Compliance

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.

CareSource recommends and participates in data sharing and reducing member and provider burden with standardization. We support a standardized health risk assessment (HRA) and agree that data sharing can increase quality of services for members. Operationally, we recommend the maximum sharing of data using one adopted data sourcing hub for health records that is available to all managed care plans (MCPs). This will allow participating plans to access existing data sources and use that data to simplify the member experience, ultimately helping reduce the burden so members don't have to complete an HRA multiple times. Implementing one system can also make technology administration easier and more affordable for providers across Nevada. In addition, small clinics, mobile units, FQHCs, and other provider groups would be able to access and report care in real time with member approval.

Health Information Exchange

The key to supporting a CO D-SNP with data is the ability to share information among providers. To support a centralized data collection hub, we believe the Division should concentrate on improving the health information exchange (HIE) as it exists today, allowing for electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

By implementing contract provisions that facilitate or require data sharing across entities, the Division could improve coordination and avoid duplication of services for members. For example, the HIE can improve the completeness of patient records, resulting in a substantial positive effect on care. With access to the HIE, providers can collectively review previous history, current medications, and any other information during visits. CareSource believes integrated technology can assist in providing the best available care for members. It is crucial to choose adequate systems to efficiently create a culture of trust between the Division, hospital systems, and providers.

To ensure the most accurate and up to date information is being collected, we recommend the Division also share any available data through the designated centralized hub, which would provide MCPs with valuable data points. A centralized data collection hub also ensures members have access to the best network with the largest number of full Dual Providers, resulting in an improved member experience across all populations and improved provider experience.

Covered Populations

2. Covered Populations.

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.

CareSource agrees with the current populations covered through the Division's CO D-SNP. However, we request the Division consider the following additional recommendations as part of the scope of dual eligibles enrolling in the CO D-SNP.

Integrated Populations

Consistent with federal guidance that all states should move to fully integrated plans by 2027, the Division should consider adding Aged, Blind, or Disabled (ABD) and Long-Term Services and Supports (LTSS) populations to all Medicaid Managed Care contracts. By implementing a comprehensive approach to the care of populations with advanced opportunities for these individuals, health improvement is more attainable. This comprehensive approach focuses on the individual and is designed to leverage best practices for families and communities.

Exclusively Aligned Enrollment

Following the adaptation of integrated populations, the Division should consider having exclusively aligned enrollment to lessen member burden. The following benefits could be covered through the CO D-SNP or an affiliated MCP:

- Medicaid primary and acute care benefits
- Medicare Cost Sharing
- One of the following, at a minimum: Behavioral Health, LTSS, Home Health, or Durable Medical Equipment (DME)

Specified Low-Income Medicare Beneficiary Plus

We recommend the Division cover the Specified Low-Income Medicare Beneficiary Plus (SLMB+) as part of the CO D-SNP offering. The member's benefits include payment of the member's Medicare Part B premium in addition to traditional Medicaid benefits throughout each month of eligibility, including deductibles, co-insurance, and co-pays (except for Part D). The SLMB program also provides valuable assistance to beneficiaries with low income and limited resources, helping them to manage healthcare costs.

As a company that wants to win for the people we serve, CareSource understands that Medicaid wants to offer the best choice for members. We believe adding SLMB+ provides more options and flexibility, especially when a member's income fluctuates.

Behavioral Health Focus

We also recommend that each of the above category of duals listed should consider including a behavioral health focus.

Expansion of Service Area

3. Expansion of Service Area.

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?

With the Division's approval to expand the CO D-SNP operations to all counties, CareSource recommends Nevada consider developing a statewide program with regional emphasis.

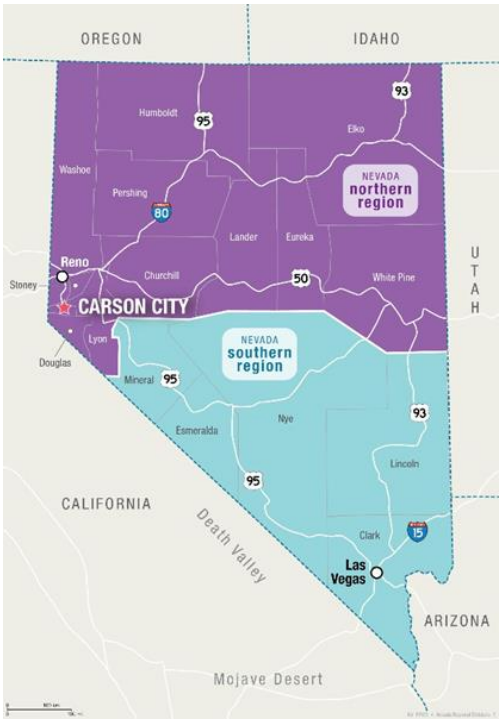
Rural and Frontier Integration

As the Division considers service area planning, we recommend a statewide plan that incorporates rural and frontier areas into a north-south regional model. In this model, as visualized in **Exhibit 1**, MCPs would be required to bid the north region, south region, or statewide.

