Division of Health Care Financing and Policy Solicitation of Public Input Regarding Dual Special Needs Program Procurement

Submitted to:
Department of Health and Human Services
Division of Health Care Financing and Policy
CO D-SNP State Medicaid Agency Contracts (SMACs)
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Due by June 17, 2024, at 5:00 PM PST

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June 14, 2024

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RE: Division of Health Care Financing and Policy of Public Input Regarding Dual Special Needs Program Procurement

Thank you for the opportunity to provide public input on critical items for a future Dual Special Needs Program Procurement for the Coordination Only Dual Special Needs Plan. Molina Healthcare of Nevada has submitted below a response to all five questions included within the Request for Information.

Again, we appreciate the opportunity to provide input on these critical issues. Thank you for your continued partnership with Molina Healthcare of Nevada.

Sincerely,

Rob Baughman

Molina Healthcare of Nevada, Inc.

Re: Division of Health Care Financing and Policy Solicitation of Public Input Regarding Dual Special Needs Program Procurement

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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.

Data sharing among managed care organizations (MCOs), providers, and the State is crucial for ensuring compliance with CMS federal requirements, supporting continuity of care, promoting transparency, and facilitating effective communication. We therefore encourage the development of **data sharing agreements, policies, and tools that simplify data sharing** across the healthcare system. We support and applaud the continued development of the **all-payer claims database**. It is a scalable example of simplified data sharing that will provide opportunities for all D-SNP plans to use claims history, avoid duplication of services, and promote consumer engagement.

We further encourage the State to consider allowing data sharing between D-SNP MCOs and FFS providers of services not covered under managed care that will allow collaboration on care coordination. Bidirectional information sharing ensures all parties have accurate and timely information to promote continuity of care that best supports members, to the extent permitted under HIPAA and other applicable laws. We also recommend **convening stakeholders to develop processes** for streamlining data collection, access, and sharing. Stakeholders across Nevada have varying levels of access to tools and systems for data sharing. This collaborative effort increases transparency, identifies barriers to data sharing, and facilitates coordinated care. **Standardized data collection and education** at every level are fundamental to ensuring all stakeholders understand the impact of health disparities on outcomes. Clear standards help maintain consistency and quality in data management.

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.

Molina agrees that CO D-SNPs should be required to enroll FBDE, QMBs, and QMB+ populations and encourages the State to expand choice to all partial dual beneficiaries. All full and partial dual eligible enrollees face a multitude of challenges, including lower incomes and a higher prevalence of social risk factors and needs; higher risk for poor health outcomes associated with age or disability; a fragmented, unaligned service delivery system; and a complex social support system that can be confusing to navigate. D-SNPs demonstrate better health outcomes for all dual eligible populations.

According to CMS, as of March 2023, 52% of Nevadans currently have partial Medicaid benefits[1]; however, CO D-SNPs are not required to offer coverage to those who are partial dual eligible (e.g., Specified Low Income Beneficiary, Specified Low Income Beneficiary Plus, Qualifying Individual categories). By including all partial dual population categories, these Nevadans are afforded the option to elect the benefits of managed care that typically include care coordination, value-based provider payment models, supplemental benefits, and social supports. Consistent with Nevada's rebalancing objectives, these managed care strategies translate to earlier interventions that help dual eligible

[1] Centers for Medicare and Medicaid Services, "MMCO Statistical and Analytic Reports," CMS.gov, https://www.cms.gov/data-research/research/statistical-resources-dually-eligible-beneficiaries/mmco-statistical-analytic-reports, 2024, accessed June 1, 2024.

individuals improve and sustain functional abilities and independence, which help individuals age in place. Inclusion of partial dual eligibles into CO D-SNP plans will also decrease confusion for caregivers, family members, and volunteers who educate seniors on their Medicare choices annually. The Medicaid categories of aid that determine an enrollee's eligibility are not always clear to those who are supporting dual eligible individuals. Often, this lack of clarity results in frustration among consumers and caregivers due to the inability to access the benefits they see advertised. Additionally, the State should allow flexibility to revisit FBDE enrollment in CO D-SNPs, in the event it pursues Medicaid managed care for dual eligibles.

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?

Molina supports the State's efforts to expand the mandatory service areas for CO D-SNPs statewide. To fully support enrollees, providers, and D-SNP plans, we recommend the State continue to maintain flexibility and a phased-in approach. We suggest prioritizing areas that have the highest populations of dual eligible enrollees to provide options to those enrollees as quickly as possible. The major obstacle to getting a statewide D-SNP is network adequacy. Two factors that contribute to the delay in building an adequate network are an insufficient number of providers in the area and exclusive provider/payer relationships. For CO D-SNPs, CMS requires an adequate network nearly 10 months prior to the go-live date of D-SNP products, which demands a very advanced time frame that further supports a phased-in approach. For example, for a January 1, 2026, go-live date, network adequacy must initially be submitted to CMS in February 2025, with a notice to CMS of the intent to expand required in November 2024.

