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Nevada Medicaid ABD Program Analysis Project

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SECTION 1: THE CHALLENGE FOR NEVADA'S MAABD PROGRAM

Defining and Addressing MAABD's Challenges

Since the late 1960s, the State of Nevada has been providing Medicaid services to residents of limited socioeconomic means and with special needs to support their health and well-being. As one of the state's primary Medicaid programs, the fee-for-service (FFS) Medicaid delivery model supporting the needs of the Medical Assistance for the Aged, Blind, and Disabled (MAABD), has been providing long-term services and supports (LTSS), including home and community-based services (HCBS), to a burgeoning population of some of the state's most vulnerable people, including those who are frail and elderly and/or who have physical disabilities.

The largest, and growing, age group within the Nevada MAABD population are people aged 65 and older, forming nearly 48 percent of the MAABD population. Much of the MAABD population experiences fragmented healthcare because close to 70 percent of the population relies on Medicare as a primary source of coverage, with Nevada Medicaid as a secondary payer. In comparing the MAABD population with Nevada's total population, Blacks/African Americans (19 percent versus 10.8 percent) and Native Hawai'ian/Other Pacific Islanders (8 percent versus 0.9 percent) are overrepresented. Clark (home to Las Vegas) and Washoe (home to Reno) Counties account for 84.3 percent of the MAABD population in the state. However, the experience of the 15.7 percent of MAABD recipients living in rural counties with less access to LTSS services differs vastly from that of their urban counterparts.

Though the MAABD program has accomplished a great deal during its long history, Nevada recognizes that its LTSS services can be improved. In the 2023 AARP LTSS Scorecard, a comprehensive assessment of how each state's LTSS system performs, Nevada ranked 44th out of 50 states and Washington, DC. Though these results are not specific to services provided only to the MAABD LTSS population, they still show a pressing need for change. The significant challenges today and likely in coming years include:

- **The MAABD population has some of the greatest needs but experiences the most fragmented care.** The needs of participants in the MAABD program are inherently going to be larger than most of other populations qualifying for Medicaid since the MAABD population qualifies for coverage related to age and disability status. But because those participants are in an FFS system with limited case management or coordination with other state programs (such as D-SNPs), system inefficiencies and administrative burden jeopardize optimal health outcomes.
- **The MAABD program is costly**. Of the 904,158 enrollees in the state's Medicaid program as of December 2022, the MAABD population accounted for 15 percent (134,193) of the total enrollees but approximately 25 percent of all Medicaid spending.
- **At the same time, the MAABD program is relatively underfunded.** US spending on HCBS accounts for 63 percent of all LTSS spending, but Nevada spends only 57 percent of its LTSS dollars on HCBS. For older adults and individuals with physical disabilities, the AARP 2023 LTSS State Scorecard report showed that 53.3 percent of national LTSS spending went to HCBS, whereas only 33.5 percent of Nevada's LTSS spending went to HCBS.[1]
- **Geographic gaps exist in access to MAABD services.** Nevada's MAABD program meets federal Centers for Medicare & Medicaid Services (CMS) standards for having enough providers to care for the state's entire population (known as the network adequacy ratio). State staff interviewed for this project expressed concern about workforce shortages across just about all provider groups in rural Nevada.

To address these challenges, the state realized it must make concerted efforts to shift more LTSS dollars from institutional settings to HCBS settings and to increase access to care management and care coordination services for all MAABD participants to efficiently use available resources. In 2021, CMS approved Nevada's Section 9817 American Rescue Plan Act (ARPA) Home and Community-Based Services Spending Plan. The plan calls for the state to conduct three studies highlighting means to improve the MAABD program [2] and care for the MAABD population:

- Conduct a study to improve care delivery for the Aged, Blind and Disabled populations
- Lay the groundwork for developing value-based payment (VBP) models for HCBS services under MAABD
- Explore the potential benefits of introducing the Program of All-Inclusive Care for the Elderly (PACE) model of care for MAABD participants

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[1] AARP Public Policy Institute. Long-Term Services and Supports State Scorecard, 2023 Edition. Innovation and Opportunity: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. September 28, 2023. Available at: https://ltsschoices.aarp.org/scorecard-report/innovation-and-opportunity. Accessed February 26, 2024.

[2] The Aged, Blind and Disabled (ABD) population represents 13 percent of Nevada Medicaid recipients. As with the dual-eligible population, ABD enrollees often are among the highest users of services. Nevada has previously evaluated whether the ABD population would benefit from a managed care model. Most recently, Nevada had a Section 1115 demonstration waiver offering case management targeted to high-cost, high-needs recipients. With the continued increase in this population, Nevada would like to use the enhanced FMAP to assess various service delivery options for the ABD population under Section 9817 ARPA HCBS Spending Plan Narrative—Quarter 3 of Federal Fiscal Year 2023.

As outlined in DHCFP's initial ARPA Spending Plan letter, Nevada lawmakers recognized the importance of ARPA efforts by codified them in statute in 2021. The laws call for:

- Increasing access to HCBS
- Supporting disadvantaged communities
- Strengthening Nevada's workforce, supporting small businesses, and revitalizing the state's economy
- Investing in infrastructure
- Modernizing and enhancing state government services[3]

During an especially dynamic time in healthcare and social service reform, the Nevada Medicaid program and CMS have launched multiple initiatives to improve access and strengthen care delivery models. It is vital that Nevada align its MAABD program reforms with these other policy, regulatory, and operational initiatives rather than develop strategies in isolation. Achieving this alignment is Nevada's best chance to avail itself of possible synergies and funding opportunities, improve its support of the complex needs the MAABD population experiences, and boost the Nevada LTSS system.

[3] Weeks S. Section 9817 American Rescue Plan Act Home and Community Based Services Spending Plan Narrative − Quarter 3 of Federal Fiscal Year 2023, January 17, 2023. Division of Health Care Financing & Policy, Nevada Department of Health and Human Services. Available at: https://www.medicaid.gov/sites/default/files/2024-01/nv-spend-pln-ffy23q3.pdf. Accessed February 18, 2024.

HMA Scope and Approach

In March 2023, the Nevada Division of Health Care Financing and Policy (DHCFP) contracted with Health Management Associates, Inc. (HMA), a national healthcare research and consulting firm, to evaluate Nevada's MAABD program and the needs of its participants. The evaluation initially focused on HCBS services for the Frail Elderly (FE) and Physically Disabled (PD) waiver populations and implementation of the PACE model of care. It did not include a study of the Intellectual/Developmental Disabilities (ID/DD) waiver population. After focus groups were convened and feedback was considered, DHCFP determined that value-based payment (VBP)—a method of paying providers based on their ability to meet identified quality measures rather than volume of services—would not move forward as a priority for this project.

HMA's scope of work has included:

- Data analyses of Nevada's population and LTSS landscape, the state's ongoing efforts to rebalance LTSS dollars from institutional to HCBS services and demographic and other information about the MAABD population
- Stakeholder engagement, including three focus groups that engaged 55 stakeholders and individual interviews, to provide stakeholders a greater voice in the MAABD improvement process
- Evaluation of the MAABD structure and administration
- Program recommendations (in both written report and PowerPoint presentation forms) to help inform and guide DHCFP's considerations for better serving the FE and PD MAABD populations throughout the state

The scope of this project did not include analysis of payment rates, actuarial services, nursing home utilization and trends, or Nevada's Area Agency on Aging (AAA) program.

SECTION 2: THE MAABD POPULATION, PROGRAMS, AND REBALANCING

A solid foundation of the MAABD population's composition is necessary to then be able to understand how the population receives and uses key services, has access to services, and is supported in navigating care and service needs. This exploration, and later portions of this report, reviews much of what HMA learned through the structural analysis of the Nevada MAABD programs and population.

General MAABD Population

MAABD Population Data

The MAABD population includes disparate demographic and geographic groups. To understand the MAABD population's needs, it is necessary to understand its members' Medicaid enrollment, age and dual eligibility status, race/ethnicity, gender, geographic location.

The Division of Welfare and Supportive Services (DWSS) offers several Medicaid-related programs, including the MAABD program. As of December 2022, a total of 904,158 people were enrolled in the state's Medicaid program (see Figure 1).[4] Nevada Medicaid is the largest provider of health insurance in the state, covering approximately one in three Nevadans. The state ranks close to the midpoint in the percentage of the population with a disability.[5] Many disability-related costs in Nevada are preventable. The burden of depression, smoking, obesity, diabetes, and heart disease that people with disabilities disproportionately bear across the state suggests lack of access to high-quality preventive, primary, and behavioral health care.

The prevalence of disabilities in Nevada directly affects the state's healthcare costs. Approximately 34 percent, or $6 billion, of the state's annual healthcare spending is directed toward disability costs, averaging out to approximately $14,225 per person.[6]

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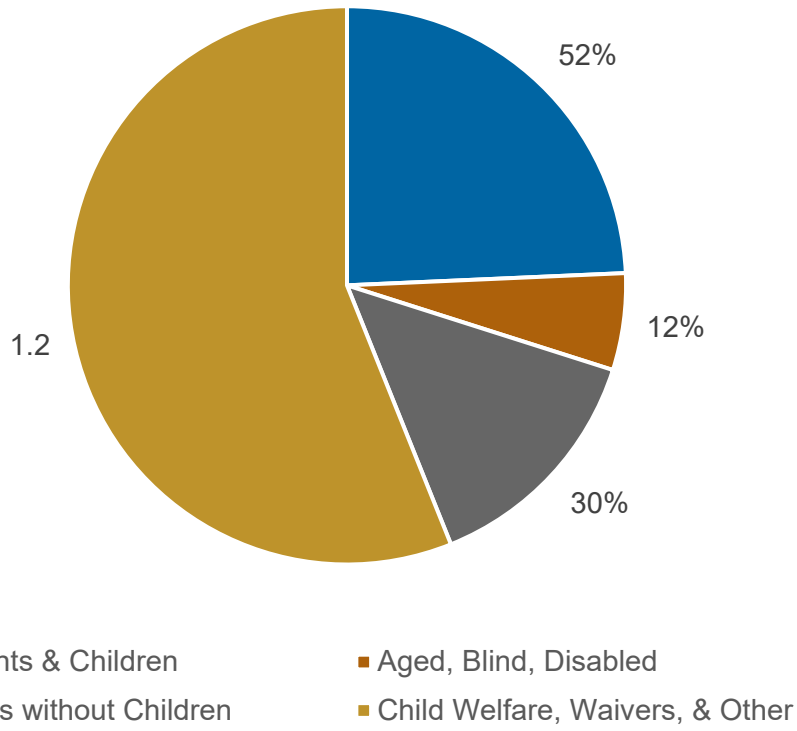
[4] Nevada Department of Health and Human Services. Monitoring Medicaid Enrollments, Disenrollments, and Renewals in Nevada. Available at: https://app.powerbigov.us/view?r=eyJrIjoiNWE2NWJjNDctZDJiMy00ZmRjLWJhMTktNDI3NzMyYmUwYTVkIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9. Accessed February 26, 2024.

[4] Disabled World. U.S. Disability Statistics by State, County, City and Age. Updated February 20, 2020. Available at: https://www.disabled-world.com/disability/statistics/scc.php#google_vignette. Accessed November 24, 2023.

[6] Centers for Disease Control and Prevention. Nevada Disability Estimates—2021. Disability and Health Data System. Available at: https://dhds.cdc.gov/SP?LocationId=32&CategoryId=DISEST&ShowFootnotes=true&showMode=&IndicatorIds=STATTYPE,AGEIND,SEXIND,RACEIND,VETIND&pnl0=Chart,false,YR6,CAT1,BO1,,,,AGEADJPREV&pnl1=Chart,false,YR6,DISSTAT,,,,,PREV&pnl2=Chart,false,YR6,DISSTAT,,,,,AGEADJPREV&pnl3=Chart,false,YR6,DISSTAT,,,,,AGEADJPREV&pnl4=Chart,false,YR6,DISSTAT,,,,,AGEADJPREV&t=1709083584875. Accessed February 27, 2024.

Elders Count statistics,[7] as well as data on older Nevadans' education level and rent burden,[8] suggest the population of individuals eligible for ABD will only continue to rise.

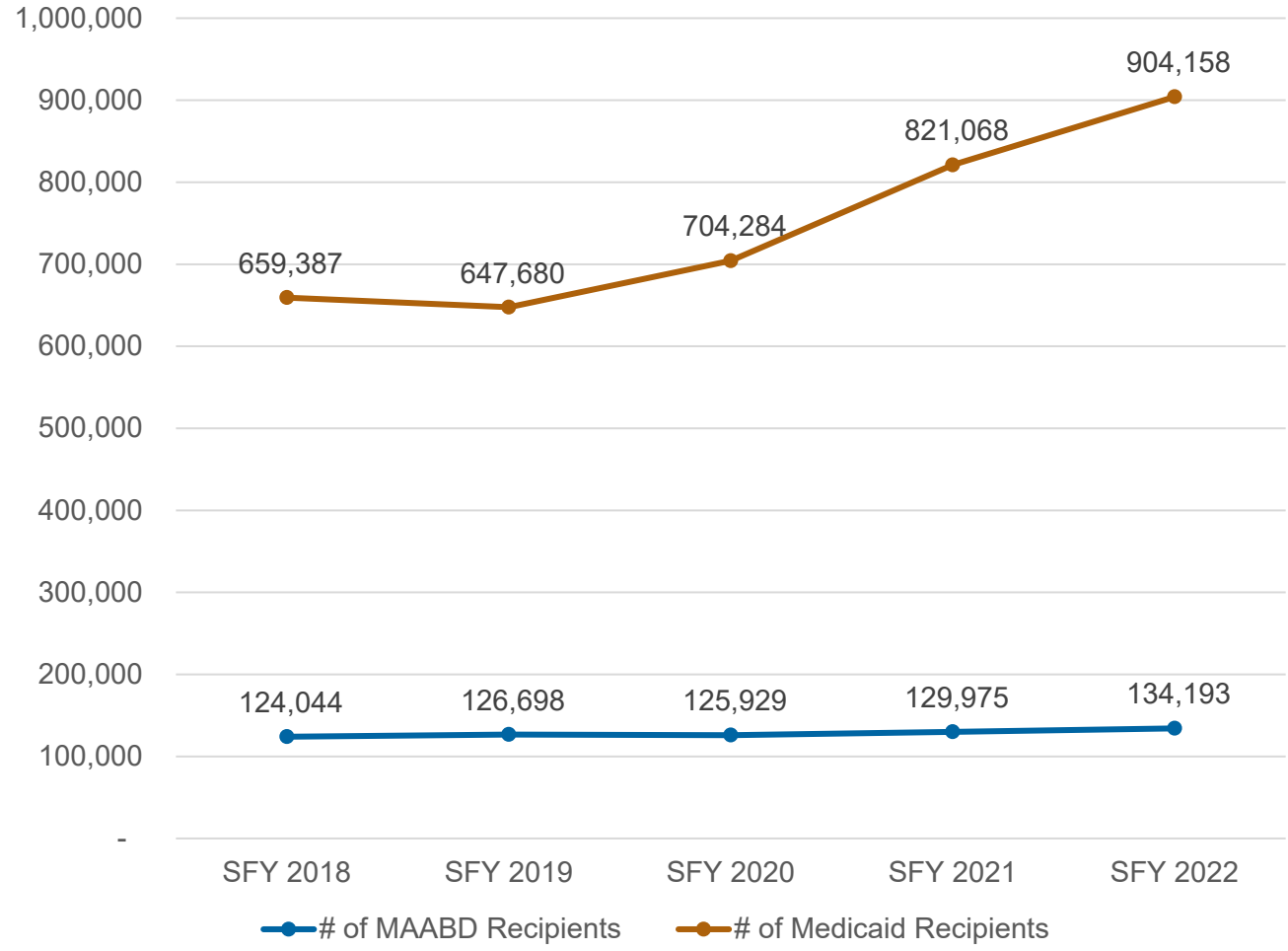
Figure 1. Nevada Medicaid Enrollment[9]



HMA's analysis revealed that in state fiscal year (SFY) 2022, the MAABD population accounted for 14.8 percent (134,193) of the total Medicaid population. Figure 2 compares the overall Medicaid enrollment growth with MAABD enrollment growth.

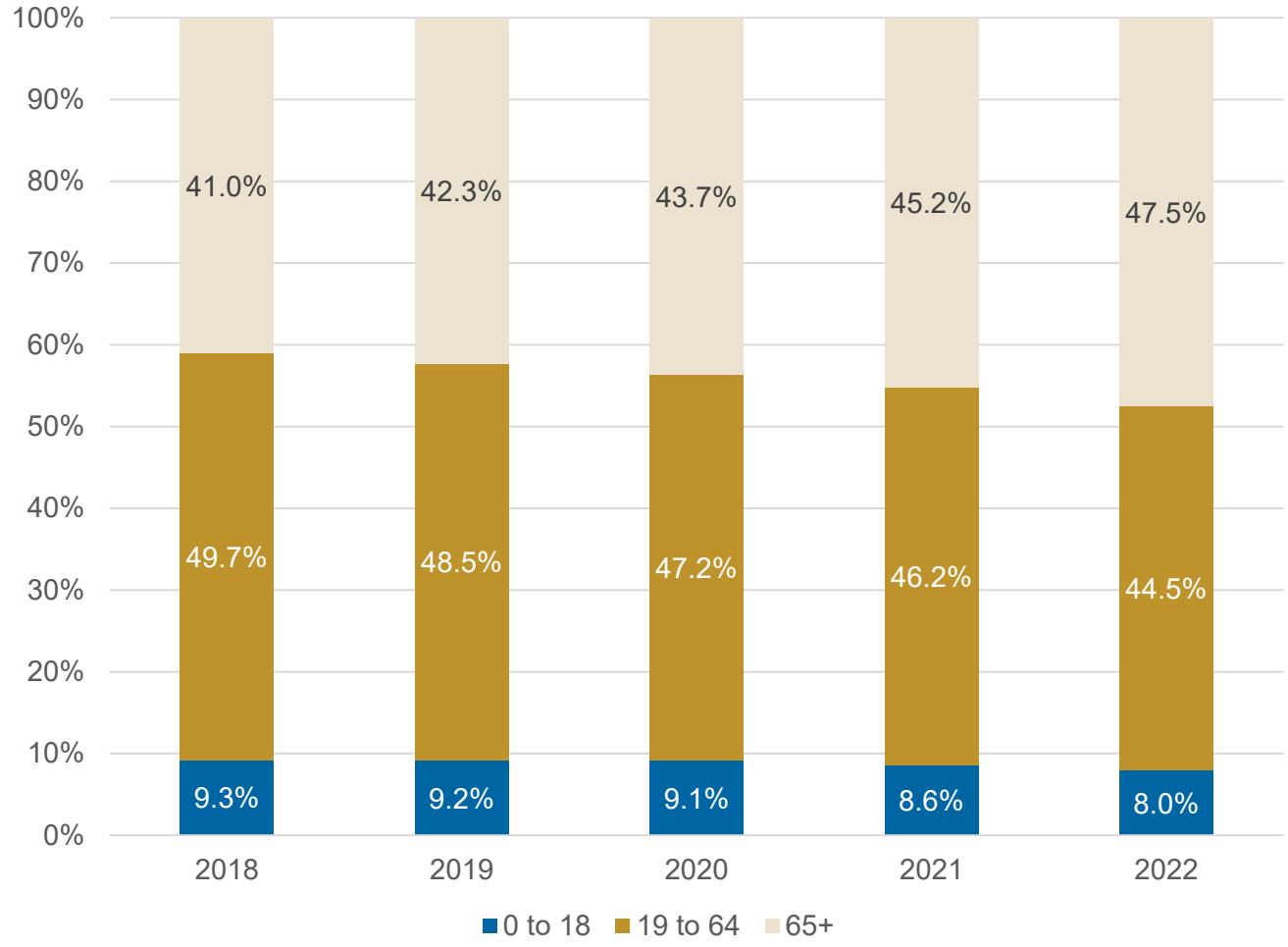
[7] Center for Healthy Aging. Elders Count Nevada 2021 Report. January 2021. Available at: https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders%20Count%202021%20-%20FINAL%201.28.2021.pdf. Accessed March 26, 2024.
[8] Lyle M. Rent Stabilization for Seniors Among a Handful of Bills Proposed to Address Housing Crisis. *Nevada Current*. March 31, 2023. Available at: https://nevadacurrent.com/2023/03/31/rent-stabilization-for-seniors-among-a-handful-of-bills-proposed-to-address-housing-crisis/. Accessed March 26, 2024.
[9] Division of Health Care Financing and Policy. *Nevada Medicaid Matters*. May 2022. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Medicaid%20Program%20Overview_2022_FINAL(2).pdf. Accessed March 26, 2024.

Figure 2. Comparison of MAABD Enrollment versus Medicaid Enrollment, SFY 2018–SFY 2022



Medicaid enrollment appears to be increasing more rapidly than MAABD enrollment. Since 2018, Medicaid enrollment has increased by 37.1 percent, and MAABD enrollment has increased by 8.2 percent. An isolated drop in the MAABD population between SFYs 2019 and 2020 is likely attributable to the effects of the COVID-19 public health emergency (PHE).

