Response to the Request for Information for the Coordination Only Dual Special Needs Plan (CO D-SNP) Program

State of Nevada Department of Health and Human Services
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Transforming the health of the communities we serve, one person at a time

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.

INFORMATION AND DATA SHARING TO SUPPORT CMS COMPLIANCE

Through information and data sharing, D-SNP plans play a critical role in ensuring program integrity, transparency, and accountability by allowing the Division to monitor compliance with CMS requirements. D-SNP plans should maintain and share complete, accurate, and timely beneficiary information to support the Division in monitoring D-SNP operations, access to care, and care coordination. To facilitate information and data sharing, we encourage the Division to continue to maintain secure data exchanges with D-SNP plans.

Health Risk Assessments. We encourage the Division to support use of valid, comprehensive, and standardized health risk assessment and screening tools to ensure consistency and reliability in data. We recommend the following measure domains be included in assessment and screening tools: cognitive, psychosocial, medical, behavioral, functional, and social determinants of health (e.g., transportation, housing, and food insecurity). D-SNP plans should be equipped with systems to collect, share, and report Health Risk Assessment information and data collected from screening tools with the Division. For a more seamless experience that reduces potential duplication, we encourage the Division to support integrated Medicare and Medicaid assessment processes. D-SNP plans should have capabilities that allow for the ability to build upon assessments with added rules such as skip pattern logic, auto-calculation, or field validation. Shared information from assessments and screenings supports the Division in monitoring assessment/screening completion rates, gaps in care, and population health needs of beneficiaries across D-SNP plans.

Enrollee Advisory Committee. Direct member and caregiver involvement and input are critical to establishing meaningful programs that support D-SNP operations and individual health goals. D-SNP plans should solicit formal input on their operations, policies, materials, programs, and services through a D-SNP Enrollee Advisory Committee (EAC) at least annually. EACs are useful tools for connecting with members and caregivers to better understand their experiences with their D-SNP plan. For transparency and to increase attendance, D-SNP plans should share in advance with members and caregivers meeting dates, locations, agendas, and materials. Sharing meeting details with the Division such as individuals involved, activities, and outcomes of the EAC fosters accountability and transparency and provides detailed information to demonstrate CMS compliance. Examples of EAC input that can be shared include complaints, improvements, recommendations, and concerns.

Tracking of Beneficiary Cost Sharing. Communicating to beneficiaries that they have full cost sharing protection (also referred to as "Zero Cost" protection) is critical for establishing trust

and assurance for those in D-SNP plans who often have the greatest needs and barriers to care. We encourage the Division to eliminate any possible Medicaid cost sharing on Medicare Part A and Part B benefits to promote access to care and prevent confusion to beneficiaries. For those beneficiaries who do have cost sharing obligations, we encourage the Division to share the specific A/B services and co-pay or cost-share amounts with D-SNP plans by January of the bidding year (e.g., January 2025 for Coverage Year 2026). This information enables D-SNP plans to accurately communicate benefits to beneficiaries, collect, track, and share beneficiary-level cost sharing data, and produce reporting on co-payments, coinsurance, out-of-pocket costs, and/or deductibles.

D-SNP plan systems should be able to receive claims and apply allowable costs against patient liability to ensure beneficiary responsibility is met. Collecting accurate beneficiary-level cost sharing data allows D-SNP plans to calculate maximum out-of-pocket expenses over time. D-SNP plans should also be equipped with systems to apply waivers, exemptions, or reductions to cost sharing rules and to share information back to beneficiaries and providers, so they easily understand the financial obligations of care. D-SNPs should share with the Division reports and information on the amounts the beneficiary paid toward their copayment, coinsurance, and/or deductible for the covered services on the claim. D-SNPs should also share with the Division data and information on beneficiary inquiries, complaints, grievance, and appeals associated with cost sharing (e.g., charges or billing errors).

Identification of Providers that Serve Both Medicare and Medicaid Beneficiaries in the Network Provider Directory. D-SNP plans should support aligned provider networks by recruiting providers for participation across both Medicare and Medicaid. Development and maintenance of D-SNP provider networks should consider inclusion of high-quality providers with proven experience serving Medicare and Medicaid beneficiaries. Aligned provider networks promote continuity of care and improve beneficiary access to providers. D-SNP plans should maintain accurate, complete, and timely provider network data identifying aligned providers through internal data management systems. This allows online and printed provider directories to display if a provider services both Medicare and Medicaid. D-SNP plans should be equipped with systems and quality assurance mechanisms to update provider data on a regular basis to ensure information in directories is timely to avoid inaccurate or outdated information which could impede access to care. Information on network providers directories should be easy to find and easily understood by beneficiaries. D-SNPs should also be equipped to share with the Division information and reporting on provider network directory data identifying these aligned providers.