While CMS provides certain conditions for a plan to receive an exception request, if there is even one available provider in the area that meets time and distance requirements, a plan will likely not meet an exception request by CMS. In counties where there are limited providers for required CMS specialties, it will take time for MCOs to build rapport with such providers to create a network that meets network adequacy requirements. We recommend the State collaborate with MCOs in initial education efforts to inform providers on the benefits of Medicare for both them and their patients, particularly in the rural counties with low Medicare penetration. For example, in Elko, Pershing, and Lander counties, the penetration rates are below 2%. In Eureka and Esmeralda, the Medicare penetration rate is at 0%.

Second, it is in the best interest of the State, MCOs, and providers to expand enrollees' access to care. Therefore, to support greater access for enrollees, we recommend the State explore opportunities with CMS to restrict or discourage CO D-SNPs from forming exclusive provider arrangements in Health Professional Shortage Areas to support greater access for enrollees, which may be accomplished via a provision in the SMAC.

4. **Change of Supplemental Benefits.**
   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?

While the current eight Nevada core Supplemental Benefits address the historical needs of many health plan members, it is important for the State to allow benefit innovation to prioritize health equity and address SDOH. This includes allowing the State's CO D-SNPs the flexibility to offer more supplemental benefits that meet the diverse needs of the dual eligible populations served to enhance their overall well-being and address their specific healthcare needs. Additionally, the State should continue to allow its CO D-SNPs to solicit input from Nevadans on supplemental benefit preferences and customize its product solutions based on consumer needs. Engagement with Nevadans, coupled with their input, affords health plans an increased understanding of the implications of these updates and enables them to make necessary adjustments. The central goal is to continue to provide highly accessible, high-quality care and services to D-SNP enrollees that is tailored to meet their unique needs.

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.

Molina fully supports driving quality improvement with the use of Medicare Advantage Star Ratings and the Model of Care as preferred measures. By using Medicare Advantage Star Ratings and the Model of Care under the SMAC to monitor and track performance of Contract awardees, the Division will ensure all awardees will be measured equally using a consistent set of standards.

Molina agrees that CO D-SNPs should submit copies of their CMS corrective action plans (CAPs) to the State to promote transparency and opportunities to improve an integrated experience for individuals receiving Medicare and Medicaid services. Furthermore, we encourage the Division to require CO D-SNPs to notify the Division when a CMS CAP is closed.

We ask that the State align and communicate preferred measures or topics selected for D-SNPs with **CMS National Quality Strategy goals**: Equity and Engagement; Outcomes and Alignment; Safety and Resiliency; and Interoperability and Scientific Advancement. These broad-based goals will allow for greater consistency between the State and CMS priorities. The following list expands on the importance of incorporating CMS measures, along with recommended topics that further support CO D-SNP plans and the State to meet CMS goals.

- **Equity and Engagement.** We support measures that stratify results by geography, zip codes, and SDOH, as available, to address disparities. We recommend the addition of the Antidepressant Medication Management (AMM) HEDIS measure to support person-centered care for enrollees with chronic conditions, such as depression.
- **Outcomes and Alignment.** We support measures that focus on reducing institutional lengths of stay and the importance of other measures that can help enhance enrollee satisfaction and health outcomes. We recommend the inclusion of NCQA's Initiation and Engagement of Substance Use Disorder Treatment (IET) measures to establish standards for supporting individuals undergoing substance use disorder treatment.

- **Safety and Resiliency.** Meeting these goals, such as the management of chronic conditions, can support long-term treatment and the improvement of enrollees' quality of life and prevent complications. We recommend key physical health and behavioral health (BH) measures be used, specifically those that focus on follow-up after BH stays and emergency department visits, to support safe and coordinated care for enrollees discharged from inpatient or emergency department settings.
- **Interoperability and Scientific Advancement.** Adhering to these goals will guide how health plans collaborate with the State and each other in information-exchange processes and other strategies to ensure the implementation of effective data-exchange policies with providers. We encourage the State to work with CO D-SNP plans, providers, and other stakeholders to further enhance interoperability through health information exchanges and electronic health records. The D-SNP population has complex physical health, BH, social, and functional needs that will require effective management from a coordinated healthcare system and high-functioning data sharing processes to achieve healthcare objectives. Adhering to these goals will have a far-reaching and positive impact on the State, CO D-SNP plans, providers, and enrollees.