Figure 3. MAABD Population by Age Group, SFY 2018–SFY 2022



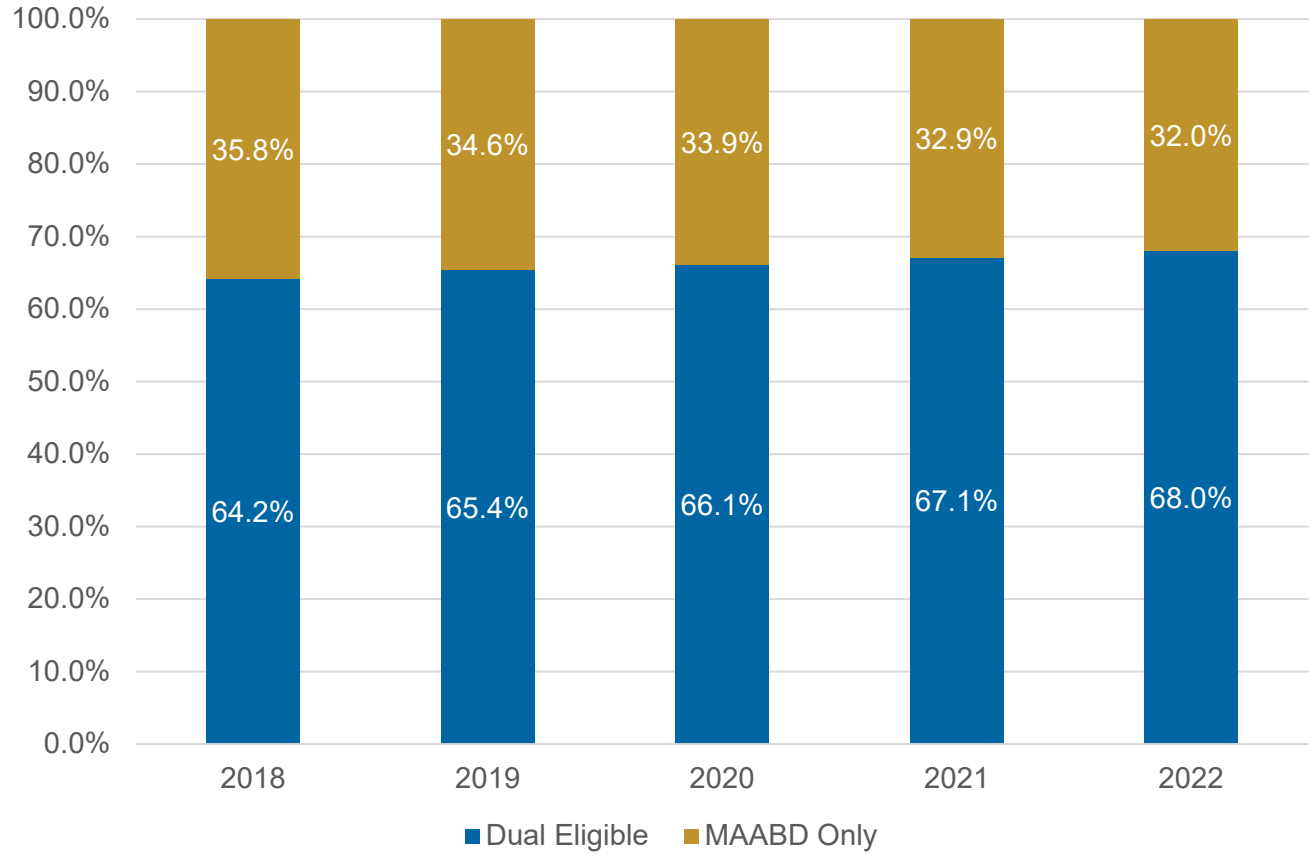
Individuals ages 65 and older are the largest and only growing age group in the MAABD population, accounting for nearly 48 percent of the MAABD population in SFY 2022. This percentage is slightly larger than the percentage of people in the same age range living in Nevada (46%).[10] Meanwhile, the percentage of all MAABD participants ages 64 and younger is declining. As of SFY 2022, participants ages 19–64 years old constitute a significant portion of the total population (44.5%), and participants ages 18 and younger comprise 8 percent of the population.

[10] Aging and Disabilities Division. Elders Count Nevada 2023 Report. 2023. Available at: https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders_Count_2023-Final.pdf. Accessed February 28, 2024.

The increase in individuals ages 65 and older and the decrease in individuals 19−64 years old is expected to place additional service pressure on Medicaid, as well as Older American Act (OAA) funded services and Senior Health Insurance Program (SHIP) support for Medicare enrollment. Still, a substantial number of the MAABD population are ages 19−64 and dually eligible and/or receiving PD waiver services. These data show Nevada will have to account for the unique needs of both age groups when program planning and cultivating workforce skillset and expertise that can serve the needs of people with disabilities and older adults.

As depicted in Figure 4, the number of people who are dually eligible for Medicare and Medicaid in the MAABD population has increased by 3.8 percent over the past five years. This trend runs parallel to the increasing older adult population noted above.

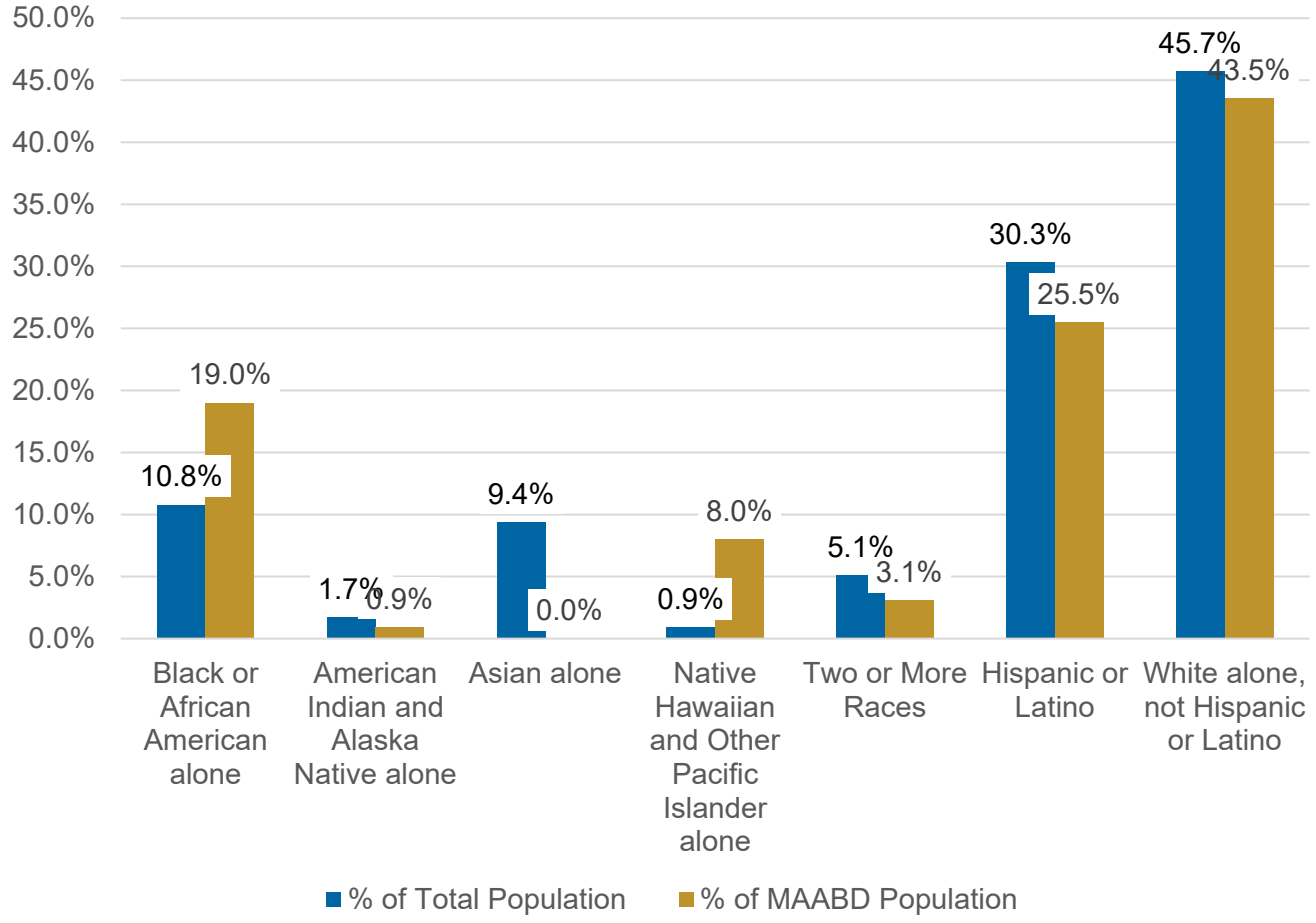
Figure 4. Percentage of Dually Eligible People in MAABD



Race/Ethnicity

Similarly, from SFY 2018 to SFY 2022, racial and ethnic breakdowns remained fairly consistent, with a few exceptions. Figure 5 below compares the race and ethnicity of the total population with the MAABD population.[11] Between 2018 and 2022, Native Hawai'ian/Other Pacific Islander MAABD enrollees experienced a 0.9 percent increase and Hispanic/Latinx MAABD enrollees experienced a 1.7 percent increase. The heightened enrollment of people who identify as members of these racial and ethnic communities can be attributed to various factors, including but not limited to demographic changes in the general population, increased or decreased outreach efforts to certain groups, and availability of providers in various communities. In comparison with the total population, Blacks/African Americans (19.0% versus 10.8%) and Native Hawaiian and Other Pacific Islanders (8.0% vs. 0.9%) are disproportionately represented in the MAABD population.

Figure 5. Racial and Ethnic Breakdown of Total Population versus MAABD Population, 2020



[11] US Census Bureau. : QuickFacts – Nevada. Available at: https://www.census.gov/quickfacts/fact/table/NV/PST045223. Accessed February 26, 2024.

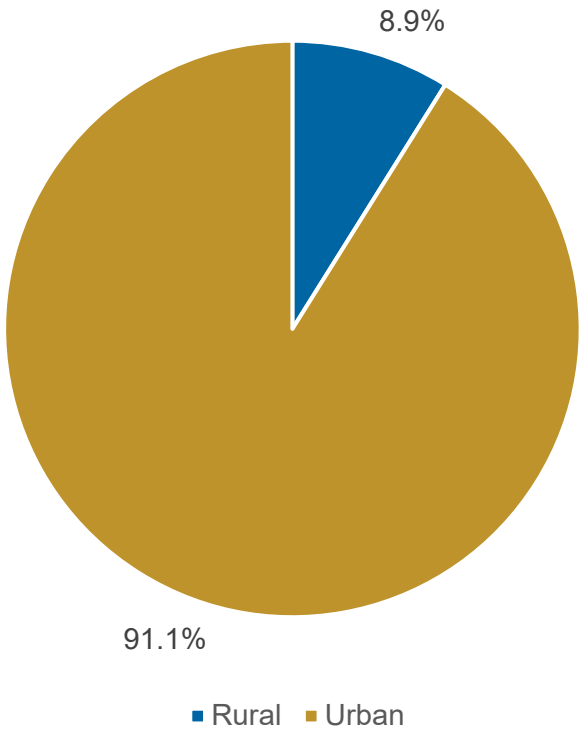
From SFY 2018 to SFY 2022, the gender breakdown has remained consistent within the MAABD population, with a slight increase in the number of women MAABD enrollees. The female MAABD population, at 66 percent, is notably larger than the male population of enrollees.

Geographic Distribution

Nevada has two large population centers in Clark and Washoe Counties that account for 44 percent of the state population and 12.51 percent of the Medicaid population. Clark and Washoe counties account for 84.3 percent of Nevada's MAABD population, with 15.7 percent of the MAABD population living across the rest of the state. Among the rural MAABD population, nearly 50 percent live in just four counties—Nye (2.4% of total MAABD), Carson City (2.1% of total MAABD), Lyon (1.6% of total MAABD), and Elko (1.1% of total MAABD). Five counties have fewer than 200 MAABD enrollees each: Esmeralda (29), Storey (50), Eureka (68), Lincoln (178), and Lander (191).

Most of the MAABD population lives in urban areas (Clark County, Carson City, and Washoe County) of Nevada. As depicted in Figure 6, only 8.9 percent live in rural parts of the state.

Figure 6. Urban and Rural Nevada MAABD Populations, SFY 2022

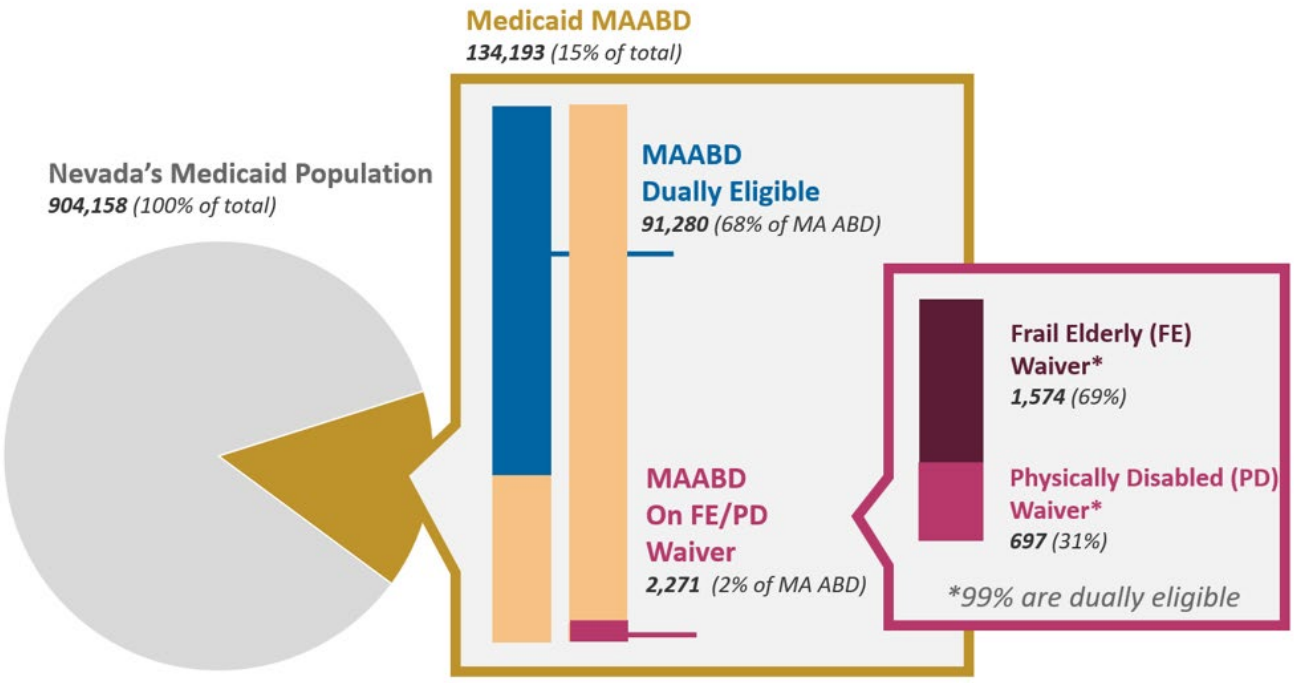


Administration of Current Medicaid Programs

Three key population attributes affect MAABD Nevadans services and supports. For the purposes of this report, DHCFP instructed HMA to focus on home and community based services (HCBS), while acknowledging the experience of the MAABD population receiving institutionalized care is significant and relevant, particularlyin terms of rebalancing the system.

- **HCBS Waiver Eligibility**: MAABD enrollees who meet the nursing home level of care qualify for an HCBS waiver that offers an added benefit set to support their ability to remain in the community. Nevada administers three 1915(c) HCBS waivers: I/DD, FE, and PD.
- **Institutional Care Eligibility:** Nevada Medicaid covers the cost of long-term custodial care in Medicaid-participating nursing homes for MAABD enrollees who need nursing home level of care and cannot or choose not to remain in the community.
- **Dual-Eligible Status:** In 2022, approximately 68.0 percent of Medicaid ABD enrollees also had Medicare coverage. Dual-eligible Nevadans have Medicare as their primary insurance and Medicaid as their secondary source of coverage.

Figure 7. Medicaid Population Distribution across MAABD, Dual-Eligible and FE/PD Populations



Nevada runs a bifurcated healthcare system—Medicaid managed care and FFS—for Nevadans who qualify for Medicaid. The Nevada MAABD population and rural Medicaid-eligible Nevadans form 22 percent of the Medicaid population and are served through a Medicaid FFS model.[12] Beginning in 2025, the Medicaid managed care model will expand to offer statewide coverage, serving all Medicaid eligible Nevadans except for the MAABD population, 1915 (c) HCBS waiver participants and a few other select populations.

As FFS Medicaid participants, the MAABD population may be at a disadvantage compared with Medicaid members who are enrolled in managed care organizations (MCOs). FFS Medicaid members have less support accessing Medicaid enrolled providers; limited access to providers accepting new patients; limited access to care management services, with most benefit navigation defaulting to rules around prior authorization requirements and limits on services; and are unable to choose providers based on reported quality.[13]

In the FFS healthcare system, the state sets the benefit and service limits and contracts with a Medicaid provider network to deliver care and services to MAABD enrollees. Once services are rendered, providers bill Nevada Medicaid's fiscal agent and are reimbursed at the Medicaid rate.[14] Nevada law requires the state to review Medicaid rates every four years to ensure the rate is sufficient to cover provider costs. Other than reporting caseload and rate information as needed to create an annual budget, no formal analyses (i.e., quality measures, benchmarking, or dashboards) are conducted to determine the quality of care that MAABD enrollees in FFS receive (exclusive of the waiver participants), making it difficult to determine how quality varies across geography or providers.

NEVADA MEDICAID MANAGED CARE

Beginning in 2025, the Medicaid managed care model will expand to offer statewide coverage, serving all Medicaid eligible Nevadans except for the MAABD population, 1915 (c) HCBS waiver participants and a few other select populations.

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[12] Nevada Department of Health and Human Services. Overview of Medicaid and Social Services Programs in Nevada. Presented to Nevada Department of Health and Human Services. February 10, 2023. Available at: eg.state.nv.us/App/NELIS/REL/82nd2023/ExhibitDocument/OpenExhibitDocument?exhibitId=62845&fileDownloadName=0210_Weeks.S_Pres.pdf. Accessed February 17, 2024.

[13] Nevada Division of Health Care Financing and Policy (DHCFP) and Division of Welfare and Supportive Services (DWSS). Medicaid Delivery System and Payment Reforms: A Guide to Key Terms and Concepts. KFF. June 22, 2015. Available at: https://www.kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/. Accessed February 17, 2024.

[14] Division of Health Care Financing and Policy, Nevada Department of Health and Human Services. Nevada Medicaid Matters: 2022 Biennial Report on the Condition, Operation and Functioning of Nevada Medicaid. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Medicaid%20Program%20Overview_2022_FINAL(2).pdf. Accessed February 17, 2024.

Nevada Medical Assistance (Medicaid) Services for the ABD Population

The Nevada ABD population has access to the same mandatory and optional benefits as other Medicaid enrollees. The Medicaid benefit set covers the following:

Mandatory Benefits	Optional Benefits
• Certified Pediatric and Family Nurse Practitioner • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Family Planning • Federally Qualified Health Center (FQHC) • Freestanding Birth Center • Home Health • Inpatient and Outpatient Hospital • Laboratory and X-Ray • Nursing Facility • Nurse Midwife • Physician • Rural Health Clinic • Transportation to Medicaid • Tobacco Cessation Counseling for Pregnant People	Adult Day Health Care • Chiropractic (recipients under age 21, qualified Medicare beneficiaries) • Dental (full coverage for people who are pregnant and recipients under age 21; pain and palliative care for other adults) • Habilitation - Day or Residential services (individuals with traumatic or acquired brain injury) • Hospice • Inpatient Psychiatric Services (recipients under age 21; recipients aged 65+) • Intermediate Care Facility (individuals with intellectual disabilities) Optometry • Nurse Anesthetists • Personal Care Services • Pharmacy • Physical, Occupational, and Speech Therapies • Podiatry • Private Duty Nursing • Prosthetics and Orthotics • Psychologist

Network adequacy of Nevada's Medicaid FFS network

Network *adequacy* does not equate to network *access*. Network adequacy is a regulatory term for meeting a minimum threshold to follow contract requirements. Network access infers that a network allows individuals to access care they need promptly without undue burden. The Centers for Medicare & Medicaid Services (CMS) issues guidance and policies related to state efforts to ensure network adequacy. In some instances, CMS is quite specific about requirements, and in others the agency defers to the states to set thresholds because states know their geography, population needs, and unique patterns of care best. CMS has been slow to implement these types of standards in HCBS, as the nature of service provision in the home/community makes measuring time and distance from an office moot. Most states, including Nevada, prove network adequacy based on CMS standards, and differentiating from network access is important.

Nevada offers a distinct geography that must be considered when examining service delivery and provider access as well as MAABD program participant needs. Though Nevada is the seventh largest state nationally, it is within the top 10 most densely populated states. However, the experience of individuals living in rural Nevada vastly differs from that of metropolitan-dwelling populations living largely in two counties: Washoe, where Reno and Carson City are located, and Clark, home to Las Vegas. Most people living in rural areas are native to the state, in contrast to those in the two metropolitan counties, who largely come to Nevada from other states, particularly California.[15] This influx of people from elsewhere is relevant to medical and HCBS provider access because Nevada competes with workforce from neighboring states.

The variance in population between more urban and rural counties underlies the difficulty in finding providers for rural MAABD enrollees and in supporting their ability to remain in the home and community rather than institutional settings. For example, in a 2019 study published in the *Journal of the American Medical Directors Association*, Siconolfi and colleagues concluded that state Medicaid programs should consider supply-side barriers to HCBS when working to improve rebalancing efforts in rural areas.[16] The researchers identified urban versus rural disparities related to approachability (informational access and knowledge of service availability), acceptability (what is socially and culturally acceptable to the population being served), availability and accommodation (ability to access services when and where needed), and affordability (financial capacity for services).[17] Practically, these challenges are perpetuated through limited communications and information, a preference for informal supports, limited availability of providers and transportation options, and the difficulty businesses that provide HCBS have succeeding in rural communities where volume is too low to sustain affordable services.