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.

EXPANDING SCOPE OF DUAL ELIGIBLES THAT MAY ENROLL IN THE CO-D-SNP

SilverSummit HealthPlan (SilverSummit) recommends the Division assign a second D-SNP Plan Benefit Package (PBP) to serve partial dual members. CO D-SNPs have requirements beyond standard Medicare Advantage plans. Although partial dual eligibles may not require the same level of benefit integration as fully dual eligibles, they have unique needs beyond those of the typical Medicare-only population that the CO D-SNP could meet.

Partial dual eligibles can benefit from a CMS-approved model of care with supplemental benefits tailored to meet their specific socioeconomic and medically complex needs. This population relies on the Medicare Savings Program to lower their out-of-pocket costs and/or premiums. Having access to a CO D-SNP PBP will further reduce barriers to care and improve health outcomes and member satisfaction. Members will receive care management and complete annual health risk assessments to understand gaps of care. Members will complete screenings to identify their social needs and the CO D-SNP will refer them to community-based organizations for services.

Expanding the scope of dual eligibles that can enroll in the CO D-SNP also reduces state costs by:

- Coordinating and managing care received
- Improving care access
- Tailoring benefits to eliminate waste
- Investing in dual-focused benefits for improved health outcomes and increased independence

Both Medicare Advantage and CO D-SNP members who utilize supplemental benefits experience a significant reduction in inpatient admissions and days, and a higher rate of PCP visits.

CMS will not approve or renew a non-D-SNP plan if more than 70% of total enrollment is dually eligible, which includes partial duals. If the Division does not allow partial duals to enroll in D-SNPs, there is a risk the non-SNP plans will exceed the 70% threshold resulting in CMS plan termination and member abrasion.

3. EXPANSION OF SERVICE AREA

Currently, all health carriers offering CO D-SNPs in Nevada must make such plans available to 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 timeframe for achieving a statewide operations of CO D-SNP operations?

Our parent company, Centene Corporation, has participated in Medicare-Medicaid Plans since their first launch in 2014, demonstrating our deep commitment to State and Federal partnerships for innovation and improved member outcomes. SilverSummit has been serving CO D-SNP members since 2021. From 2021 to 2023, SilverSummit successfully expanded our CO D-SNP operations from four to eight counties, covering approximately 97% of Nevada's dual eligible members. SilverSummit supports the Division's intention to expand CO D-SNP operations statewide over the term of the contract.

ACHIEVING STATEWIDE EXPANSION OF CO D-SNP OPERATIONS

Considering Network Adequacy Standards Within Expansion Timeframe. Member access to providers in rural and frontier counties is a challenge in many states, including Nevada. SilverSummit recommends the Division consider the following network adequacy suggestions when planning the statewide expansion:

Adopting Exchange network adequacy standards. SilverSummit recommends that the Division adopt the Exchange network adequacy standards approved by the Nevada Department of Insurance for Marketplace. The Exchange network adequacy standards determine adequacy on a regional basis instead of by county and will enable managed care plans (MCPs) to successfully meet network adequacy requirements in rural and frontier counties. We recommend the Division submit a request to CMS for similar network adequacy exceptions for CO D-SNP.

Selecting MCPs with established statewide provider networks and experience serving CO D-SNP members. SilverSummit recommends the Division award contracts to MCPs with experience developing and managing Exchange networks. MCPs with proven statewide relationships with providers offer multiple benefits to the State, members, caregivers, and providers, such as:

- Established contracts and relationships in the expansion counties to meet network adequacy standards quickly and efficiently.
- Reduced administrative burden for providers. Providers already contracted with an MCP to serve Marketplace members in the expansion counties would have a more seamless contracting experience through an addendum to their existing contract. Additional administrative functions, such as timely filing rules and quality adherence programs, may be consistent across products to create less burden on providers.
- Seamless access to care for individuals who move to other counties.
- Strong network foundation if the Division elects to carve in any new populations or services to managed care in the future.

- Established reciprocity agreements with providers in bordering states.

Ensuring sufficient payment rates and reducing administrative burden for rural providers. MCPs with statewide contracts have established relationships and understand the needs of rural providers in Nevada. SilverSummit recommends that the Division:

- Encourage MCPs to implement value-based payment measures.
- Encourage MCPs to implement innovative and proactive payment strategies.
- Encourage MCPs to increase alignment of processes for Medicaid and Medicare.