Allocating the rural and frontier geographies into a north or south framework will encourage broader network coverage and provide a better member and provider experience through a phased in approach.

For example, we recommend two urban hubs - Washoe County and Clark County. By dividing the state into two halves, each of these hubs would cover the associated rural counties. Additionally, we suggest contract negotiations to incentivize urban hubs into creating an integrated system. By dividing Nevada in this way, we believe the northern counties have potential to pull resources from California while the southern counties can access resources from Utah, creating broader network access for members.

Exhibit 1: Northern and Southern Regional Model Option



We also recommend the Medicare service area expansion follow the Medicaid service area expansion roll out. This would allow providers and payers to contract both products at the same time to lessen administrative burden.

We believe year one should consist of collaborating with the Division through education on potential opportunities and advantages with a focus on critical access. Together, with the Division, we recommend working on a phased in approach that begins with the larger rural-urban counties such as:

- Douglas
- Carson
- Lyon
- Nye

Commencing year two, our recommendation would be to start phasing in the remainder of the rural counties, followed by frontier counties, with a timeframe approach of approximately 12 months for each frontier region added in the state. Given the opportunity to hub specialists in these areas while addressing network adequacy for areas where telehealth is the only option, we believe phasing in adequacy or changing adequacy language should include all virtual options.

A State requirement to contract across specific regions, including rural and frontier service areas and all populations, ensures an equitable population mix to help rate predictability. This approach can also help develop a stronger infrastructure to address coverage gaps.

Improved Alignment

To better align with the Division's goals for effectiveness and efficiency, we recommend a statewide plan integrating rural and frontier services with existing urban service areas to facilitate an improved member and provider experience, including the following.

- Improved member experience could include:
  - Increasing access to essential services
  - Improving health outcomes for all Nevadans
  - Improving integration for care coordination and care management
  - Strengthening coordination of benefits

- Improved provider experience could include:
  - Minimizing provider abrasion and decreasing provider burden
  - Reducing fraud, waste, and abuse
  - Improving coordination of services with integrated healthcare solutions for Native populations
  - Leveraging better pricing controls for prescriptions

- Alignment with Divisions goals could mean:
  - Improving data collection and goal-sharing as identified in the Nevada Health Equity Action Plan (HEAP)
  - Leveraging MCP infrastructure to better support and serve members
  - Coordinating resources to help resolve care gaps, manage workforce development, and recruit and retain necessary medical personnel
  - Improving implementation and easier member alignment
  - Significant cost savings for the Division
  - Strengthening support for health literacy and support of healthcare equity goals identified in HEAP

Change of Supplemental Benefits

4. Change of Supplemental Benefits.

There are eight core Supplemental Benefits currently offered by CO D-SNPs as outlined below:

- Dental
- Vision
- Non-emergency transportation to and from medical visits, including pharmacy
- Personal Emergency Response Systems (PERS)
- Nursing Hotline
- Telemedicine
- Meal Services after a hospital stay

Are there other supplemental benefits the Division should consider to best serve and enhance member experience as well as to improve access to services?

The table below represents the eight core Supplemental services the Division currently provides, in addition to the benefits CareSource recommends the Division offer to members eligible through the CO D-SNP.

Supplemental Benefit	Proposed New Benefit	Benefits That Enhance Member Experience	Benefits That Improve Access to Services
Dental		**X**	
Vision		**X**	
NEMT			**X**
PERS			**X**
Nursing Hotline			**X**
Post Discharge Meals		**X**	
Telemedicine			**X**
Hearing Aids		**X**	
Caregiver Support	**X**	**X**	
Remote Patient Monitoring	**X**		**X**
Behavioral Health	**X**	**X**	
OTC Prescription Card	**X**	**X**	
Housing Remediation	**X**		**X**

Caregiver Support

CareSource recognizes that the solution for developing strong caregiver supports does not lie with one organization. As a convener, we bring together innovative local thought leaders, community organizations, stakeholders, providers, and advocates to innovatively serve the CO D-SNP population including informal caregivers. The Division should partner with agencies and informal caregivers to provide viable solutions for caregivers as a result of collaboration. Respite programs, coordinated care information access, and similar resources should also be added benefits.