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[15] World Population Review. Nevada Population 2024. Available at: https://worldpopulationreview.com/states/nevada-population. Accessed February 28, 2024.
[16] Siconolfi D, Shih RA, Friedman EM, Kotzias VI, Ahluwalia SC, Phillips JL, Saliba D. Rural-Urban Disparities in Access to Home- and Community-Based Services and Supports: Stakeholder Perspectives from 14 States. *J Am Med Dir Assoc*. 2019;20(4):503−508.e1. doi: 10.1016/j.jamda.2019.01.120
[17] Ibid

Nevada, like all other states, is struggling with workforce shortages. These challenges are particularly profound in the HCBS network. DHCFP is accountable for the ongoing monitoring and oversight of Medicaid networks and has contracted with the Health Services Advisory Group (HSAG) to conduct validation annually to ensure compliance with network adequacy requirements. The most recent network adequacy report was published in June 2023. This network analysis includes measures that use provider ratios for existing member populations for some services (primary care physicians and specialists) and some measures that use other metrics. According to the 2023 report, Nevada has satisfied all provider network adequacy ratio requirements.

Primary Care, Pharmacy, Mental, and Dental Health Access – Key Providers for MAABD

For most ABD Medicaid beneficiaries, access to primary care and pharmacies is critical, as they tend to use healthcare services more than younger, healthier Medicaid enrollees, largely because many ABD beneficiaries experience at least one chronic condition that requires ongoing management, such as hypertension, arthritis, and heart disease.[18] They also tend to have higher needs for medication and pharmacy services. In Nevada, access to primary care providers (PCPs) and pharmacies varies significantly by county. Though FFS network adequacy reports indicate that the state has an "adequate" number of PCPs and pharmacies (see Tables 1 and 2), stakeholder feedback reveals that, particularly in rural and frontier areas, access to Medicaid services, including primary care and pharmacy services, is a challenge.

[18] https://www.ncbi.nlm.nih.gov/books/NBK215400/, Institute of Medicine Committee on the Future of Health Care Workforce for Older Americans. National Academies Press, 2008. Accessed February 23, 2024.

Table 1. FFS Enrollment by County and PCP, Provider to Member Ratio

County	Adults	Children	Total	Total Statewide Providers	Ratio
Carson City	8,839	5,119	13,958	5,780	1:3
Churchill	4,272	2,662	6,934	5,780	1:2
Clark	106,605	24,271	130,876	5,780	1:23
Douglas	4,642	2,446	7,088	5,780	1:2
Elko	6,691	4,905	11,596	5,780	1:3
Esmeralda	147	64	211	5,780	1:1
Eureka	227	146	373	5,780	1:1
Humboldt	2,323	1,712	4,035	5,780	1:1
Lander	773	522	1,295	5,780	1:1
Lincoln	606	408	1,014	5,780	1:1
Lyon	8,860	5,630	14,490	5,780	1:3
Mineral	1,093	528	1,621	5,780	1:1
Nye	12,132	5,314	17,446	5,780	1:4
Pershing	984	580	1,564	5,780	1:1
Storey	339	132	471	5,780	1:1
Washoe	19,021	4,644	23,665	5,780	1:5
White Pine	1,367	791	2,158	5,780	1:1
Statewide	**178,921**	**59,874**	**238,795**	**5,780**	

*Data in Table 1 are from the CMS Health Services Advisory Group (HSAG) network adequacy validation (NAV) SFY 2023 Annual Report. The table shows the total number of individuals enrolled in FFS Medicaid as of December 1, 2022. The providers column includes all PCPs registered as Nevada Medicaid FFS providers and available to any FFS member in the state. Though the FFS PCP network

is considered adequate, access to care issues because of geography, member location, transportation needs, and so on persist.

Table 2. FFS Pharmacy Provider to Member Ratio*

County	Total Number of Statewide Providers	Ratio
Carson City	540	1:26
Churchill	540	1:13
Clark	540	1:243
Douglas	540	1:14
Elko	540	1:22
Esmeralda	540	1:1
Eureka	540	1:1
Humboldt	540	1:8
Lander	540	1:3
Lincoln	540	1:2
Lyon	540	1:27
Mineral	540	1:4
Nye	540	1:33
Pershing	540	1:3
Storey	540	1:1
Washoe	540	1:44
White Pine	540	1:4

*Data in Table 2 are from the HSAG Nevada SFY 2023 Annual Report and show the statewide total of pharmacy providers, not by individual county. Though the FFS pharmacy network has been considered adequate, enrollees still may experience access to care issues because of geography, member location, and transportation needs.

According to the Health Resources & Services Administration (HRSA), most of Nevada is considered rural or frontier, and virtually the entire state is designated as some type of health professional shortage area (HPSA), including the three urban counties of Clark, Washoe, and Carson City. Figure 8 shows that HRSA considers essentially the entire state to be rural, with the exception of parts of Washoe County, Clark County, and Carson City.

In addition to PCPs, access to mental health providers and dental providers is limited across Nevada for all populations, not only MAABD. Figures 9, 10, and 11 show the HRSA-designated primary care, mental health, and dental HPSAs across the state. Again, virtually the entire state is designated as some type of either geographic (access is limited to all populations within that area), population (access is limited to certain types of populations within that area), or high needs geographic (access is significantly limited within that area) HPSA.[19]

These HPSAs present distinct challenges for DHCFP and other stakeholders looking to address the needs of MAABD enrollees living outside of Washoe and Clark Counties. A 2019 study by Cohen and Greaney found that although only 15 percent of the US population lives in what is considered to be a rural area, a disproportionate share (22%) of all Americans ages 65+ live in rural communities.[20] Population aging is occurring more rapidly in rural than urban areas across the country and in Nevada. Given the shortage of all these types of providers, even in many urban communities, the state must find innovative solutions to increase access to key services for MAABD—primary care, pharmacy, behavioral health, and dental care—across rural Nevada.

As noted earlier, Siconolfi and colleagues found that the supply-side disparities and different cultures of rural versus urban areas are important considerations when contemplating network development and ability that will meet the unique needs of all communities across the state.[21]

Moving the MAABD population from an FFS system of care to either MLTSS or PACE could support improved access for this at-risk and fragmented population. MLTSS and PACE organizations are incentivized to help members get and stay healthy through a robust, high-quality, accessible network and care management activities, including in rural areas.

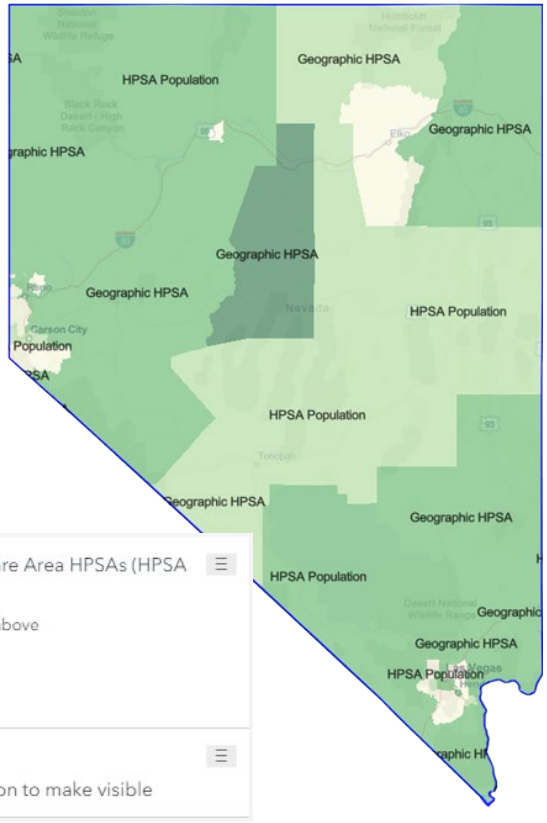
KEY PROVIDERS FOR MAABD

For most ABD Medicaid beneficiaries, access to primary care and pharmacies is critical, as they tend to use healthcare services more than younger, healthier Medicaid enrollees.

[19] Health Resources & Services Administration. Scoring Shortage Designations. Available at: https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring. Accessed February 23, 2024.
[20] Cohen SA, Greaney ML. Aging in Rural Communities. *Curr Epidemiol Rep*. 2023;10(1):1-16. doi: 10.1007/s40471-022-00313-9.
[21] Rural-Urban Disparities in Access to Home- and Community-Based Services and Supports: Stakeholder Perspectives from 14 States.

Figure 8: Nevada Rural Health Areas by County, HRSA Mapping Tool[22]

Figure 9: Nevada Primary Care HPSAs, HRSA Mapping Tool[23]

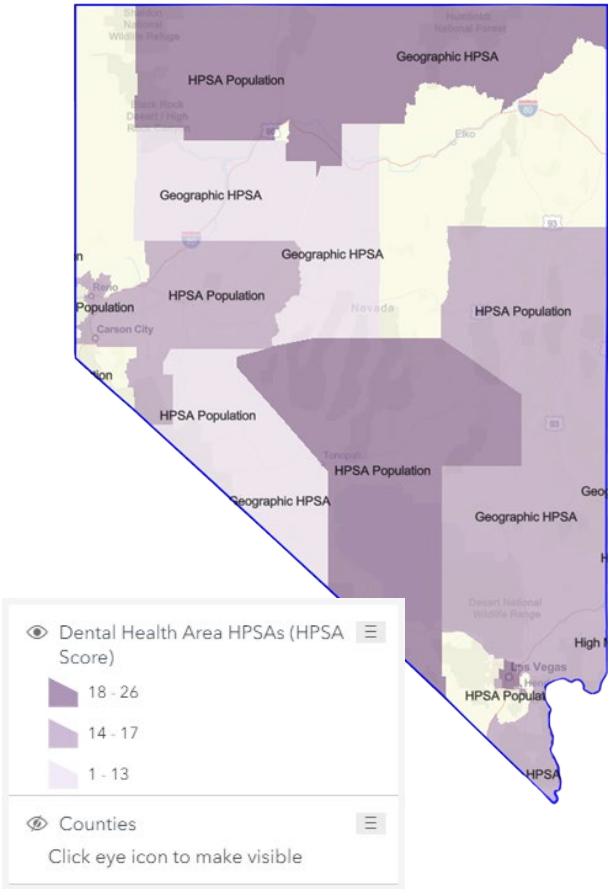


[22] https://data.hrsa.gov/maps/map-tool/, accessed February 23, 2024.

[23] https://data.hrsa.gov/maps/map-tool/, accessed February 23, 2024.

Figure 10: Nevada Mental Health Care HPSAs, HRSA Mapping Tool[24]

Figure 11: Nevada Dental Health HPSAs, HRSA Mapping Tool[25]



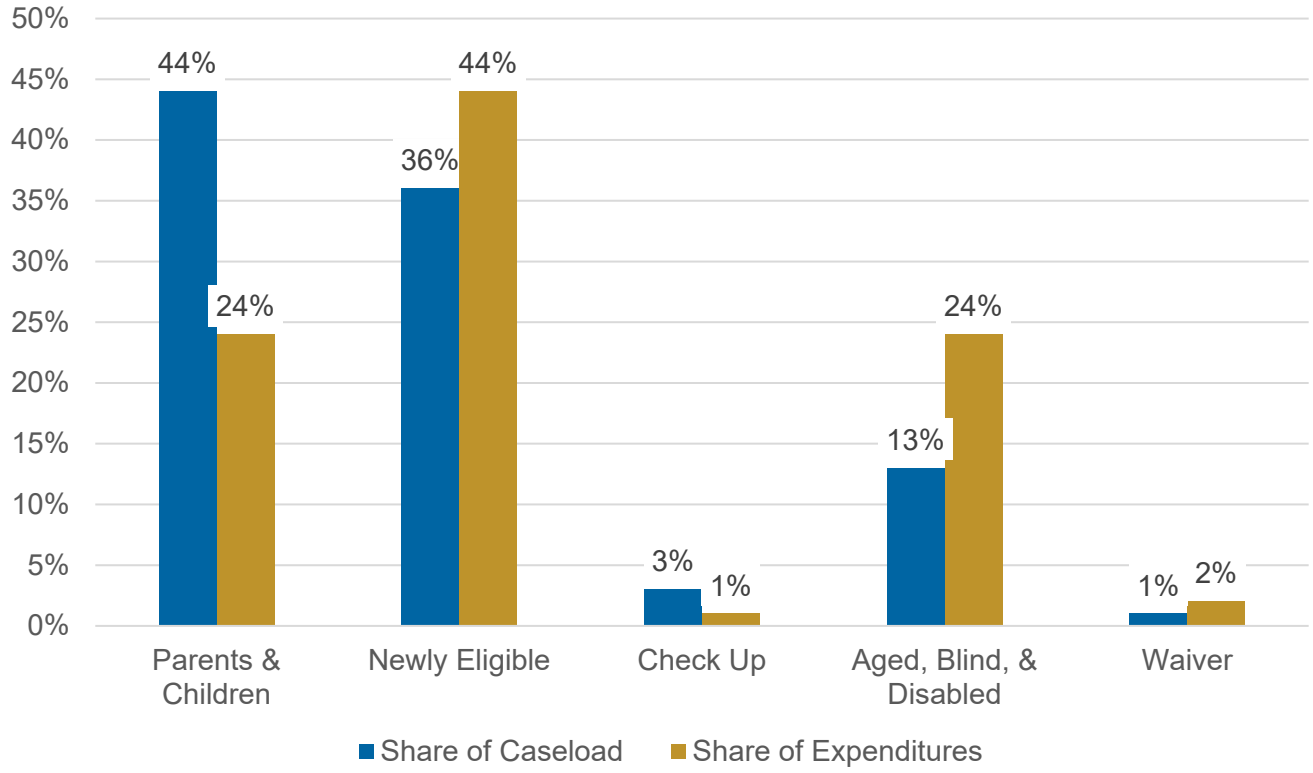
[24] https://data.hrsa.gov/maps/map-tool/, accessed February 23, 2024.

[25] https://data.hrsa.gov/maps/map-tool/, accessed February 23, 2024.

Nevada MAABD Population Utilization

Given the increased healthcare concerns of older adults and people with disabilities, the MAABD population will have a higher need for care than the general Medicaid population. The Nevada MAABD population represents 14−15 percent of all Nevada Medicaid enrollees but accounts for about one-fourth of Medicaid spending.[26] Other Nevada Medicaid coverage groups account for higher expenditures, though individual costs are lower than for MAABD enrollees (see Figure 12).[27]

Figure 12. MAABD Share of Medicaid Caseload and Medicaid Spending



MAABD expenditures are expected to continue to outpace caseloads after the impact of redeterminations are fully included in the state's Medicaid program results. MAABD participants are likely to keep their eligibility.

[26] Nevada Medicaid Matters: 2022 Biennial Report on the Condition, Operation and Functioning of Nevada Medicaid.
[27] Ibid

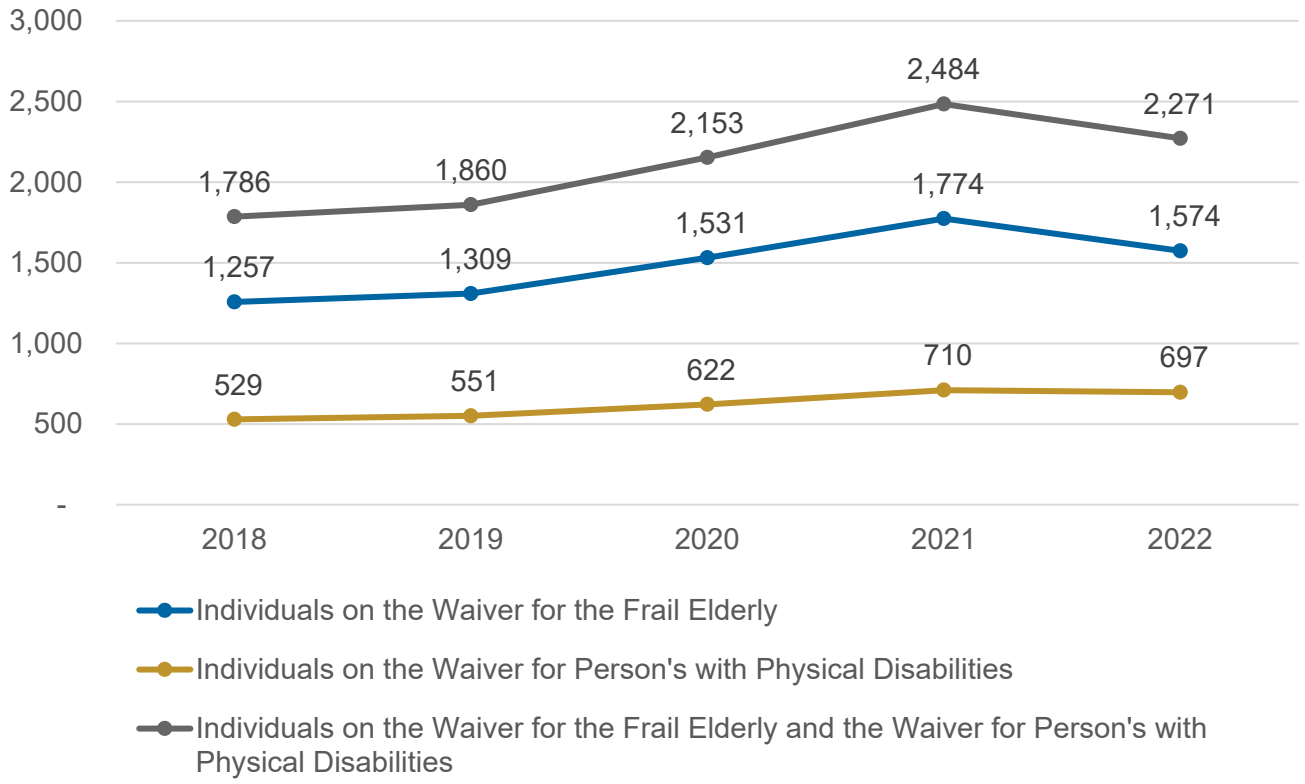
According to the 2023 Nevada Medicaid Cost Driver Analysis,[28] the number of people enrolled in Medicaid (also known as member months) are increasing, but total spending is stabilizing. In 2020, total and per member per month (PMPM) costs peaked at $1.3 billion and $1,015, respectively. Since 2020, expenditures for the MAABD population have been stabilizing as the result of a combination of service levels remaining fairly steady and the relatively stable average cost of services because reimbursement rates have been relatively flat.

Because of the timing of recent developments occurring as a result of the Families First Coronavirus Response Act (FFCRA), it is difficult to predict whether the favorable cost trends will continue or will revert back to historical averages for member use and annual unit cost increases.

FE and PD Population Data

HMA conducted an analysis of the MAABD to further examine the population of individuals enrolled in the FE and PD waiver programs. Our analysis showed that in 2022, a total of 2,271 individuals were on either the FE or PD waiver, with 69 percent on the FE waiver and 31 percent on the PD waiver. As Figure 13 indicates, the number of individuals on these waivers has steadily increased over the course of five years. In 2018−2022, the FE population increased by 22.4 percent, and the PD population grew 27.4 percent.

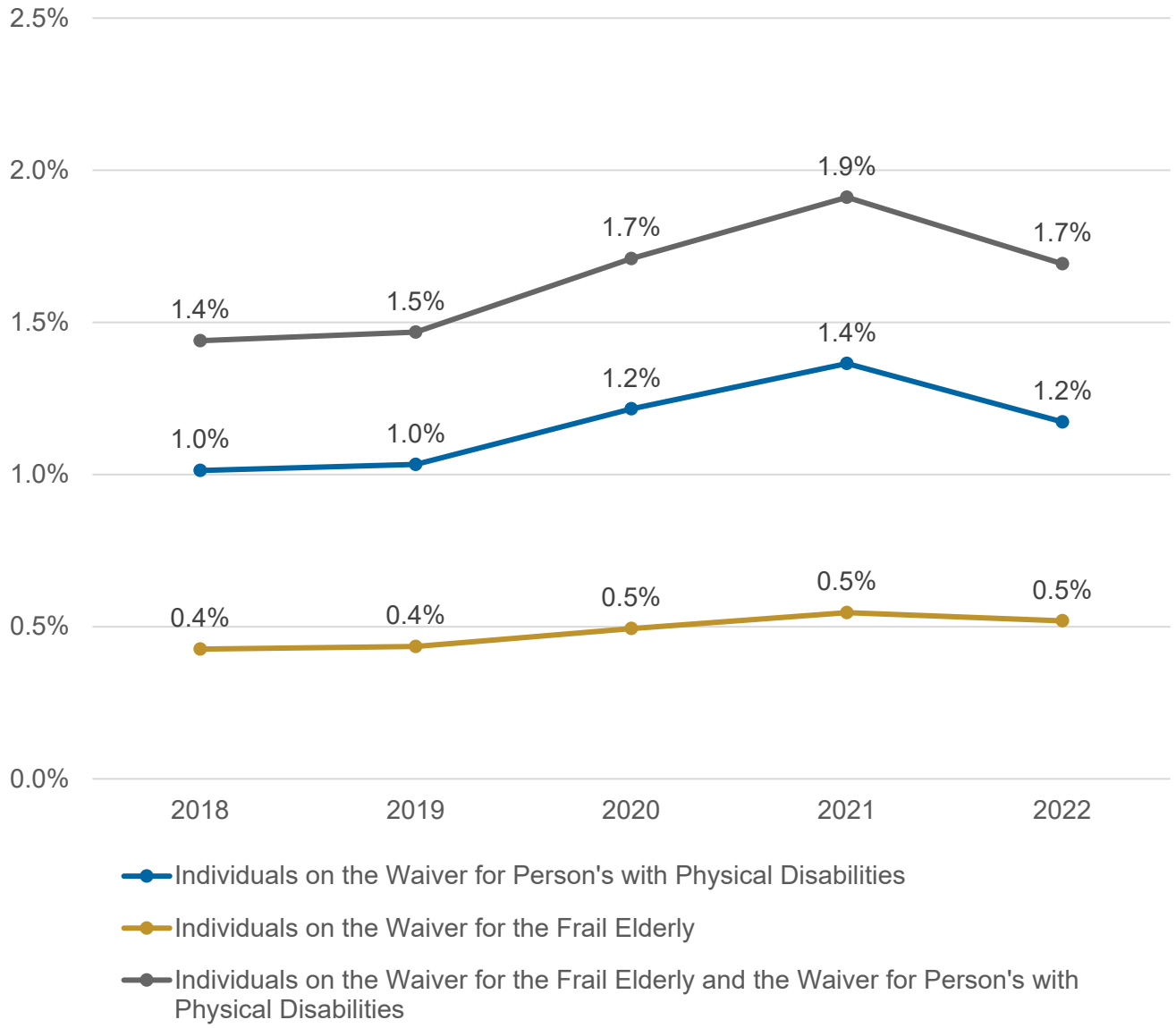
Figure 13. Number of Nevadans on FE and PD Waivers



[28] Nevada Medicaid Cost Driver Analysis - 2023 (nv.gov)

In 2022, the FE and PD population accounted for approximately 1.7 percent of the MAABD population. Figure 14 depicts the percentage of MAABD enrollees on either the FE or PD waiver.