Planning Appropriate MCP Infrastructure to Coordinate Services. SilverSummit recommends that the timeframe for expanding CO D-SNP operations statewide affords MCPs ample time to recruit, hire, and train qualified staff to serve members and providers in rural and frontier counties.

Planning Multi-Stakeholder Education for Successful Statewide Expansion. SilverSummit recommends that the phased-in statewide expansion of CO D-SNP Operations include planning for multi-stakeholder education. The stakeholders would ideally include members, caregivers, providers, MCP staff, and the broader community. The education would include benefits of Medicare and Medicaid integration and/or coordination across the physical health, behavioral health, and LTSS continuum of care, aligned with other Division programs and State health care initiatives. The Division and the MCPs providing CO D-SNP services could collaborate to provide education on the benefits and operations of the CO D-SNP.

Assisting Providers with Telehealth Capability. When planning the timeframe for statewide implementation, SilverSummit recommends that the Division account for the time MCPs will need to assist providers with establishing or expanding telehealth capabilities to increase access to the appropriate level of care for members and caregivers. Telehealth helps eliminate barriers to care created by limited numbers of providers and transportation options in rural and frontier counties. It is also helpful for members and their caregivers in all geographic areas who are homebound.

Obtaining CMS Approval of Service Areas within Expansion Timeframe. MCPs will need to complete developing their provider networks by December of the same year in which CMS releases its annual network adequacy standards and submit the provider network to CMS by February of the following year. MCPs will need to complete developing their provider networks at least 12 months prior to CO D-SNP go live.

Tiered CO D-SNP Implementation. To complete the extensive application process required by CMS and address the factors identified above, SilverSummit recommends the Division consider a tiered CO D-SNP implementation. We recommend the initial implementation include nine counties with higher populations: Carson City, Churchill, Clark, Douglas, Lyon, Mineral, Nye, Storey, and Washoe. Completing the provider network and submission to CMS for the remaining, less populous counties will entail the same factors and timeframes noted above.

Combining Requests for Proposals (RFPs). SilverSummit recommends the Division combine the CO D-SNP RFP with the upcoming Medicaid RFP. This would require one response from MCPs. One combined contract would reduce administrative burden for the Division, providers, and MCPs. Less administrative burden may attract more providers, including those in rural counties with workforce shortages and lean staffing patterns, to serve eligible members.

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?

EVALUATING AND UPDATING SUPPLEMENTAL BENEFITS

Medicare Advantage (MA) Plans submit an annual Medicare bid each year in June in advance of the effective calendar year, and in consideration of emerging CMS regulatory requirements, rules, and MA Capitation Rates and Part C and Part D Payment Policies (the Rate Announcement). The eight core Supplemental Benefits currently offered by CO D-SNPs align with the core set of supplemental benefits that MA Plans evaluate each year in anticipation of a plan benefit package that will meet the needs of Nevada's dual enrollment beneficiaries.

SilverSummit recommends the Division allow MCPs to evaluate and update supplemental benefit offerings annually during this process to ensure regulatory and actuarially sound offerings for each benefit year that will address member needs throughout the anticipated three-year contract. Allowing MCPs to adjust these critical benefits each year based on member need, Enrollee Advisory Committees, market surveys feedback, and utilization trends will ensure MCPs offer the most relevant benefits centered on member needs and access.

SilverSummit encourages the Division to consider adopting the following practices between the Division and MCPs, to optimize member experience and access:

- In addition to the Medicare Required Annual Wellness Exam, SilverSummit encourages the Division to consider inquiring about an MCP's intent to offer an additional Annual Physical Exam. This Annual Physical Exam offers an additional opportunity over a 12-month period for a provider to engage with the member and ensure they are addressing any preventive care needs, tests, and screenings, as well as managing conditions they may have.
- Annually, by mid-January of the bidding year, sharing the anticipated Medicaid coverage of any supplemental benefits, such as transportation, to ensure an aligned non-duplicative approach and anticipate appropriate coordination, maximizing available Medicare funds across other benefits not covered by the Division.
- Annually, by mid-January, sharing all anticipated Medicaid coverage of services in an agreed upon, data driven format for use in coordinating services, care, customer service, and materials. The Division's partnership in sharing this information will be essential to the MCP building a best-in-class experience for members and providers.
- In consideration of CMS's guidance on the definition of Zero Cost-Share Protected requirements for a DSNP plan, we request that the Division communicates any spend-down requirements to MCPs by mid-January. We encourage the Division to make every attempt to eliminate any spend-down or cost-sharing on Medicare A/B benefits for "full" duals (FBDE, QMB+, and SLMB+) as well as cost share protected partial duals (QMB) to maintain the ability to communicate these plans as intended – Zero Cost-Share Protected. SilverSummit has observed when a cost-share protected individual must navigate spend-down or cost-shares for Medicare A/B services, the member is confused about their coverage and will have a poor understanding and experience of their CO D-SNP plan.

