Prominence Health

This document is in response to the **Nevada Medicaid Solicitation of Public Input Regarding Dual Special Needs Program Procurement** and has been prepared by:

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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.

To ensure optimal efficiency, we recommend that the Division consider the following data sharing requirements:

Batch Eligibility: To assist the eligibility process, implementing batch eligibility through the automation of data (e.g., 270 or 271 data pathways) would enhance the health plan's ability to ensure accurate eligibility into the program. Aligning the eligibility process with enrollment processes on a monthly cadence is recommended.

Medicaid Provider Participation: The Division should ensure health plans are informed about provider Medicaid participation and enrollment. Health plans need access to an up-to-date roster of providers enrolled/registered with Medicaid in the state of Nevada. This data should be accessible electronically via data feed or API connections to streamline operations. Furthermore, having this information assist health plans in having up-to-date provider directories, which helps beneficiaries access timely care.

Health Risk Assessment (HRA): Each health plan's HRA is a vital tool to assess member risk using a standardized questionnaire. Since each plan's HRA may vary significantly, we do not recommend a standardized HRA. Instead, we support monitoring HRA administration through the form's quality measure. Health plans should continue to submit the quality measure to the state and CMS according to regulatory cadence.

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.

   We recommend that the Division considers expansion of eligible population to include SLMB and SLMB+. We make this recommendation to enhance affordability and quality of care.

   SLMB+ enrollees have Medicaid coverage, whereas non-plus SLMB members are excluded. Given the limited resources and income of this subset, it is recommended that the Division consider including non-plus SLMB members in contracts. Although non-plus SLMB members are not eligible for Medicaid services, their Part B premium is covered. Through a D-SNP plan, this subset will receive enhanced benefits and access to case management support and programming.

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?

   We recommend that the Division consider the necessary resources and time required for a new service area expansion. Traditional network expansion typically requires a minimum of twelve months, encompassing tasks such as partnering with providers to establish clinic operations, strengthening operational processes for the expanded network, credentialing additional providers, broadening broker relationships, and enhancing quality and performance monitoring. Additionally, CMS mandates that Medicare Advantage plans submit Service Area Expansion (SAE) networks for adequacy review in February of the prior contract year. For example, the health plan would submit to CMS in February 2025 for a 2026 operational go-live.

   In addition to the timeline considerations for expanding a network in a given service area, additional factors must be addressed when considering rural counties in the eastern portion of Nevada, which significantly lack adequate network options. To offer sufficient access in these

regions, it is expected that plans will need to partner with providers in other regions to expand or offer satellite clinic access options.

The Division may want to consider regional service areas as opposed to statewide. In this approach, a CO D-SNP would be required to offer plans in one major metropolitan county (Washoe or Clark) and a number of neighboring rural counties to make up a service region. For example, health plans operating in Clark County would also be required to offer services in the other surrounding counties (e.g., Lincoln, Nye, Esmeralda, White Pine etc.) Statewide services area can create isolation for the smaller rural counties, and a regional approach would assist in keeping intact regional and local partnerships.

Should the Division opt to expand the mandatory service areas for CO D-SNPs statewide over the term of the contract., our recommendation is to plan a two-year phased timeframe for achieving a statewide expansion of CO D-SNP operations, with a goal of expanding to 30% of the remaining counties within the first year, and all expansion counties by the second year. For example, if the health plan has ten counties outside their service area at the time of the SMAC effective date in 2026, it would be required to expand to three counties by 2027 and all ten by 2028.

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?.

   We recommend that the Division does not require or deem mandatory supplemental benefits without consideration of the health plans' efforts to tailor the plan benefits to the population(s) being served. Such additional benefits would seek state-funding support. Also, caution should be applied to not overlap Medicaid & Medicare Supplemental benefits as it would be duplicative and potentially wasteful. Increased standardization reduces the capacity for innovation and over-allocates funds to benefits that do not translate to better health outcomes. Additionally, funds that are allocated to mandatory supplemental benefits limits the funds that could be directed to the Value Based Care model. Furthermore, the type and need of supplemental benefit varies drastically throughout the state, and certain mandatory supplemental benefits may not be available or useful across the state.

We recommend that the Division avoid mandating supplemental benefits without considering the health plans' efforts to tailor benefits to the populations being served. Such additional benefits would require state funding support. Care should also be taken to avoid overlapping Medicaid and Medicare supplemental benefits, as this would be duplicative and potentially wasteful. Increased standardization reduces the capacity for innovation and allocates funds to benefits that may not lead to better health outcomes. Furthermore, allocating funds to mandatory supplemental benefits limits the resources that could be directed to internal health plan care management programs and interventions that are not considered plan benefits in the traditional sense of the term.

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.

Our recommendations to improve the quality of the CO D-SNP Program include minimum performance standards, corrective action controls and consider featuring certain quality measures as areas of focus and performance transparency statewide. We also believe that the CMS Plan Star Rating program is a robust and effective way to monitor health plan quality, and should be leveraged to reduce additional administrative burden and/or cost associated with running parallel quality reporting programs.

- CMS Plan Star Rating Minimum Performance: The health plan must achieve and maintain a minimum of 3.5-star rating to qualify for inclusion in the CO D-SNP Program.

- Corrective Action Plans: The health plan will undergo a mandated corrective action plan if the star rating falls below 3.5 stars.

    - If the health plan remains below 3.5 stars for two consecutive years, it should be deemed ineligible for the D-SNP program.

    - Bidding health plans must meet or exceed the minimum star rating threshold to be eligible for a DNSP SMAC.

We recommend featured the following CMS Plan Star Rating measures as part of the D-SNP Plan Performance Monitoring Program listed below. Furthermore, we recommend the Division consider some form of transparency in reporting to beneficiaries so that they can make informed decisions around DSNP plan selection.

- CAHPS
    - C19 – Getting Needed Care
    - C23 - Rating of Health Plan
- HEDIS
    - C05 – Special Needs Plan (SNP) Care Management (Health Risk Assessment Administration)
    - C06 - Care of Older Adults - Medication Review
    - C07 - Care of Older Adults – Pain Assessment
    - C15 - Plan All-Cause Readmissions
- Administrative
    - C26 - Members Choosing to Leave the Plan