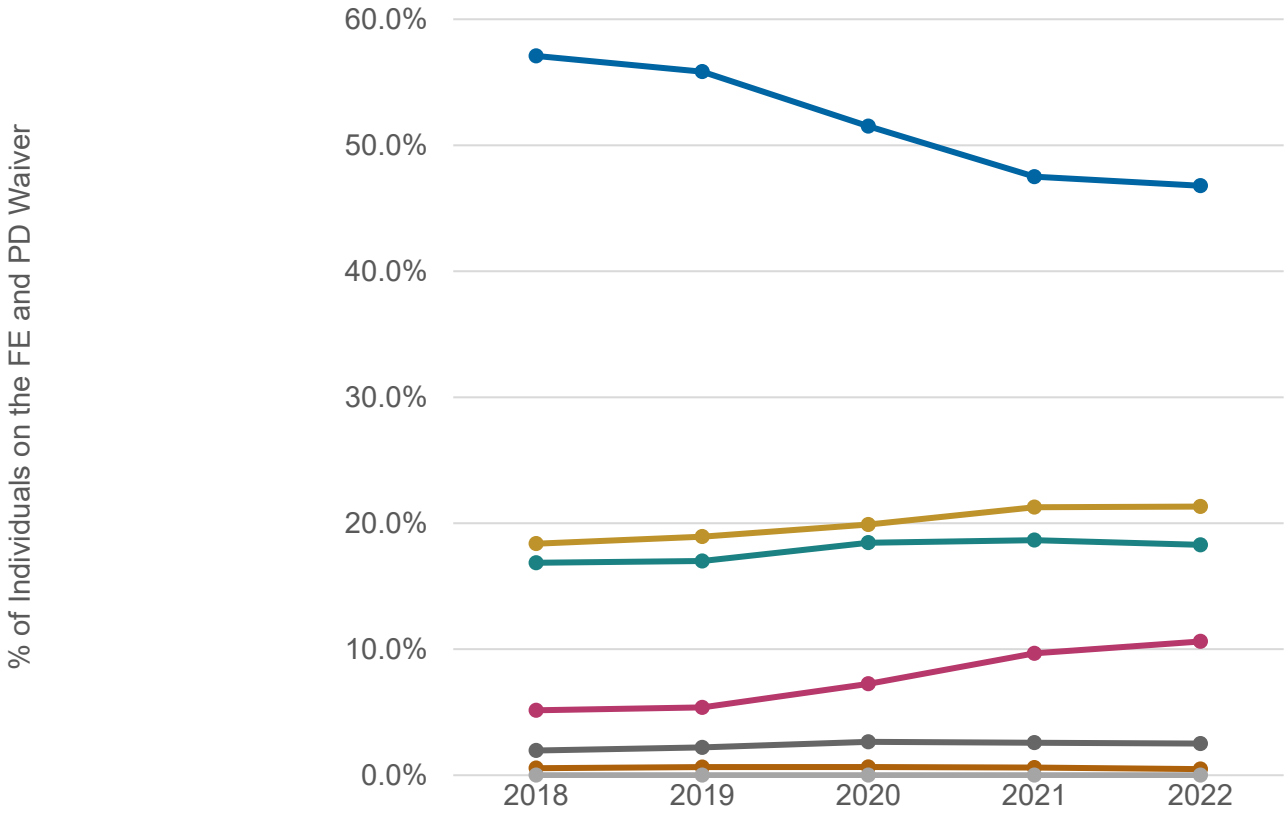
Figure 14. Percentage of MAABD Population enrolled in FE and PD Waivers



Race/Ethnicity

Figure 15 provides a breakdown of individuals on the FE or PD waiver by race and ethnicity. Although individuals who identified as White were the largest population served in 2022, the percentage of White people in the FE or PD waiver program has declined by 10.3 percent over the past five years. The population that experienced the most growth within the FE or PD waivers are Native Hawai'ian/Other Pacific Islander. In 2018−2022, the number of people on the FE or PD waivers who identified as Native Hawaiian/Other Pacific Islander increased by 5.5 percent.

Figure 15. Individuals on the FE and PD Waivers by Race/Ethnicity



	2018	2019	2020	2021	2022
Black or African American alone	16.9%	17.0%	18.5%	18.7%	18.3%
American Indian and Alaska Native alone	0.6%	0.6%	0.7%	0.6%	0.5%
Asian	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone	5.2%	5.4%	7.3%	9.7%	10.6%
Two or More Races	2.0%	2.2%	2.6%	2.6%	2.5%
Hispanic or Latino	18.4%	18.9%	19.9%	21.3%	21.3%
White alone, not Hispanic or Latino	57.1%	55.8%	51.5%	47.5%	46.8%

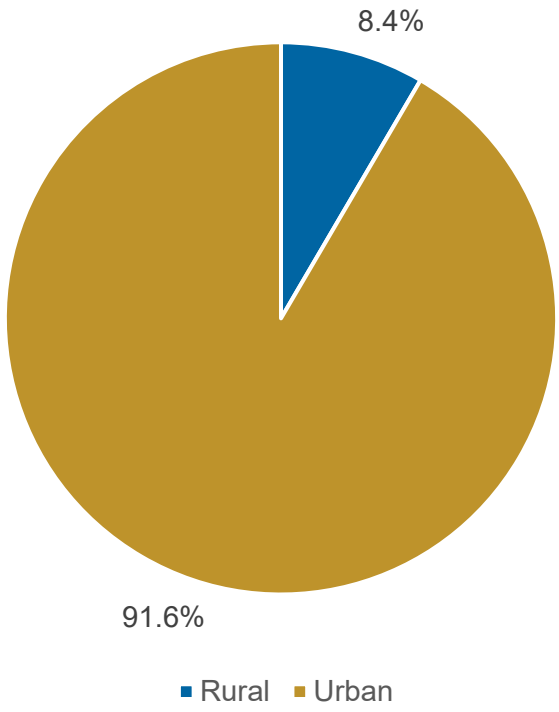
Gender

From SFY 2018-2022, significantly more females than males participated in the FE/PD waivers. In 2022, approximately 71.2 percent of individuals on either the FE or PD waiver identified as a female, and 28.8 percent identified as a male.

Geographic Distribution

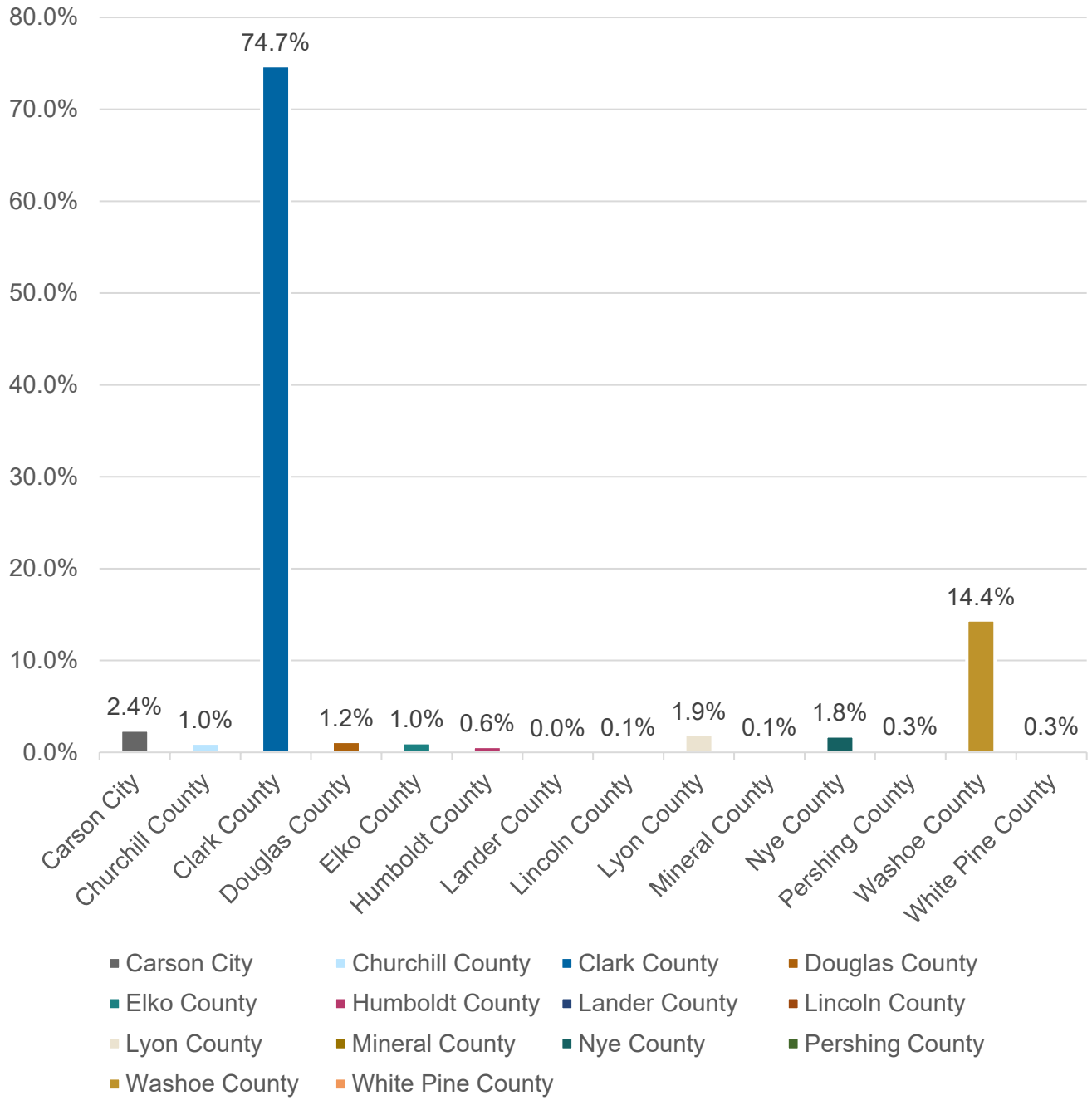
In SFY 2022, approximately 91.6 percent of the MAABD population on either the FE or PD waiver lived in urban areas of Nevada (i.e., Clark and Washoe Counties and Carson City).

Figure 16. Percentage of MAABD Population on FE or PD Waivers by Geographic Region, SFY 2022



Understanding where the FE and PD populations reside is directive information for the state when contemplating access to waiver services and waiver provider workforce planning. Analysis found that nearly 75 percent of the MAABD population on either the FE or PD waiver lived in Clark County and nearly 15 percent resided in Washoe County.

Figure 17. Percentage of People with FE or PD Waivers by County, SFY 2022



Nevada Medicaid FE & PD HCBS Services

In addition to the basic care Medicaid benefit set, MAABD Medicaid members enrolled in the FE or PD waiver have access to additional health and human services through HCBS waiver benefit sets.

The FE and PD waiver programs cover a variety of HCBS services designed to meet the needs of each specific population. Below is a listing of services offered through each waiver.

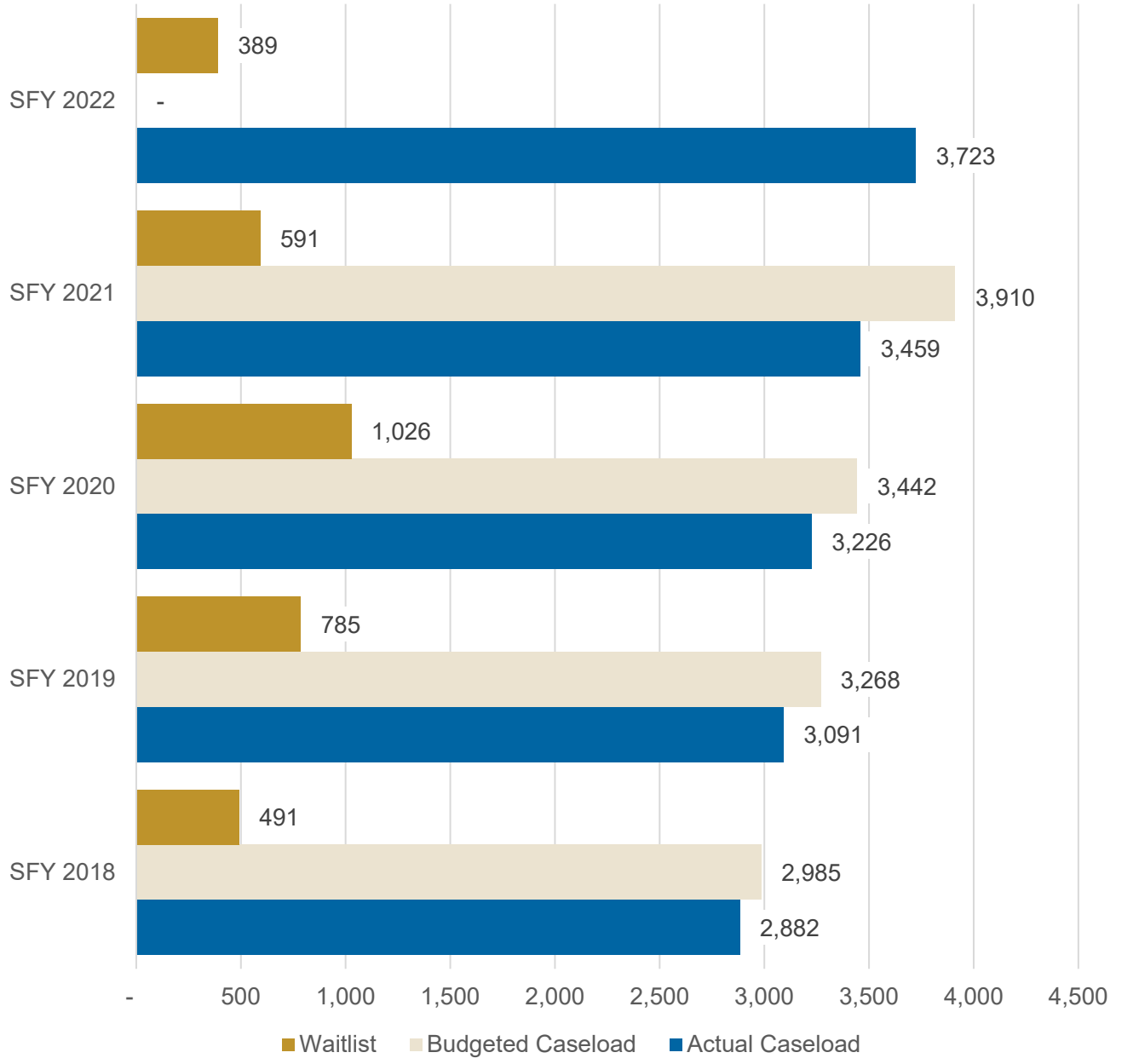
Table 3. Waiver Program and Services Summary

HCBS Waiver Service/Element	Frail Elderly (FE)	Physical Disabilities (PD)
Waiver Case Management	Either Public, State-employed Option (ADSD) or Private Option (CareLink)	Either Public, state-employed Option (ADSD) or Private Option (CareLink)
Adult Companion	X	
Adult Day Care	X	
Augmented Personal Care	X	
Chore	X	
Homemaker Services	X	X
Respite	X	X
Personal Emergency Response System	X	X
Home-Delivered Meals		X
Specialized Medical Equipment and Supplies		X
Assisted Living		X
Environmental Accessibility Adaptations		X

Nevada Medicaid FE & PD HCBS Utilization

Since 2018, FE and PD caseloads have increased nearly 46 percent. In 2018−2022, the number of individuals receiving HCBS through the PD waiver increased by nearly 39 percent, while the number of people receiving HCBS through the FE waiver increased by nearly 49 percent (see Figure 18).

Figure 18. Number of People Receiving HCBS through PD and FE Waivers, 2018−2022



Nevada's FE and PD waiver both have waitlists, showing an unfulfilled need for services for the MAABD population. Interviews with state staff inferred the cause for waitlists- despite having available waiver slots- were the result of assessor workforce shortages, which is an issue the state is trying to address. FE and PD waiver waitlists peaked in 2020 and then declined for the next two years.[29]

Other Medicaid delivery systems may help address the assessor workforce shortages that are creating notable access issues for waiver programs, which already are underfunded when compared with the rest of the nation. Other Medicaid program models such as PACE or MLTSS offer financial flexibilities that would support workforce cultivation or pay higher rates to attract workers to care coordination jobs. Had all the waiver slots available been filled the 2021 waiting list for FE would have been only 127 people (versus 437) and would have been only 13 people (versus 154) for the PD waiver.

DHCFP has included annual increases in total caseload numbers in their waiver submissions to CMS. DHCFP also has requested additional funds annually to increase caseloads for both the PD and FE waivers, ranging from 3.6 percent to 11.6 percent increases. Although these increases are not expected to fully accommodate both waitlists, they do allow more capacity for enrollees to move off the waitlists more quickly. The governor's office has countered these requests, allowing only a portion of the requested amount to be included in the governor's budget proposal.

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[29] Waitlists for HCBS are common in other states. In fact, Nevada is one of 38 states that had waitlists as of 2023, with some individuals waiting three years to start receiving these services. Many factors contribute to the need for waiting lists, ranging from limited funding to workforce shortages, to the administrative processes in place for each state. Historically, states have waited to screen waitlisted individuals for Medicaid eligibility until they were selected to leave the waitlist. Nevada is among the majority of states that conduct Medicaid eligibility determinations before placing individuals on a waitlist. This process ensures that individuals on the list will likely be eligible for waiver program enrollment when they move off the waitlist and decreases the amount of time it takes to complete enrollment. Waiting for Care: Three-Fourths of States Have Waiting Lists for Some Medicaid Home Care Programs | KFF