- We recommend the Division encourage eligible MCPs to apply for the Value Based Insurance Design (VBID) program through the CMS/Center for Medicare and Medicaid Innovation (CMMI) separate annual application on or about mid-April of each bidding year. The MCP must request permission from CMS/CMMI to offer innovative benefits such as food and utilities, allowing the MCP to participate in the "demonstration" of said benefits to address social determinants of health or barriers to health equity.

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.

MEDICARE ADVANTAGE STAR RATINGS AND MODEL OF CARE

SilverSummit supports the Division's decision to use the Medicare Advantage Star Ratings and Model of Care to monitor and track performance for the CO D-SNP program. We will also submit a copy of corrective action plans when applicable to the Division for review.

HEDIS Measures Aligned with Stars and DHCFP Quality Strategy. SilverSummit recommends focusing on a core set of HEDIS measures relevant to the CO D-SNP population and prevalent conditions within Nevada. We evaluated these measures for alignment with Medicare Stars measures and the Nevada Division of Health Care Financing and Policy State Quality Strategy priority measures.

HEDIS Measures Aligned with Stars and the State Quality Strategy

Goals	HEDIS Measures (*align with Stars)
Goal 1: Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services	Adults' Access to Preventive/Ambulatory Health Services (AAP) Breast Cancer Screening (BCS)*
Goal 2: Increase use of evidence-based practices for members with chronic conditions	Controlling Blood Pressure (CBP)* Eye Exam for Patients with Diabetes (EED)* Glycemic Status Assessment for Patients with Diabetes (GSD)* Kidney Health Evaluation for Patients with Diabetes (KED)* Asthma Medication Ratio (AMR) Blood Pressure Control for Patients with Diabetes (BPD)
Goal 3: Reduce misuse of opioids	Use of Opioids at High Dosage (HDO)
Goal 4: Improve health and wellness of pregnant women and infants	We do not recommend using maternal and infant measures to track CO D-SNP program performance, as the member count would likely be too low to yield valid data.
Goal 5: Increase use of evidence-based practices for members with behavioral health conditions	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) Antidepressant Medication Management (AMM) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Follow-Up After Emergency Department Visit for Substance Use (FUA) Follow-Up After Emergency Department Visit for Mental Illness (FUM) Follow-Up After Hospitalization for Mental Illness (FUH) Initiation and Engagement of Substance Use Disorder Treatment (IET)

Goal 6: Increase utilization of dental services	We do not recommend measures related to dental care since managed care plans (MCPs) do not provide these services.
Goal 7: Reduce and/or eliminate health care disparities for Medicaid members	MCPs report stratified data on race and ethnicity in compliance with the HEDIS technical specifications published by NCQA. This information is captured within Cultural Competency trilogy documents and within Health Equity Accreditation requirements.
Additional Star HEDIS measures	Care for Older Adults Medication Review (COA MR)* Colorectal Cancer Screening (COL)* Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)* Osteoporosis Management in Women Who Had a Fracture (OMW)* Plan All-Cause Readmissions (PCR)* Transitions of Care (TRC)*

Model of Care Measures. SilverSummit supports use of the Model of Care. We recommend MCPs submit Model of Care measures appropriate to the population they serve using evidence-based practices that improve health outcomes, access to care, and health status. SilverSummit will share our approved Model of Care with the Division.

The National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services update specifications annually and SilverSummit incorporates new measures as needed. SilverSummit will work with the Division to update reporting as the needs of the CO D-SNP population change.

OTHER MEASURES AND REQUIREMENTS TO IMPROVE QUALITY OF THE CO D-SNP PROGRAM

SilverSummit recommends the State require MCPs obtain Health Equity Accreditation for the Medicaid plans supporting the D-SNP plans. Health Equity Accreditation demonstrates the MCP's capability incorporating health equity into their operations and commitment to eliminating disparities, aligning with State priorities.