefits from a longer list, or alternatively, must cover one to two benefits from each of two to three benefit categories.

5. Quality Measures and Reporting

5. To enhance the quality of the CO D-SNP program for recipients, Nevada will begin utilizing the Medicare Advantage Star Ratings and Model of Care as a requirement under the SMAC to monitor and track performance of awardees. Throughout the contract period, anytime CMS requires a corrective action plan of a Medicare Advantage organization, a copy of that corrective action plan must be submitted to the Division for review. The Division is seeking input on consideration of these preferred measures. The Division is also seeking feedback on other measures or requirements it should consider as part of the upcoming RFP and SMAC to improve the quality of the CO D-SNP program and access to services.

Response

Anthem proposes the Model of Care (MOC) scoring, along with the CMS-National Committee for Quality Assurance (NCQA) detailed summary, be used to determine a D-SNP's effectiveness. We also recommend D-SNPs submit the CMS MOC scores and detailed summary within 30 days of CMS approval. The MOC detailed summary and score will demonstrate how MOC quality metrics have been met, upheld, amended, or improved as well and verification of ongoing revalidation of effectiveness. This will allow the D-SNP to show its commitment to meeting the needs of Nevadans.

The Division's proposed plan to use the Star Ratings and MOC scoring system as preferred measures is sound in that the Star Ratings assess member outcomes, care, access, and satisfaction across a variety of domains. The goals set by the D-SNP within the MOC should remain flexible, given they incorporate appropriately identified Star and Healthcare Effectiveness Data and Information Set (HEDIS®) measures for the plan. We are open to future discussions about specific measures that encourage State health improvement targets and collaborative partnerships.

This proposed collaboration aims to identify correlating Star measures that support an increased integration and evaluation focus on high-risk groups. Moreover, it supports the long-term waiver population, with the suggested later implementation of a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). This will meet the CMS requirements for duals integration as well as match Health Management Associates' recommendation to the Division for a 2030 implementation alongside a companion managed long-term services and supports (MLTSS) program.