Figure 19. HCBS Caseloads for People with PD and FE Waivers, 2018−2022

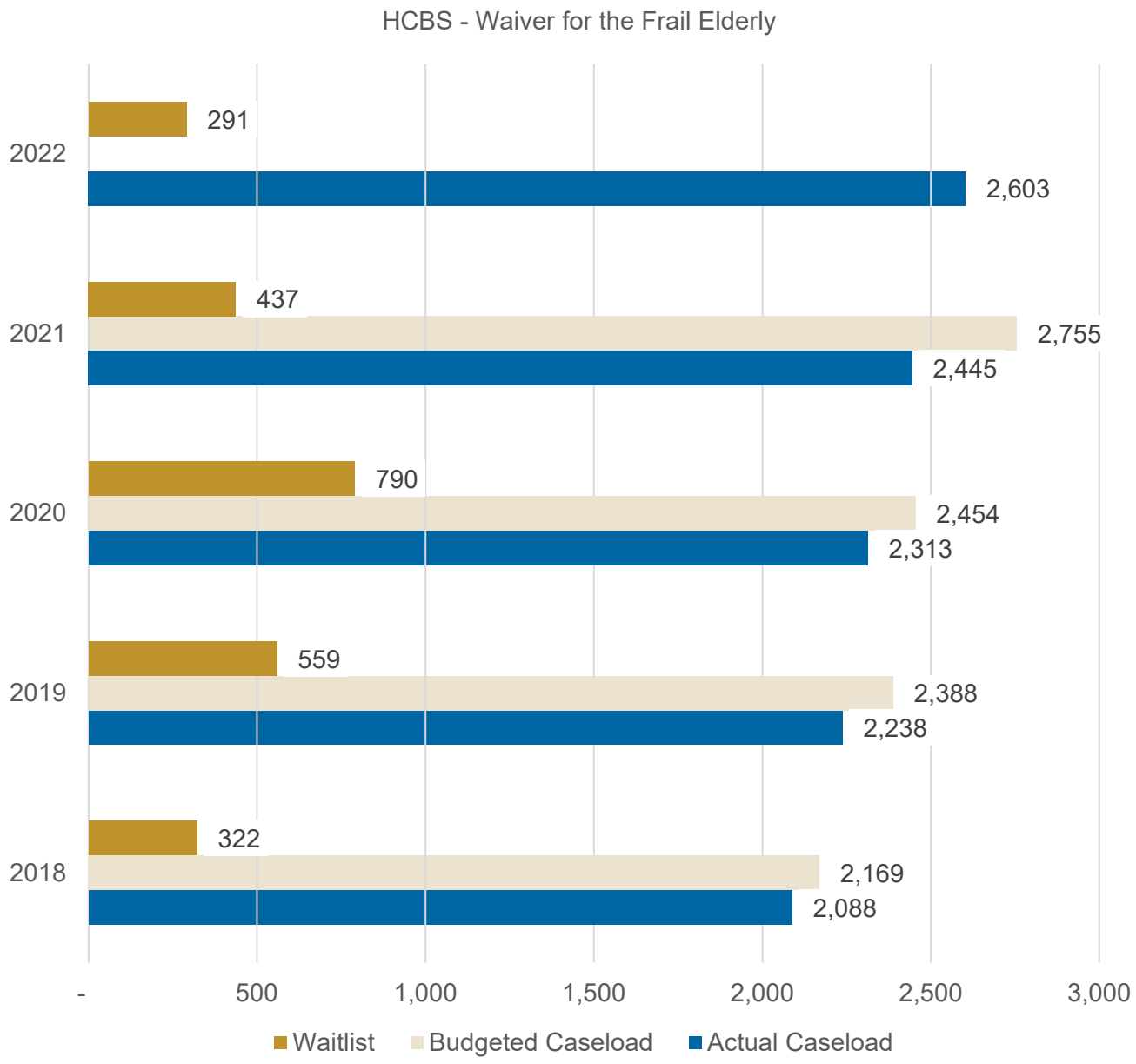
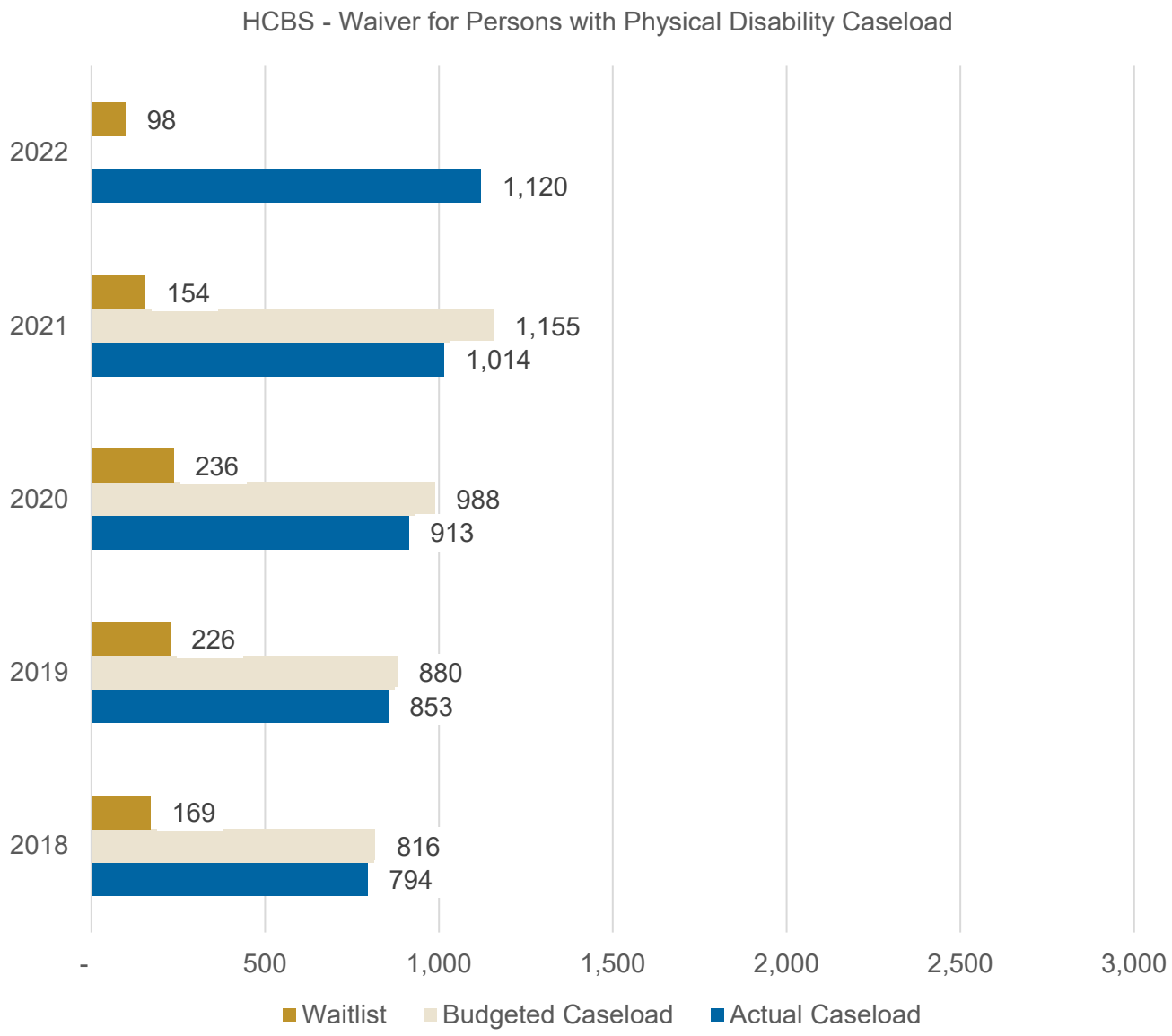
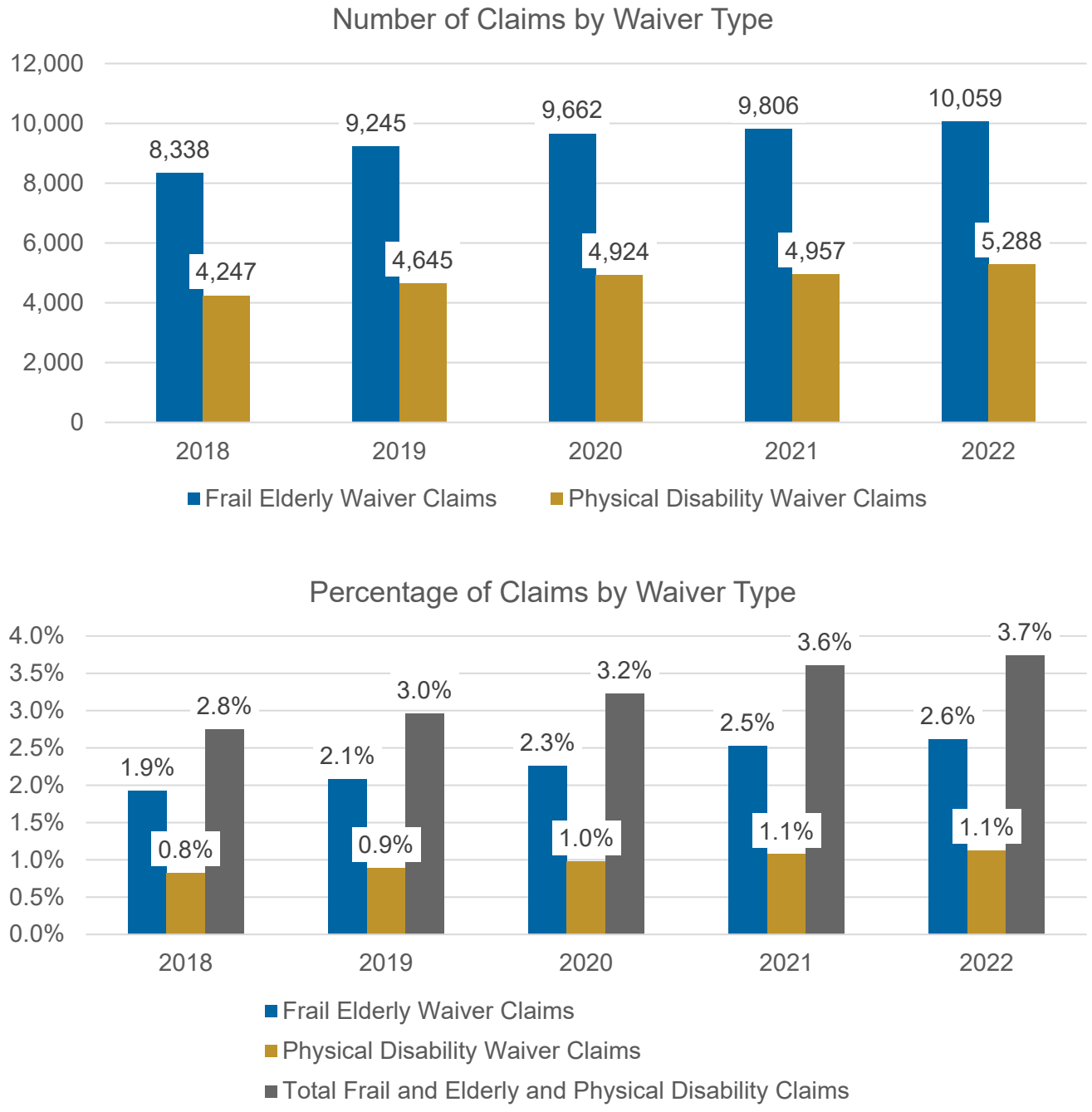


Figure 19 Continued. HCBS Caseloads for People with PD and FE Waivers, 2018−2022



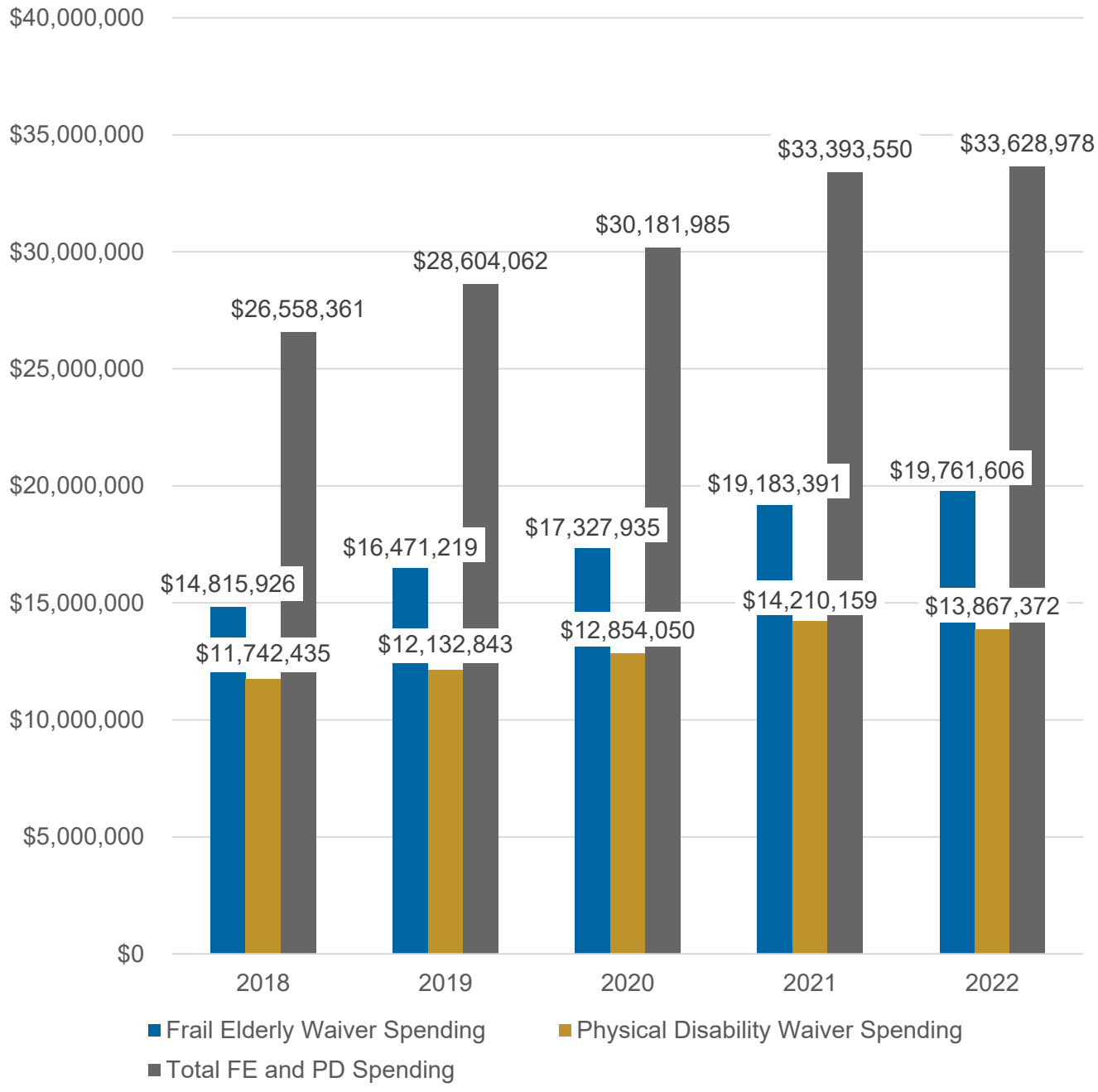
In the last SFY, based on claims data from DHCFP, 2,425 individuals received services through either the FE or PD waivers. These individuals generated 14,380 claims, 70 percent of which were generated by FE participants and 30 percent by PD participants. Figure 20 provides a visual representation of the number of claims generated by the FE and PD population.

Figure 20. Number and Percentage of Medicaid Claims by Waiver Type



As Figure 21 shows, total Medicaid spending on the MAABD population on either the FE or PD waiver increased from $26.6 million to $33.6 million over the course of five years. This demonstrates an increase of 26.6 percent. It is important to note that in SFYs 2018−2022, the number of MAABD individuals on either the FE or PD waiver increased by nearly 50 percent; however, the Medicaid spending on this population increased by over 26 percent over the same period.

Figure 21. Total Medicaid Spending for FE and PD Populations



Based on claims data from SFYs 2018−2022, the percentage of Medicaid spending on the MAABD population on either the FE or PD waiver remained relatively consistent. This trend is consistent when HMA analyzed Medicaid spending for the MAABD population on the FE and PD waivers separately, as seen in Figure 22.

Figure 22. Percentage of Medicaid Spending by Waiver Type

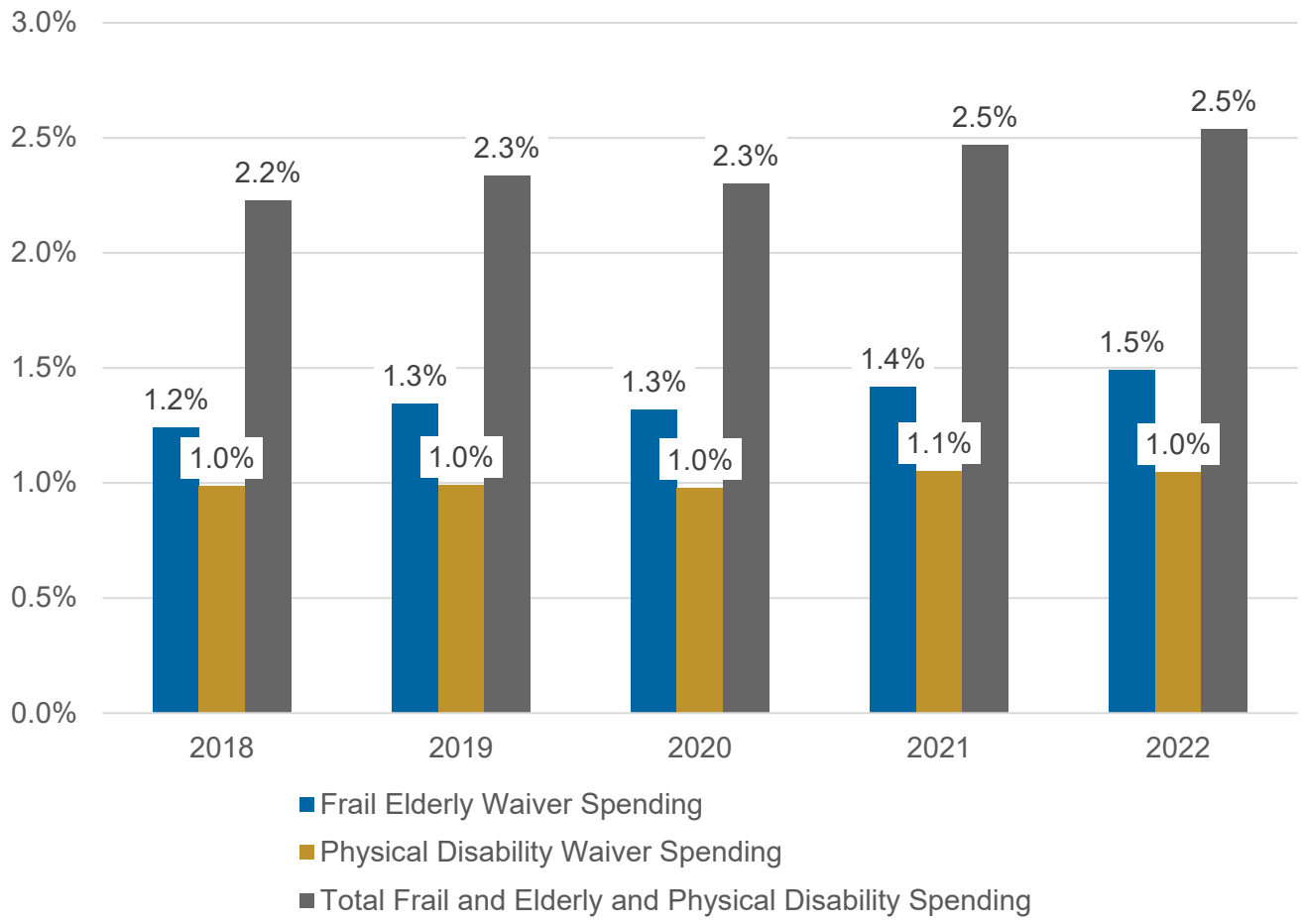
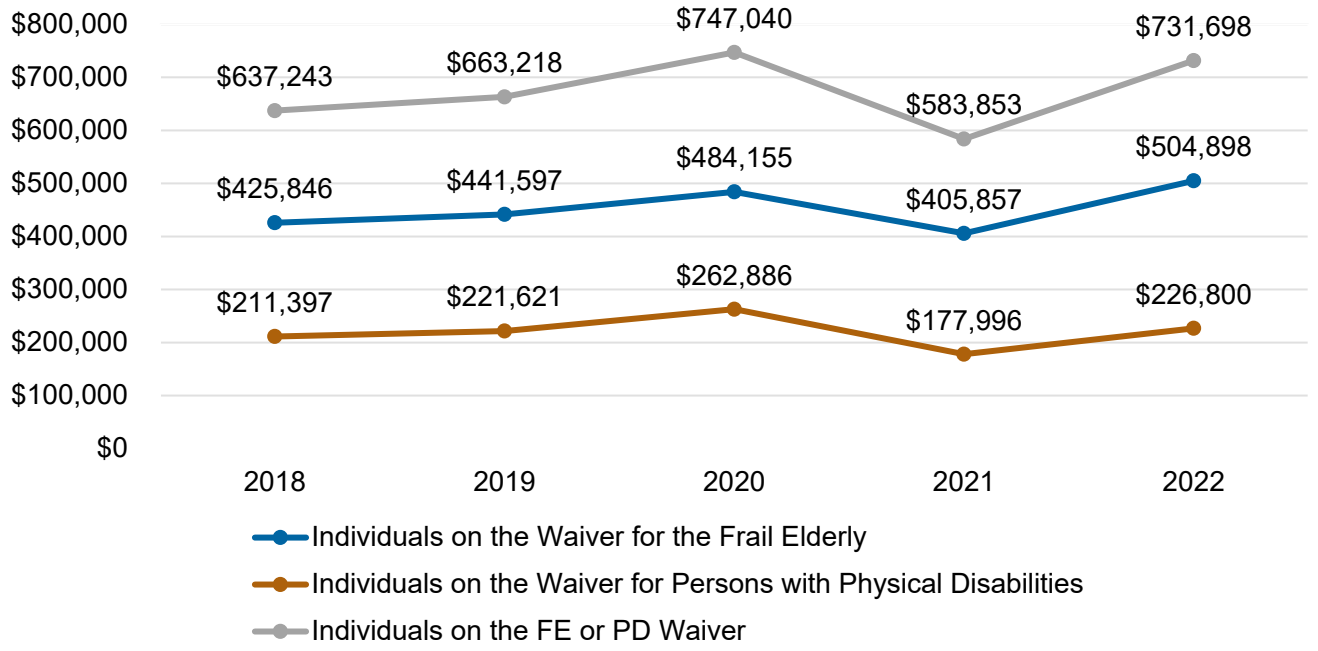


Figure 23. Medicaid Spending on Case Management by Waiver Type



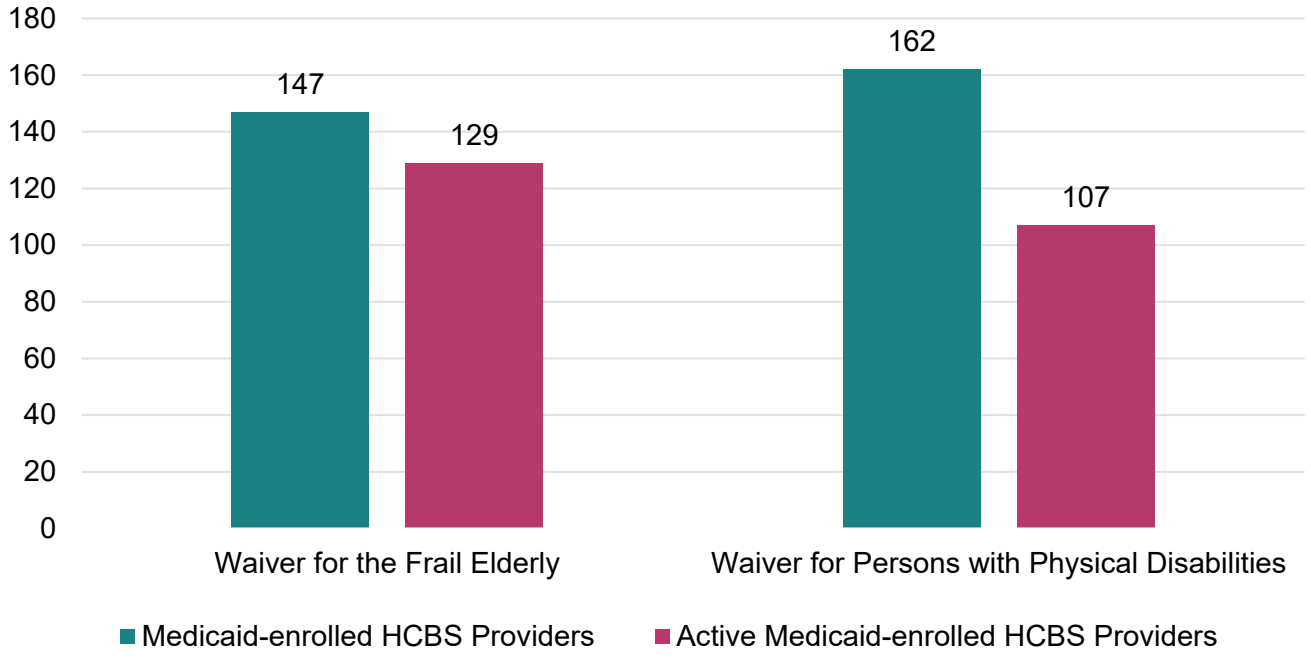
Nevada Medicaid FE & PD HCBS Provider Network

To assess the HCBS provider network, HMA requested Nevada Medicaid-enrolled HCBS provider network data, as well as a subset of data reflecting only those providers with a claim in the past 12 months. This subset of provider data was obtained to assess the number of active providers in the FE and PD HCBS networks. This definition of active providers is useful, as it is common in Medicaid HCBS programs for providers to stop providing Medicaid services but continue to be enrolled with the state as a provider. Comparing the full HCBS enrolled provider list to the active provider list supplies some additional insight into HCBS provider network availability and true capacity to meet current service demand.