For example, in Michigan, Governor Gretchen Whitmer has announced a plan to ease the burden on families with tax credits up to $5,000[1]. These funds cover caregiver expenses including counseling, transportation, and nursing respite services.

Remote Patient Monitoring

There are many benefits to offering remote patient monitoring (RPM) to eligible individuals enrolled in the CO D-SNP. RPM technology integrates seamlessly within a member's home to provide peace of mind, a personal emergency response system, reminders and friendly check-ins, personalized response and support protocol, and stove support. Technology-enabled RPM allows members to monitor their chronic conditions and communicate results directly with the health plan or the provider's office so they can adjust in real time.

Providing RPM benefits to members not only helps improve self-management and care plan adherence, but also helps improve providers' clinical insight on a patient's status in between office visits and offers tools that inform proactive care delivery. The cost of caring for a patient remotely is less than typical brick-and-mortar costs and can reduce potentially avoidable emergency department admissions and readmissions.

Behavioral Health

Recognizing that nearly 60% of patients who receive behavioral health treatment from their primary care provider reflects the need for offering behavioral health services. CareSource recommends the Division add behavioral health services to the CO D-SNP supplemental benefits. As shown in recent years, there has been a growing focus on the varying mental health complexities of individuals. Offering behavioral health to eligible individuals enrolled in the CO D-SNP will help ensure all members have timely access to care that is focused on strategies and interventions to address their social and emotional needs and prevent the development or exacerbation of behavioral health issues.

For example, social isolation adversely affects a member's physical and mental health. Therefore, we recommend offering platforms to improve member and family connectivity through tools like a member portal or digital solutions. These address social isolation needs by connecting members with loved ones while also allowing for emergency outreach. This type of connection can provide members with valuable support services while combating thoughts such as loneliness or suicide.

Over-the-Counter Prescription Card

Members can earn rewards for healthy activities such as completing prenatal or wellness visits. Rewards are added directly to a member's Over-the-Counter (OTC) card, and they can use their cards at participating retailers when the member's provider advises a healthy activity has been completed.

Housing Remediation / Social Determinants of Health

Social determinants of health refers to the social and economic needs individuals experience which affect their ability to maintain their health and well-being, such as housing, which is not currently covered under Marketplace plans. By improving access to health care and services outside of traditional medical care and focusing on a member's specific social determinants of health, we can realize:

- Improved utilization rates
- Better chronic disease management and maternal health outcomes
- Improved recidivism rates
- Empowered members moving toward self-sufficiency and improved healthcare system navigation
- Social supports for all populations, including fostered youth and those transitioning out of foster care
- Reduced healthcare costs
- Diminished health disparities

Through routine and periodic re-screenings of health risks to proactively detect and address emerging needs and ensure each member's care plan is current, members are stratified into the appropriate risk

[1] Governor Gretchen Whitmer, 2024 State of the State Address: https://www.michigan.gov/whitmer/news/state-of-the-state/2024-state-of-the-state

level, and they receive services matching their needs. Outreach to re-administer screenings should be completed in intervals and at least annually.

Quality Measures and Reporting

5. Quality Measures and Reporting.

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.

We agree with the use of Medicare Advantage STARS Ratings and Model of Care requirements under the SMAC to monitor and track performance of MCPs.

As an accredited organization, CareSource believes the Division should require all MCPs to hold accreditation. Accreditation contributes to the assurance of high-quality care and adherence to industry standards with dedication to the quality care provided to members.

In addition, we would recommend tracking for the recommendation for HRA required screenings and including the Division of Health Care Financing and Policy (DHCFP) feedback for future planning and incorporating the Division's focused initiatives.

Any additional measurements or requirements should align with the quality goals put forth by the Division as determined by the work of DHCFP. Specifically, DHCFP will develop a strategy for procurement and contracting that promotes quality improvement and strengthens the Division's oversight of the CO D-SNP plan.

Along with the above recommendations and having reviewed the available quality scores, we recommend the Division require true scores be utilized in lieu of narrative when defining the role of quality. A Model of Care (MOC) scoring exercise has demonstrated the value of numbers when comparing to narrative, which clearly details MOC standards and elements at the contract level.