Figure 24 compares the number of HCBS providers that are Medicaid-enrolled with the number of active HCBS providers that billed for a claim through the FE or the PD waiver. The data revealed that 309 Medicaid-enrolled HCBS providers delivered services to people enrolled in the FE and PD waiver programs—149 for services provided through the FE waiver and 162 through the PD waiver. An analysis of claims data from 2022 revealed that 88 percent of the providers enrolled in the FE HCBS network are active providers (billed a claim in the past 12 months) and 66 percent of PD HCBS providers are active.[30]

[30] The assessment of active HCBS providers was based on individual HCBS provider businesses and not national provider identification (NPI) billing numbers.

Figure 24. Number of Medicaid-Enrolled HCBS Providers versus Active Medicaid-Enrolled HCBS Providers



Workforce shortages, particularly among the HCBS direct care workforce (DCW), are of increasing concern nationally. The implementation of electronic visit verification (EVV) systems and requirements will yield more data opportunities that states can leverage to obtain a clearer understanding of DCW patterns and shortages. Without a targeted data collection effort, it is difficult for states to assess how the HCBS workforce may be changing. Though Nevada's implementation of EVV is well under way, historically the data have not been used to assess DCW and workforce issues.

State staff interviewed for this project reported less workforce concern for the state PCS in urban areas but noted they are concerned about workforce shortages across virtually all provider groups for rural areas of Nevada. As described earlier, more than 80 percent of the MAABD population, including people in the FE and PD waiver programs, live in two counties, leaving nearly 16 percent in rural communities.

A 2023 Kaiser Family Foundation (KFF) HCBS survey asked respondents whether their states had experienced a shortage of DCWs, personal care attendants, nursing staff, home health aides, and case managers. Nevada indicated that the state was experiencing workforce shortages and consequently adult day, group home, assisted living and "other" HCBS settings have closed down within the past year. The KFF Medicaid HCBS survey also asked states about strategies they have in place to increase the number of HCBS workers.[31] Nevada's results are listed in Table 4.

[31] Kaiser Family Foundation. Payment Rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges. October 24, 2023. Available at: https://www.kff.org/report-section/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges-appendix-tables/. Accessed February 17, 2024.

Table 4. Nevada Responses to KFF Medicaid HCBS Survey

	Nevada	Number of States Responding Yes
Has Any Strategy	Yes	50
Increasing Provider Payment Rates	Yes	48
Offering DCW Education or Training Programs	Yes	42
Recruitment or Retention Incentive Payments	Yes	41
Minimum Wage Requirement for HCBS Workers	No Response*	20
Offering paid Sick Leave	No	19
Other	No	16

* Nevada has since implemented some minimum wage strategies for HCBS DCW.

The KFF Medicaid HCBS survey asked states about HCBS payment rates, which vary largely across the nation, as shown below:

	Personal Care Agencies	Home Health Agencies	Personal care Providers	Home Health Aides	Registered Nurses
Total unknown or no response	8	24	16	24	23
Nevada Response	$18.04	Unknown	$17.56	$40.80	$37.55
Nevada ranking*	39 (out of 42 reporting)	N/A	25 (out of 35 reporting)	7 (out of 16 reporting)	10 (out of 12 reporting)
Rate range reported	$9.57 - $36.24	N/A	$9.00- $36.00	$15.91- $46.55	$27.00- $98.53

* Lowest paid rates denoted by higher ranking

As the study results show, Nevada has been taking some measures to address HCBS workforce shortages. Stakeholders in each of the focus groups that contributed to this report voiced concern about ongoing workforce challenges and a need for increased payment. Workforce concerns also have been a recurrent topic at Nevada Medical Care Advisory Committee meetings, specifically nursing, community health workers, doulas, case management, and nursing homes. Nevada's most recent efforts at operationalizing HCBS rate increases are listed in Table 5.

Table 5. Status of Nevada's Efforts to Operationalize HCBS Workforce Rate Increases

LTSS Service	Rate Impact	Impact	March 2024 Status
Personal Care Services	Rate increase, wages	Rate equivalent to $25/hour with $16/hour minimum wage	Approved by CMS and implemented
Home Health and Private Duty Nursing	Rate increase	15% and rural differentiator payments	Approved by CMS and implemented
Assisted Living	Rate increase	Averages 98%	Approved by CMS and implemented
FE Residential Facility for Group Providers	Rate increase	Averaging 50%	Approved by CMS, currently being operationalized
Nursing Facilities including Skilled Nursing Facilities (SNF)	Rate increase	>14% (total >24% with other recent rate increases) >10% (SNFs)	Pending CMS approval (retro effective date of 1/1/24 requested)

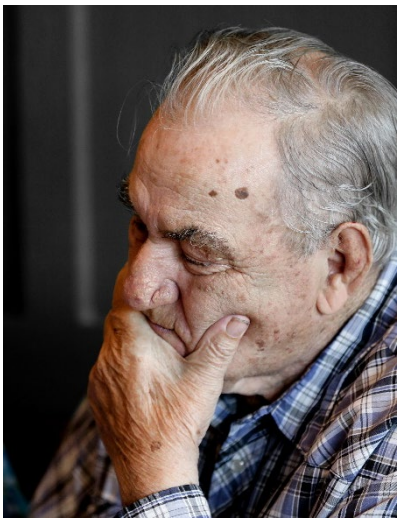
Nevada MAABD Population Care Coordination

Care coordination and care management are becoming increasingly important as healthcare coverage grows more complex, particularly for populations that have greater needs, such as the MAABD population, who may also be navigating multiple benefits sets. The absence of care coordination may result in fragmented or nonexistent communication between providers and services, with the risk of exacerbated health conditions and decreased quality of life. CMS has found that individuals without care coordination have an increased risk of getting unnecessary redundant tests and a "…lack of coordination can lead to negative health outcomes for patients, more use of emergency care, medication errors, poor transitions of care from hospital to home, and medical errors. These effects can have a greater negative impact on chronically ill patients or patients with multiple complex health conditions."[32]

The Nevada Medicaid program does offer some care coordination support to different subsets of the Medicaid population, but the current FFS Medicaid system of care for the MAABD population offers little in terms of intentional design and strategy to comprehensively support the MAABD populations.

Dually eligible MAABD members have Medicare benefits available, with Nevada Medicaid supplementing their Medicare coverage. MAABD populations who select a Medicare Advantage dual eligible special needs plan (D-SNP) have added benefits available through the D-SNP, referred to as Supplemental Benefits.

The MAABD population that qualifies for an HCBS waiver and/or is enrolled in a D-SNP does have access to some form of ongoing care management or care coordination. The state determines HCBS care manager requirements per the parameters at 42 CFR Part 441, Subpart G, and outlined in the CMS-approved 1915(c) waiver. Medicare determines the foundational D-SNP care management requirements, which the state may enhance through the state Medicaid agency contract (SMAC). The care coordination service is a key differentiator for Nevada MAABD populations who otherwise are left to navigate a fragmented Medicaid FFS healthcare system. Below is information about FE and PD HCBS care coordination, with information specifically about D-SNP care coordination located in Appendix F: D-SNP Care Coordination requirements.



CHALLENGE

The Nevada Medicaid program does offer some care coordination support to different subsets of the Medicaid population, but the current FFS Medicaid system of care for the MAABD population offers little in terms of intentional design and strategy to comprehensively support the MAABD populations.

[32] Centers for Medicare & Medicaid Services. Care Coordination. Available at: https://www.cms.gov/priorities/innovation/key-concepts/care-coordination. Accessed February 17, 2024.

Nevada Medicaid FE & PD Care Coordination

HCBS waiver case management had been supplied exclusively through a public option of state-employed case managers under the purview of the Aging and Disability Service (ADSD) until 2023. At that time, a private case management entity, CareLink, also started providing HCBS case management. The ADSD unit further administers an intake department that offers options for counseling and intake/referral functions. The ADSD unit is the designated state provider of aging and disability services and is the single Area Agency on Aging (AAA) in the state. Nevada also set up the Nevada Care Connection in 2005, which offers individualized assistance through Resource Centers, functioning as one of 50 “no wrong door” systems nationally.

The state-employed case management team is composed of approximately 70 case managers and 16 supervisors. Approximately 31 percent of the case managers are in the northern part of the state, with the remaining 69 percent in southern Nevada. The case distribution is noted below:

	Program Participants Served	Number of Public Case Managers	Case Load Ratios
Northern Case Management	944	22	43
Southern Case Management	2,289	47	46
Statewide Case Management	3,233	69	49

Interviews with state staff from ADSD conveyed some current challenges with the FE and PD case management system specific to capacity and case manager workforce. Specifically, the FE and PD case management division has a 25 percent vacancy rate, contributing to waiting list challenges. When the state has difficulty filling vacant positions, it affects the FE and PD MAABD population’s access to waiver services because case managers are needed to support caseloads. ADSD commented that this situation is under review, and potential solutions are being explored. The private case management entity has been minimally effective in helping the state get caught up with backlog as the new case management entity is only located in Clark County and is also experiencing hiring challenges.

Rebalancing

LTSS includes long-term care (LTC), such as nursing facility care, and HCBS services. Many of the MAABD population's LTSS are provided through HCBS FE and PD waivers,[33] as well as state plan coverage of home health and PCS. Since Medicaid's inception in 1965, states have been required to provide coverage for medically necessary nursing home care. HCBS funding options became available to states much later and have increased in significance because many individuals prefer to remain in their homes and communities, and HCBS usually is less costly than nursing facility care. In addition, HCBS plays an important role in states' efforts to comply with the Americans with Disabilities Act (ADA), the HCBS settings rule, and the Olmstead decision in which the Supreme Court held that the unjustified institutional isolation of people with disabilities is a form of unlawful discrimination under the ADA. Separate from the ADA, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) recently published a proposed rule under Section 504 of the Rehabilitation Act of 1973 (the Act) to ensure consistency with the integration mandate in the Olmstead case.[34]

Despite the evolving policy activity supporting greater focus on HCBS, a structural bias still persists in Medicaid programs toward institutional care based on the mandatory nature of covering custodial LTC, whereas HCBS is optional.[35] In light of the overarching federal policy in support of individuals living in the least restrictive setting of their choice, state rebalancing efforts are imperative to ensure consistency with federal policy. The need and demand for HCBS will continue to increase over the next 10 years as the population aged 65+ is both getting older and growing. Nevada's growth trend in the age 65 and older population continues to outpace growth in other age groups (i.e., 40% growth among people ages 65 and older in 2021−2023). Moreover, Nevada's population is expected to continue to age at higher rates through 2030.[36]

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[33] Nevada administers a 1915 waiver for individuals with intellectual and related disabilities that is outside the scope of this work and, therefore, is omitted from this report.
[34] Proposed rule titled Discrimination on the Basis of Disability in Health and Human Service Programs or Activities, HHS-OCR, FR Vol. 88, No. 177, September 14, 2023. The proposed rule, 42 CFR 84.76 (Integration) can be found on pages 63507−63508, and preamble language can be found on pages 63486−63487. The proposed rule is consistent with OCR's responsibility for enforcing Section 504 of the Act, which prohibits discrimination on the basis of disability in programs and activities that receive federal financial aid as well as programs and activities conducted by any federal agency.
[35] Medicaid and CHIP Payment and Access Commission. Considerations in Redesigning the Medicaid HCBS Benefit. March 4, 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/03/HCBS-Roundtable.pdf.
[36] Aging and Disability Services Division, Elders Count Nevada 2023 Report, p. 6.

National Medicaid spending on HCBS now exceeds spending on institutional services,[37] and similarly, Nevada's spending on HCBS exceeds spending on institutional services.[38] However, Nevada's percentage of expenditures for HCBS is lower than overall national spending on these services. Nationally, 62.5 percent of all LTSS spending is on HCBS, whereas 56.8 percent Nevada's LTSS spending is directed toward HCBS.[39] But, when looking at spending specifically for older people and adults with physical disabilities, a stark contrast is revealed. The AARP 2023 LTSS State Scorecard report shows that 53.3 percent of national LTSS spending went to HCBS, and 83.2 percent of "best state performer" LTSS spending went to HCBS, whereas only 33.5 percent of Nevada's LTSS spending went to HCBS.[40]

Nevada also continues to rank below the national average for HCBS services based on the five dimensions measured in the 2023 AARP Scorecard (see Table 6).[41] The 2023 AARP Scorecard shows that today Nevada is significantly behind the rest of the country in its rebalancing efforts. Notably, Nevada ranks 49th out of 51 (states and the District of Columbia) in the "affordability and access" dimension and 48th out of 51 in the "choice of setting and provider" dimension. Its overall ranking is 44.[42]

The affordability and access dimension measures consumers' ability to easily find and afford services, without LTSS disparities by income, race/ethnicity, or geography. The "choice of setting and provider" dimension measures consumer choice and control of services, including self-directed models, as well as whether people can access a well-trained and adequately paid LTSS workforce, culturally competent services and supports, and with wide availability of HCBS. These measures and others in the 2023 AARP Scorecard reflect needs that health plans generally manage well. Nevada's challenges with rebalancing HCBS for older adults and individuals with physical disabilities could be mitigated through a managed care model.

RURAL CONSIDERATIONS

Given that nearly 16 percent of the MAABD population in Nevada lives in rural areas, one factor in the state's rebalancing challenge is the provider and service access issues it faces in rural communities.

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[37] Centers for Medicare & Medicaid Services. State Medicaid Letter Regarding HCBS Measure Set. July 21, 2022. Available at: https://www.medicaid.gov/sites/default/files/2022-07/smd22003.pdf.
[38] According to CMS's Medicaid Long Term Services and Supports Annual Expenditures Report published June 9, 2023, as of 2020, Nevada's HCBS spending represented 56.8 percent of total LTSS expenditures, and institutional spending represented 43.2% of total LTSS expenditures.
[39] Ibid, p. (national) and p. 83 (Nevada).
[40] AARP Public Policy Institute. Long-Term Services and Supports State Scorecard, 2023 Edition. Available at: https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/medicaid-ltss-balance-spending#toc-how-to-improve.
[41] Ibid, p. 162 and Nevada LTSS Performance by Dimension.
[42] Ibid. The AARP scorecard ranks states and the District of Columbia 1−51 in overall performance, from top to bottom performance.

Siconolfi and colleagues found that disparities in rebalancing may exist because of supply-side factors, including limited availability of LTSS providers, lack of transportation services, broadband and telecommunications limitations, workforce recruitment and retention issues, and threats to business viability.[43] Given that nearly 16 percent of the MAABD population in Nevada lives in rural areas, one factor in the state's rebalancing challenge is provider and service access issues it faces in rural communities.

Table 6. AARP LTSS Scorecard 2023

Dimension	Nevada Ranking	Performance Tier Tiers 1-5, with Tier 1 = Best and Tier 5 = Worst
Affordability and Access	49	5
Choice of Setting and Provider	48	4
Safety and Quality	48	4
Support for Family Caregivers	19	3
Community Integration	33	3
Overall	**44**	**4**

Historical data also show that Nevada needs to continue rebalancing efforts aimed at older adults and people with physical disabilities. Based on CMS FY 2016 data, which was the last year CMS published the rebalancing percentage trends by population group for each state, Nevada's HCBS for older adults and people with disabilities represented 36.7 percent of its total LTSS expenditures, indicating that institutional spending represented more than 60 percent of all LTSS spending for this population.[44] As Table 7 below indicates, to catch-up with DD population efforts, Nevada has more progress to make on rebalancing efforts for older adults and persons with disabilities.

[43] Rural-Urban Disparities in Access to Home- and Community-Based Services and Supports: Stakeholder Perspectives from 14 States.

[44] Eiken S, Sredl K, Burwell B, Amos A. Medicaid Expenditures for Long-Term Services and Supports in FY 2016, Table 58. Medicaid Innovation Accelerator Program. May 2018. Available at: https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf.

Table 7. CMS Data on Nevada LTSS Percentage Trends, FY 2016 [45]

Percentages	FY 2013	FY 2014	FY 2015	FY 2016
Total LTSS as a Percentage of Total Medicaid	28.4%	23.0%	20.1%	20.8%
Percentage of LTSS that is HCBS	48.8%	50.1%	53.8%	56.7%
Percentage of LTSS that is HCBS-AD	35.0%	35.6%	36.1%	36.7%
Percentage of LTSS that is HCBS-I/DD	79.0%	81.4%	84.1%	83.5%
Percentage of LTSS that is HCBS-BHS	36.3%	40.2%	58.2%	71.0%

Although Nevada was one of 10 states with the greatest increase in HCBS expenditures as a percentage of total LTSS expenditures in 2013−2016 (achieving a 7.9% increase in the percentage of LTSS spending for HCBS during the study period, reaching nearly 57% of all LTSS spending going to HCBS by 2016),[46] funding for older adults and individuals with physical disabilities was much lower than the amount that was dedicated to individuals with developmental disabilities.

As a recipient of the Balancing Incentive Payment Program and Money Follows the Person grants, as well as by engaging in other initiatives, Nevada has invested its efforts in moving away from institutional care and toward community-based care. Presumably, Nevada intends to build on these investments by continuing to expand its choice of programs that mitigate the risk of older adults and individuals with disabilities resorting to institutional care.

[45] Ibid. (AD means older adults and/or people with physical disabilities, I/DD means intellectual/developmental disabilities, BHS means behavioral health services).
[46] Lewis E, Head MA, Saucier P. Selected Characteristics of 10 States With the Greatest Change in Long-Term Services and Supports System Balancing, 2012–2016 p. 48. Medicaid Innovation Accelerator Program. April 2019. Availablhe at: http://www.advancingstates.org/sites/nasuad/files/LTSS%20Rebalancing%20Top%2010.pdf. Accessed February XX, 2024.

SECTION 3: VALUE PROPOSITION: PACE, MLTSS, AND FIDE-SNPS

Introduction

DHCFP specifically charged HMA with assessing how PACE, MLTSS, and value-based purchasing (VBP) could strengthen the Nevada Medicaid delivery system to meet the needs of the MAABD population more effectively. After HMA gathered feedback about each option from stakeholders, DHCFP instructed HMA to turn its focus away from VBP because the Division needs to decide on other foundational changes for MAABD before considering whether to develop a VBP strategy.

To help with rebalancing (shifting LTSS dollars from institutional to HCBS care), enable more Nevadans to age in place, and decrease state Medicaid costs, Nevada should consider the value propositions of three models of care: Programs of All-Inclusive Care for the Elderly (PACE), Managed Long-Term Services and Support (MLTSS), and/or Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). Below is a high-level description of each of these models, with the remainder of this section comparing and contrasting these models.

- A **PACE** program, implemented through a CMS-approved Medicaid State Plan amendment, would integrate medical and social services for MAABD participants to receive all needed care through a PACE organization's 11-member interdisciplinary care team (IDT). Under this model, the PACE organization is at financial risk for all Medicaid and Medicare services plus any medically necessary services that the IDT prescribes. The PACE organization receives monthly capitated payments from the state Medicaid program and CMS payments to support all care needs. The model has proven successful in supplying whole person care to smaller populations, including people in rural areas, and offers the highest degree of program integration for dually eligible members.
- An **MLTSS** program would provide MAABD participants with a solid foundation of person-centered care, standardized assessments of participant need, well-organized care management with coordination of LTSS and other services, and rigorously measured performance metrics to ensure quality of care. The MLTSS plan receives monthly capitated payments from the state Medicaid program, which may include risk corridors to minimize MLTSS plan financial risk. Of the 24 states that have implemented MLTSS, some have capped profit policies, with all requiring a medical loss ratio (MLR) to ensure a state-set financial threshold is spent on participants' goods and services.
- A **FIDE-SNP** is a Medicare Advantage (MA) program specifically designed to integrate Medicaid, Medicare, LTSS, behavioral health and acute care benefits. FIDE-SNP programs offer robust care coordination models that support participants in navigating the different benefits sets, as well as completing assessments, typically having some role in HCBS waiver eligibility (assessing for, determining or recommending, etc.), completing person-centered care plans, and supporting those plans. FIDE-SNPs offer the highest degree of program integration, with most administrative processes (member materials, appeals and grievance process, etc.) fully integrated into one seamless program. FIDE-SNP models have resulted in improved health outcomes and cost savings.

More information about these models can be located in Appendix B: Analysis of Program Attributes of Recommendations.

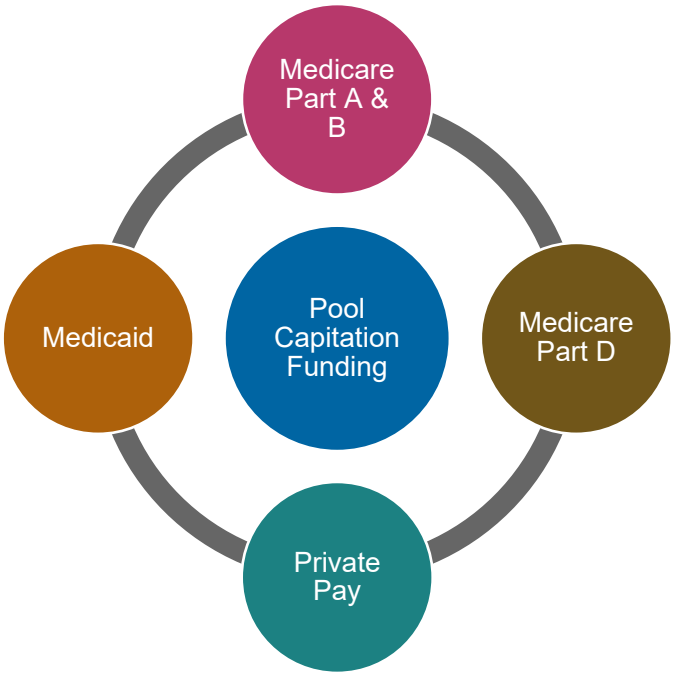
Nevada received a grant from Arnold Ventures that funded technical support to DHCFP to evaluate options for advancing Medicare and Medicaid integration for D-SNPs. Because about 70 percent of the Nevada MAABD population is dually eligible, DHCFP's vision for future D-SNP management and strategy is an essential consideration for any MAABD program recommendations.

Section Three of this report provides value proposition context for the recommendations included in Section Five. This section reviews the value proposition PACE offers as well as an MLTSS and FIDE-SNP model. The following key model components are reviewed under PACE first, followed by review of these components under an MLTSS/FIDE-SNP approach.

- Budget predictability
- Rebalancing benefits
- Extra benefits
- Care coordination
- Network development and access

PACE

PACE is a hybrid Medicaid-Medicare program option that state Medicaid agencies fund through a CMS-approved Medicaid State Plan amendment. The PACE model is designed to help older adults who meet the nursing facility level of care remain in their homes and communities as long as possible. The PACE model and its services and supports supply medical and social services and is a community-based alternative to skilled nursing facility care for many older adults. It uses an 11-member interdisciplinary care team (IDT) that includes the PACE participant. The IDT collectively focuses on the delivery of primary and preventive healthcare services and the implementation of a comprehensive and individualized care plan to address participants' medical, long-term supports, and social determinants of health (SDOH) needs. Participants' healthcare plans ensure that their medical and psychosocial needs are met.



The PACE program receives prospective monthly capitated payments from CMS to cover Medicare Part A (hospital), Part B (outpatient), and Part D (prescription drug) services for each PACE enrollee. The state Medicaid agency also makes a capitated monthly payment to the PACE organization to cover all Medicaid and non-Medicare covered service components, including institutional, HCBS, nutrition, and transportation.

PACE organizations pool member capitation payments to supply the best medically necessary care coordination for a participant. This flexibility allows the program to serve the needs of its participants without traditional Medicare and Medicaid restrictions on how the money can be spent. PACE organizations run at full risk and are incentivized to provide high-quality, comprehensive care that allows the IDT and PACE programs to provide the most appropriate care and services to meet participant needs.

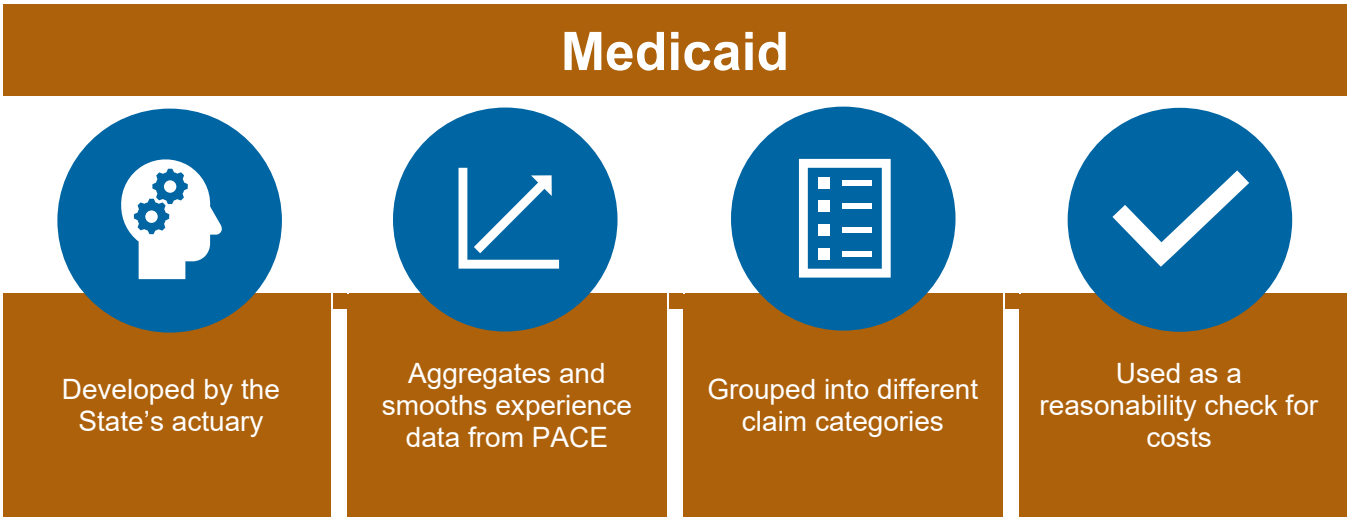
Through PACE program development, Nevada can use the opportunity to develop a targeted and intentional nursing facility (NF) diversion strategy by encouraging PACE organization development in both large urban and smaller rural service areas. PACE has a distinct advantage in addressing the service needs in smaller rural markets, as a PACE sponsor organization serves as both a direct provider and payer of care with its own delivery system. PACE organizations are tasked with building their service offerings internally through an IDT and a series of contracted specialty care service providers that augment the IDT's service offerings.

In rural service areas, PACE can develop larger internal service offerings to account for the lack of community providers. Because rural PACE organizations cover smaller populations of participants, it is easier to develop more internal capabilities that will directly assist PACE participants. PACE development in rural areas can provide Nevada with solutions to address the shortage of HCBS waiver services by supplanting the delivery system with PACE organizations that develop their own healthcare ecosystems staffed with directly employed clinicians and augmented by specialty care providers through contracts. PACE organizations are incentivized to increase their service offering ability by adding additional therapies and specialty care services as direct PACE services.

Budget Predictability

The PACE program provides state Medicaid agencies and CMS with budget predictability through the very nature of the program's capitated at-risk design. States first develop the amount that would otherwise be paid (AWOP) or non-PACE equivalent cost of supplying services in a non-PACE setting. Next, the state develops its capitation rate(s) that reimburse PACE organizations for all PACE Medicaid services. CMS develops PACE benchmark rates to reimburse PACE organizations for Medicare A and B services. PACE organizations also are paid a Medicare Part D Prescription Drug amount based on each PACE provider's annually approved Part D bid, which calculates the cost of supplying Medicare Part D drugs and covered services to PACE participants.

The Medicaid program's PACE reimbursement method is designed to provide states with programmatic cost savings, as PACE rates are always set below the AWOP. The AWOP is the state's FFS or managed care delivery system cost equivalent. States develop the non-PACE program cost of providing care to enrollees through the FFS or managed care equivalent program(s). The state then develops its actual PACE reimbursement rates. State PACE rates are based on projected and actual geographical PACE program costs. These costs are set for 18 unique service categories specific to PACE services. The state accounts for geographic cost variance in supplying services within the PACE organization's unique service area.



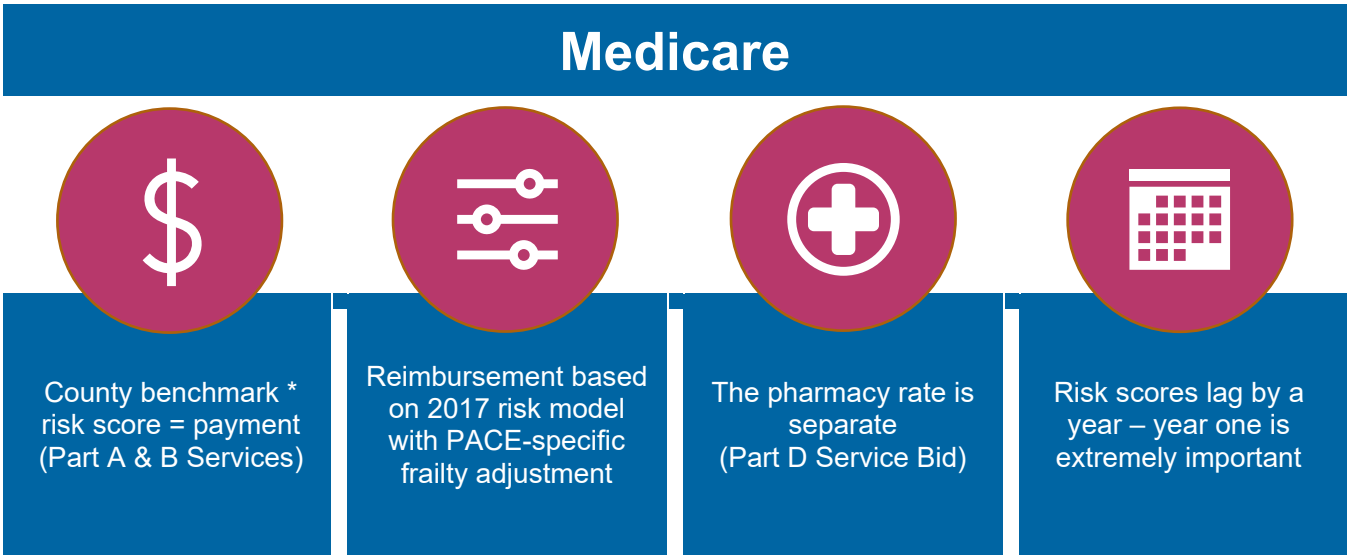
From a Medicaid program perspective, the state agency's actuaries set the Medicaid PACE rates using a blend of HCBS and institutional skilled NF care costs. These are the services that are most typically provided to Medicaid-eligible individuals who need help with activities of daily living (ADLs) and are not enrolled in a PACE program. The HCBS-institutional blend typically reflects a 60/40 mix of costs. Medicaid capitation payments to PACE organizations also are adjusted for frailty, calculated from the Health Outcomes Survey and modified data collected on PACE participants, which includes questions about physical, psychosocial, and behavioral health needs. The state's actuaries develop a payment rate range that includes low, mid, and upper limits. The state then compares its developed PACE rates to its AWOP. The state actuary will develop PACE rates within the acceptable rate range, which is always below the AWOP. Yet, it best reflects the average cost of supplying PACE services to the PACE organization's participants while ensuring cost savings to the state. Setting PACE rates below the AWOP ensures that the state will always achieve cost savings. In 2023, the National PACE Association reported that the average cost savings to the state per PACE participant was 12 percent.[47]

Table 8: Comparing PACE Medicaid Capitation Rates and State AWOPs

To assess the cost savings attributable to PACE, PACE payment rates can be compared to their corresponding AWOPs. Table 8 summarizes payment rates and AWOPs for dual-eligible enrollees age 65 and over.

Statistics	Medicaid 65+ Dual-Eligible AWOP	Medicaid 65+ Dual-Eligible PACE Rate	Estimated Savings in Percent PMPM Through PACE	Estimated Cost Savings PMPM Through PACE
Average	$4,761	$4,183	12%	$578
Median	$4,787	$4,309	10%	$478

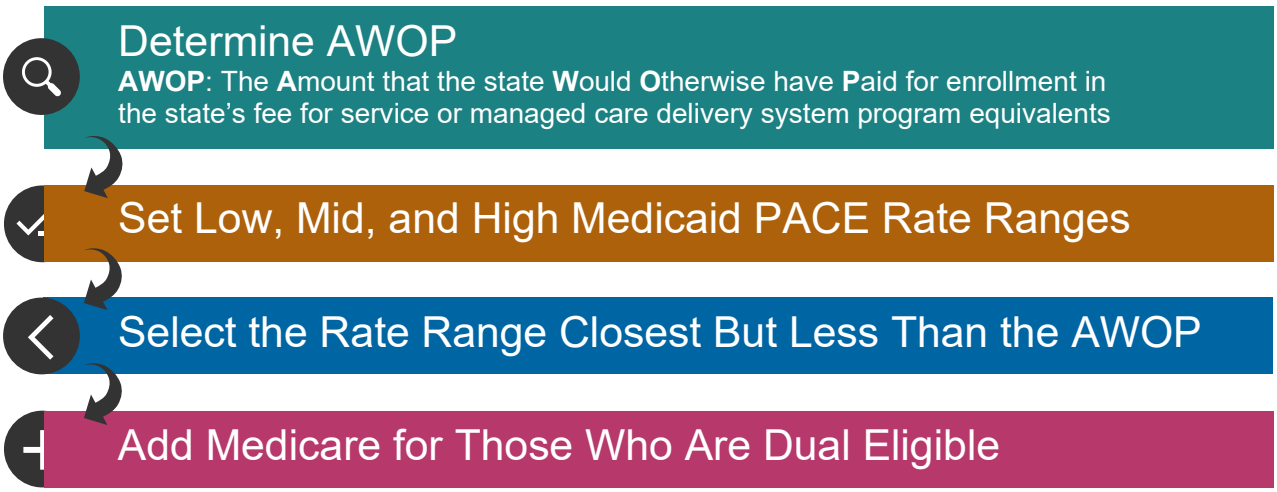
[47] National PACE Association. 2023 PACE Rates and Trends in Medicaid Payments. December 6, 2023. Available at: https://www.npaonline.org/about-npa/news/news/2023/12/06/2023-pace-rates-and-trends-in-medicaid-payments.



From a Medicare program perspective, payments to PACE organizations for Part A and Part B services are based on the MA payment system but unique to the PACE program. Under this system, a payment rate for each county is multiplied by an individual's risk score to determine the risk-adjusted payment for the participant. The payment rate for each county is either a benchmark intended to replicate what Medicare pays for beneficiaries in the traditional FFS program or last year's PACE rate with a growth percentage added. Risk is adjusted using the CMS hierarchical condition category (HCC) model, which accounts for participants' diagnoses and demographic characteristics.

Medicare payments to PACE providers for Part D (pharmacy) services are based on plan bids and adjusted for risk using the RxHCC model for drugs. PACE providers can use formularies and utilization management processes to address and control drug costs. Medicare sets up symmetric risk corridors for each plan to limit overall Part D losses or profits. The Medicare Part D drug costs are reconciled annually and may result in either over or under-payments based on the plans' submitted annual Part D bid.

Figure 25: How PACE Program Rates Are Set



Rebalancing benefits

PACE may have the greatest opportunity and strongest incentives to rebalance care from nursing facility care to community-based care and prevent or delay future inpatient expenses. PACE is an excellent institutional diversion strategy, with its primary focus and incentives on supplying all the necessary services and support for participants to lead active and vibrant lives in the community. The National PACE Association reports that 95 percent of PACE participants live in a community setting.

The IDT approach of offering care and support to PACE participants has proven that the program is effective in providing high-quality, community-based care. Studies have shown that the average PACE participant has lower hospital utilization and hospital readmission rates, which result in fewer avoidable hospitalizations than for peer populations.[48] PACE participants were found to have reduced hospitalizations and improved mental and physical health, allowing them to live another four years on average in their own homes and communities of choice while retaining a higher quality of life.

Extra Benefits

The development of PACE programs in rural areas can help ensure that frail older adults are not faced with accepting institutional care as their sole choice when they require assistance with their ADLs. Rural PACE programs can offer the needed HCBS care in the right setting, ensuring participants have access to comprehensive care coordination, accompanied by a care plan to keep participants healthy, vibrant, and active in their home and community of choice.

The PACE program supplies a range of services to improve and maintain participants' overall health as determined by the IDT, including all Medicare and Medicaid services. In addition, PACE participants can access services beyond the typical Medicare and Medicaid program offerings when the IDT decides such services are needed to improve and maintain the participant's overall health. This ability is attributable the flexibility that PACE organizations have to pool program funding, allowing the PACE IDT to select the best services for participants. The very nature of the program's all-inclusive design ensures that benefits and services stay in place even during periods of service cuts and reductions that could affect a state's Medicaid program.

Care Coordination

The PACE program's IDT coordinates all supplied primary care, preventive, specialty, outpatient, home healthcare and home care, inpatient hospital, transportation, prescriptions, and family caregiver support services, as well as participants' rehabilitative, diagnostic, and durable medical equipment needs. PACE organizations must have a written contract with each outside organization, agency, or individual that furnishes administrative or healthcare-related services that the PACE organization does not furnish directly.

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[48] Wieland D, Boland R, Baskins J, Kinosian B. Five-Year Survival in a Program of All-inclusive Care for Elderly Compared with Alternative Institutional and Home- and Community-Based Care. *J Gerontol A Biol Sci Med Sci*. 2010;65(7):721−726.

PACE IDTs also must coordinate skilled nursing facility (SNF) placement and care if a participant's acuity changes. The PACE teams direct most aspects of healthcare for participants who require SNF care. PACE participants who need SNF care remain enrolled in the program, which arranges for and covers institutional costs. Likewise, PACE members who require hospice and other end-of-life services remain enrolled in the PACE program and continue to have their care managed through IDTs.

Additionally, each PACE Center has an adult day health center or day center component to provide comprehensive medical and social services that help participants maintain their independence, quality of life, and ability to live safely in their own homes with PACE-provided supports. Services provided through the day center program include social services and supports, nutritious meals, counseling, socialization services, recreational therapy and activities, and transportation to and from a participant's residence.

Network Development and Access

The PACE program has a closed provider network, with most primary care, therapy, meals, recreation, socialization, and other healthcare and personal care services supplied directly through the PACE Center's IDT.

Each PACE Center houses a PACE Clinic that serves the medical and social needs of the PACE participants. Most PACE participants receive care at the PACE clinic through the PACE Center's IDT, which is tasked with serving most of their primary and preventive healthcare needs. The IDT includes doctors, nurses, occupational, physical, and recreation therapists, social workers, dietitians, home care coordinators, personal care aides, transportation drivers, the PACE Center manager(s), and other clinicians who coordinate and implement each participant's plan of care.

Within the PACE Clinic, the level of specialty care varies by PACE organization. Some provide specialty care services directly. Others contract with specialty care providers and or networks to deliver specialty and less common services that the IDT and PACE medical director approves. The PACE IDT coordinates all aspects of primary and preventive care, access to medical specialists, outpatient services, access to home healthcare services, inpatient hospital services, transportation, prescriptions, family caregiver support services, and its participants' rehabilitative, diagnostic, and durable medical equipment (DME) needs.

Under federal regulation 42 CFR 460.070, PACE organizations must have specialty care contract with the following 26 medical specialties.

- Anesthesiology
- Audiology
- Cardiology
- Dentistry
- Dermatology
- Gastroenterology
- General Surgery
- Gynecology
- Internal Medicine
- Nephrology
- Neurosurgery
- Oncology
- Ophthalmology
- Oral Surgery
- Orthopedic Surgery
- Otorhinolaryngology
- Palliative Medicine
- Pharmacy Consulting Services
- Plastic-reconstructive Surgery
- Podiatry
- Psychiatry
- Pulmonology
- Radiology
- Rheumatology
- Thoracic & Vascular Surgery
- Urology

In addition, PACE organizations must supply all medically necessary specialty care offered through the Medicare and Medicaid programs, plus any other medically necessary services that the PACE medical director authorizes. PACE contracted providers must be accessible to the participants and within or near the PACE Center service area.

Ten states have successfully launched PACE programs in rural areas: Arkansas, Colorado, Iowa, Kentucky, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, and Virginia. PACE development in rural and frontier communities offers potential solutions for states to address the tremendous need to increase medical and long-term services tailored to older adults in these often medically underserved areas. Federally qualified health centers (FQHCs), Tribal organizations, health and hospital systems, and hospice care providers often already offer senior care in rural areas and are positioned to be good partners for further PACE development in their communities. Most access to care issues, including transportation, can be addressed with PACE.

For example, PACE development in rural areas can be accelerated by states incentivizing local health care providers to develop solutions that address the increasing need for HCBS and the workforce shortage in their communities. Seniors trying to access services in rural areas face challenges that go beyond the limited number of providers and the complications of transportation to and from available provider sites. Access to healthcare workers is even more difficult in rural communities where providers compete for a limited pool of clinicians, social workers, and support staff.

PACE organizations can create new provider systems and access to the medical and LTSS that PACE IDTs provide. PACE organizations in rural areas can use technology such as tablets that support remote telehealth services. PACE Center programming enables participants to remotely connect with their care teams and socialize with other PACE participants. Additionally, connected devices, such as blood pressure cuffs, scales, glucose monitors, and wearables can give the IDT further insights into participant's overall health. At the same time, rural PACE models are exploring partnerships that include use of alternate care sites, community physicians, and home care services to extend a PACE Center's reach and workforce beyond the traditional PACE Center and its clinic.

Because of the potential limited availability of capital and workforce, especially individuals who can perform key functions for a PACE organization, flexibility in rural and Tribal areas is especially important. To date, CMS has shown commitment and willingness to work with rural and tribal communities to help them address the challenges of developing successful PACE programs, yet more efforts are needed to promote PACE in medically underserved areas.

MLTSS & FIDE-SNP Programs

MLTSS

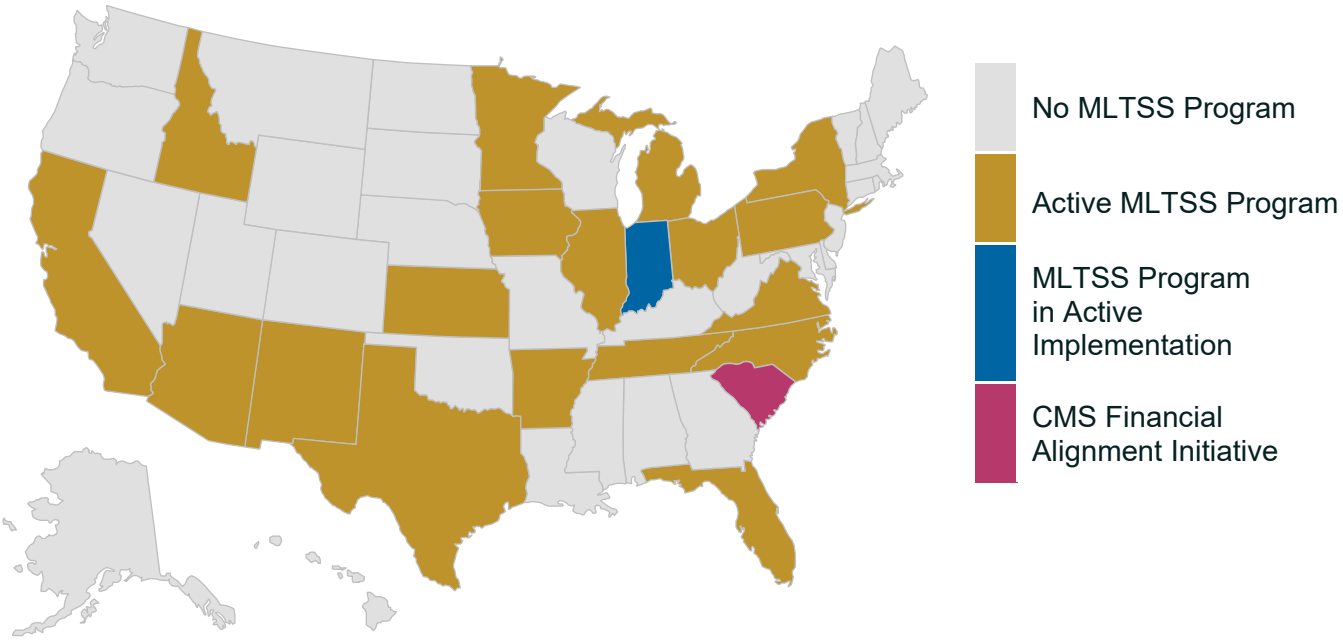
Managed long-term services and supports (MLTSS) is a Medicaid managed care option in which a state contracts with a managed care organization (MCO) for some level of Medicaid benefits, in addition to a mandatory institutional benefit and HCBS waiver services. MLTSS plans operate in nearly half of the states.

States that have implemented MLTSS programs offer varying degrees of benefit coverage, designing MLTSS programs around the needs of specific populations. MCOs have found their ability to directly manage and ease access to LTSS services effective in supporting program participants' overall goals including quality of life, independent living, and recovery. MLTSS plans must typically have a care coordinator and/or a service coordinator to complete state HCBS assessments, person-centered care planning, coordinate with care teams, and support benefit navigation and service provision. MLTSS program participants also have access to a variety of additional MCO wrap around benefits, known as value-added benefits or in lieu of services. States and plans vary in what they offer members.

Older adult (aged 65+) and adults with physical disabilities are the most common MLTSS HCBS populations. Few states include HCBS services for individuals with intellectual and/or developmental disabilities in their MLTSS programs.[49]

Figure 26. State Adoption of Managed Long-Term Services and Supports Programs, 2024[50]

MLTSS Programs as of January 2024



[49] Sellers Dorsey. State of Medicaid Managed Care Report, A Closer Look at managed Long-Term Services and Supports. 2024. Available at: https://pages.sellersdorsey.com/state-of-medicaid-managed-care?utm_campaign=MMC%20Report%202023&utm_medium=email&_hsmi=291093221&_hsenc=p2ANqtz-_kzV3OTCJel2ugVk8JbdysUCm5fPAWdS5Sy0oBKIYGBNcDPhpfAbUihye_SycuoBDJR8zTrp5dMYVOo6ll-XBGzyUr_A&utm_content=291093221&utm_source=hs_email.

[50] State of Medicaid Managed care Report, A Closer Look at Managed Long-Term Services and Supports. Sellers Dorsey, 2024. State of Medicaid Managed Care (sellersdorsey.com)

States may exercise authority to promote alignment of MLTSS dual eligible special needs (D-SNP) MA plans, facilitating higher levels of coordination for dually eligible individuals enrolled in both MCOs and D-SNPs. FIDE-SNPs provide the most integrated form of Medicare and Medicaid coverage under a single legal entity. Starting in 2025, FIDE-SNPs must operate with exclusively aligned enrollment, which means that full-benefit dual eligibles (FBDEs) enrolled in the state's Medicaid MCO for LTSS must receive their Medicare benefits from the same parent company.

FIDE-SNP Programs

FIDE-SNP programs are designed around a targeted, population-specific model of care that includes an assessment process, care team and care plan, and care coordination, which has demonstrated outcomes and could reduce preventable emergency department (ED), inpatient, and nursing home use through an increased emphasis on prevention, social needs, and HCBS.[51] FIDE-SNP plans offer the fullest integration of any D-SNP option, spanning the clinical, operational, and administrative functions of an MCO. FIDE-SNP program participants are offered deep coordination support, including medical, behavioral health, HCBS, pharmacy, and institutional services across the continuum of care. Program participants do not need to know which payment source covers specific benefits, as they are all integrated into one program with MCO supports available to help navigate when necessary.

In addition to the financial benefit of a FIDE-SNP program as a strategy to reduce cost shifting between Medicaid and Medicare, Medicare policy changes over the past decade have made FIDE-SNP models more attractive to states. These policy changes have granted state Medicaid agencies more authority and decision-making opportunities in terms of what services states can leverage FIDE-SNP plans to offer. Though MCOs need to have a contract with CMS to offer a FIDE-SNP, Medicare requires that they also contract with state Medicaid agencies. In addition, FIDE-SNPs must have CMS-approved Model of Care (MOCs). Both these tools provide states with opportunities to partner with FIDE-SNP plans to deliver upon state-set goals while more meaningfully integrate and support care for dually eligible populations.

According to CMS, "As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC supplies the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC supplies the foundation for promoting SNP quality, care management, and care coordination processes."[52]

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[51] Minnesota Managed care Longitudinal Data Analysis, ASPE, March 2016. https://aspe.hhs.gov/reports/minnesota-managed-care-longitudinal-data-analysis-0

[52] CMS.gov, "Model of Care," accessed February 27, 2024, https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care#:~:text=As%20provided%20under%20section%201859,of%20each%20of%20its%20enrollees.

States have several value propositions to incorporate FIDE-SNP models into their delivery systems. For instance, SNP MOC requirements mandate that MCOs invest in cross-functional team planning and resources to focus on how to best meet the needs of their dual eligible population. Another benefit is that MOCs provide program participants and the industry with quality data to assess plan performance because MOCs are scored with publicly posted results. Furthermore, MOCs create an avenue for FIDE-SNP provider networks to get dual-eligible and other population-specific education to support improved care and healthcare outcomes, as annual FIDE-SNP provider network training on the population is a requirement.

CMS requires that all D-SNPs have a state Medicaid agency contract (SMAC). Though CMS has been encouraging states to require that Medicaid services be incorporated into their MOCs, D-SNP MOCs predominantly focus on Medicare benefits.[53] In contrast, the SMAC is a key regulatory tool states can use to drive integration of services and supports, including key Medicaid components such as Medicaid LTSS. Nevada's SMAC outlines the responsibilities of MA plans around several areas, including cost-sharing, care coordination, and data-sharing requirements.

Key SMAC Provisions for Nevada's SMAC (January 1, 2024−December 31, 2025)

1. The MA plan agrees to coordinate the delivery of Medicaid benefits and services.
2. The MA plan agrees to share information on Medicaid provider participation with the state Medicaid agency upon request and, at minimum, annually and in writing.
3. The MA plan agrees to take such steps to verification of enrollee eligibility for both Medicare and Medicaid.
4. The MA plan agrees to make the D-SNP available, at minimum, to individuals specified.
5. The state Medicaid agency is not responsible for payment of MA premiums for mandatory or optional supplemental benefits unless specifically prescribed in the state plan.
6. The state Medicaid agency is responsible for adjudicating the cost sharing obligations under the state plan and will remain financially responsible for cost sharing obligations and Medicaid benefits for D-SNP enrollees. The MA plan has three responsibilities including cost sharing obligations, adjudicating and paying claims.
7. MA plans must offer services to urban Clark and Washoe Counties if authorized by CMS. Plans also may offer services in other Nevada counties if authorized by CMS.
8. The SMAC sets the contract period for the D-SNP.
9. The MA plan shall supply care coordination. 1) The MA plan shall supply the following state Medicaid agency services and related coordination when medically necessary and appropriate. 2) The MA plan shall supply a listing of the following supplemental benefits, subject to the CMS MA bid review and approval process. The state Medicaid agency will supply contact and resource information, including sister agencies such as those within the Department of Health and Human Services referenced above, to the extent available.

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[53] Integrating Medicaid Managed LTSS into D-SNP Models of care, ICRC, June 2019. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC-MOC-Tip-Sheet-June-2019.pdf

Budget predictability

MLTSS Programs

The financing structure for MLTSS programs is grounded in the same framework as Medicaid MCO programs; however, the capitation rate setting process for comprehensive MLTSS programs is more refined, given the complex needs of the target populations and the addition of LTSS. One additional consideration is how the state funds institutional care. There are several benefits to including institutional care in an MLTSS program, including alignment of incentives for the MCO to ensure the best effort is put forth to prioritize HCBS supports for participants to remain in the community as long as possible. Setting MLTSS capitation rates may be more complex than setting capitation rate for traditional Medicaid populations because of the wide variability across complex populations and their LTSS needs.[54] It is imperative that MLTSS payment rates be sound to encourage plans to provide whole-person, person-centered care. Assuming sound capitation rates, MCOs will have more flexibility to address participant needs because incentives will be aligned across all services to provide the most effective array of services in an integrated manner.

Medicaid Managed Care

More than 40 state Medicaid programs, including Nevada's, run comprehensive managed care programs that use a capitation model. Under this arrangement, states pay Medicaid MCOs a fixed, capitated amount to supply care focused on specific quality and access measures and outcomes for Medicaid members. This structure has supplied budget or fiscal stability for states by having MCOs assume the financial risk of administering high-quality, cost-effective Medicaid services for members. If MCOs are inefficient in supplying these services—and costs exceed the Medicaid cap—they must absorb the excess costs. If, however, they are efficient and successful in keeping costs lower than their capitation payments, they earn a modest margin. When MCOs succeed in earning margins, state Medicaid programs also succeed, as lower expenditures underpinning those margins are reflected in future capitation rates, which then helps states better manage the overall growth rate of Medicaid spending. In this way, capitation works to align state goals with MCO incentives.

Many states have developed reasonable risk mitigation strategies to balance the capitation payment system's inherent risks and opportunities for gains.[55]

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[54] Macpac. Managed long-term services and supports. Available at: https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/#:~:text=Factors%20involved%20in%20setting%20capitation,program%20goals%20through%20financial%20incentives.

[55] HMA. Medicaid Managed Care Payment Policy. Restoring Capitation's Incentives to Advance State Goals Post-Public Health Emergency (PHE). August, 2023. Available at: https://www.healthmanagement.com/wp-content/uploads/White-Paper_HMA_08.02.23_Final.pdf)

Capitation incentives are key to encouraging MCOs to achieve state goals. States benefit most from capitation rates when incentives are robust, and they are strongest in a full-risk capitation model, under which states prospectively pay MCOs a fixed amount per enrollee. The stability of this payment model creates meaningful incentives for MCOs to work efficiently because MCOs assume full risk for gains and losses. Under this arrangement, they are incentivized to spend less than 100 percent of the capitation rate and provide for members' needs, meet quality targets, and generate margins that they can use to make further investments in care quality and state goals, while continuing to operate as viable businesses.

State Medicaid programs use managed care's capitation model to achieve broad goals. They claim that Medicaid members are better served in a comprehensive managed care program than through the FFS system. States benefit from the budget predictability that fixed capitation rates provide. Capitation provides MCOs with incentives and flexibility to transform payment and care delivery, create new care models, and implement value-based payment (VBP) models. As policymakers appreciate, state Medicaid programs differ in how they design managed care programs, but their goals are similar.

According to a report that the Association for Community Affiliated Plans (ACAP) commissioned, The Menges Group estimated that "the MCO model delivered nationwide Medicaid savings of $7.1 billion in 2016, assuming that provider unit prices Medicaid MCOs are equivalent in the aggregate to Medicaid fee-for-service (FFS) levels. The $7.1 billion figure is an overall savings of 2.6 percent on all the funds paid via capitation." The Center for Evidence-Based Policy reported that Medicaid managed care has yielded savings in several states including Texas, Ohio, and Pennsylvania in the billions, when compared with FFS.[58, 59]

Risk Mitigation Strategies

State Medicaid programs use risk mitigation strategies by building on the capitation model. Across the nation, states differ greatly in how they design MCO risk mitigation strategies, with varying effects on capitation's incentives. State risk mitigation policies have varying effects on capitation's incentives. Risk mitigation can support, strengthen, or weaken incentives, depending on the state's strategies.

State Medicaid programs have considerable latitude in designing risk mitigation strategies. States typically consider the need for risk mitigation during the capitation rate development process. Some states use risk mitigation mechanisms in targeted ways to address capitation rate uncertainties in supplying certain services or covering certain populations; one example is the use of risk corridors. Others use profit caps or minimum medical loss ratios (MMLRs) to limit the total amount MCOs can spend on administrative costs and earn in profit or use risk corridors to supply financial protection for both the state and its MCOs. Finally, some states use a combination of these mechanisms; for example, risk corridors in tandem with MMLRs.

MMLR

Federal rules require Medicaid health plans to calculate and report minimum medical loss ratio (MMLR) using standards that are similar to those used in MA and commercial plans. This requirement is intended to allow comparisons of plan performance among the major healthcare programs and across states. Health plans report MMLR as an expression of healthcare spending divided by revenue, with revenue equating to adjusted premium revenue minus federal, state, and local fees and taxes.

Federal rules also require that states develop capitation rates such that health plans could reasonably achieve an MMLR of at least 85 percent for the rate year, though some states set the MMLR at a higher percentage. Medicaid plans do not have to issue rebates to a state if they do not meet the state's MMLR. In Medicaid, a state can decide whether to recoup any excess revenue between the minimum threshold and actual MCO spending on healthcare, or to adjust capitation rates in future years. MMLR is one of several tools that states can use to assess whether capitation rates are appropriately set and to assess and/or limit the total amount MCOs can spend on administrative costs and earn in profit.[56]

Many states consider MCO spending on quality improvement activities (QIAs) and value-added benefits (VABs) in calculating MCO spending on benefits to incentivize innovation. As an alternative to MMLR, some states implement other mechanisms to limit MCO profit or account for uncertainty in risk. States may use risk corridors, which allow MCOs to share in both upside (e.g., savings) and downside (e.g., loss) risk. Risk corridors can be used with or without MLRs. They also can supply financial protection for both the state and its MCOs.[57, 58]

FIDE-SNP

Budget predictability

A comprehensive state Medicaid program that includes LTSS with an aligned FIDE-SNP would provide the state with greater budget predictable and an opportunity to drive rebalancing.

The MLTSS plus FIDE-SNP options for dually eligible enrollees is based upon a capitated model of managed care. The financing arrangement for this option combines Medicaid payments from the state's Medicaid agency and Medicare payments from CMS through a single plan. The state Medicaid agency operates this plan in collaboration with CMS, using a person-centered model of care. This benefit to one plan receiving capitated payments from both Medicaid and Medicare to cover the full continuum of benefits is one of the strongest financial aspects of a FIDE-SNP plan. With this design, the MCO is incented to be efficient and effective in meeting participants needs and can innovate in ways state FFS systems cannot as MCOs have more flexibility in how they can use capitation payments.

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[56] Macpac. Medical Loss Ratios in Medicaid Managed Care. January 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/01/Medical-loss-ratio-issues-in-Medicaid-managed-care-3.pdf.

[57] HMA. Medicaid Managed Care Payment Policy. Moving Beyond COVID-19 Public Health Emergency Risk Corridors. May, 2021. Available at: https://www.healthmanagement.com/wp-content/uploads/White-Paper_Risk-Corridors_HMA_May-2021-5.7.21-v3.pdf.

[58] HMA. Medicaid Managed Care Payment Policy. Restoring Capitation's Incentives to Advance State Goals Post-Public Health Emergency (PHE). August, 2023. Available at: https://www.healthmanagement.com/wp-content/uploads/White-Paper_HMA_08.02.23_Final.pdf)

The FIDE-SNP, a type of D-SNP, holds a contract with CMS, but also holds a Medicaid contract with the state Medicaid agency. Additionally, all D-SNPs must also hold a State Medicaid Agency Contract (SMAC), which creates a FIDE-SNP. The state's SMAC outlines fundamental integrated care program details for dually eligible individuals that could enroll in the FIDE-SNP. Through the Medicaid agency contract and the SMAC, the state can advance state goals around care coordination and other provisions such as the financial and payment provisions.[59]

Under a fully integrated care program for dually eligible individuals, the state Medicaid agency makes monthly capitation payments for Medicaid covered services, and CMS makes monthly capitation payments for Medicare covered services, to a single plan to provide whole-person-centered, coordinated, and integrated care to exclusively aligned, dually eligible enrollees.

For Medicaid-covered services including LTSS, the state sets the capitation rates and payment provisions, in accordance with all applicable federal and state laws, regulations, rules, billing instructions, and bulletins. The state selects participating plans, typically based on a competitive bidding process for plans, which requires all plans submitting a bid to also be a D-SNP. For FIDE-SNP payments for Medicare-covered services, plans must comply with all Medicare Advantage and Medicare Part D requirements, in accordance with its Medicare Advantage D-SNP Contract with CMS, including an annual financial bid process that annually calculates the Medicare capitation payment rate for FIDE-SNPs.

For comprehensive Medicaid managed care programs including LTSS for dually eligible individuals, the states must set a base capitation rate, to which they might apply risk adjustment. They will then apply a risk score to the base capitation rate. States may also apply additional adjustments to the base capitation rates including quality withholds, alternative payment methodology, or other state-specific adjustments. States may vary significantly in how they design their Medicaid payment policy, based on state goals and priorities.

To ensure that the capitation rates are actuarially sound and in accordance with 42 CFR 438.4, states may establish several rating categories by region, then categorize enrollees with similar risk. Some states establish rating categories for those residing in the community versus those residing in a nursing facility. States may also establish rating categories and payment methodologies to incentivize plans to rebalance the LTSS care delivery system. For example, the state may wish to pay plans a higher rate for enrollees making the transition from the nursing home to the community, or a lower rate for enrollees making the transition from the community to a nursing home, for a short period of time.

States also use the contracting process to outline the Medicaid medical loss ratio (MLR) requirements. In general, state requires that the plan calculate an MLR for Medicaid covered services in accordance with 42 CFR 438.8. Most states will require the plan to maintain a minimum MLR requirement of 85 percent in the aggregate for the plan's total enrolled population. States may also require the plan to remit the difference between the actual Medicaid-only MLR numerator and the Medicaid-only MLR numerator.

States may require the plan to calculate a blended MLR that applies to all covered services, including Medicare. An MLR limits the administrative costs and profits for plans. The state may also use other risk mitigation tools including profit caps, risk corridors, and performance incentives.

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[59] https://www.integratedcareresourcecenter.com/resource-category/dual-eligible-special-needs-plans-d-snps

MLR

"The MLR reflects the proportion of total capitation payments received by an MCO spent on clinical services and quality improvement, where the remainder goes to administrative costs and profits. While states must develop Medicaid capitation rates to achieve an MLR of at least 85 percent (in the rate year), states are not required to set a minimum MLR for their managed care plans. While there is no federal requirement for Medicaid plans to pay remittances to the state if they fail to meet the MLR standard, states have discretion to require remittances."[60]

According to federal and state rules, state Medicaid programs and CMS calculate plan MLRs for Medicaid and Medicare separately. CMS has set the Medicare MLR at 85 percent. This holds true, even for FIDE SNPs. State Medicaid programs have the flexibility to set a minimum MLR at 85 percent or higher, apply and set remittance requirements for MCOs, and adjust the formula for calculating the MLR, according to federal rules. If the state sets a remittance requirement, then the state must account for this requirement as part of the federally required actuarial certification. States may include additional plan spending on health-related social needs (HRSNs) in the MLR calculation, as they have the flexibility to identify which health plan activities may improve health care quality. On the Medicare side, MA plans must "reasonably achieve an MLR of at least 85 percent for the rate year." On the Medicaid side, managed care plans must calculate and report MLRs to the state Medicaid program. State Medicaid programs may use a different methodology than Medicare's MLR methodology.[61]

Rebalancing Benefits

MLTSS Rebalancing

Rebalancing Medicaid LTSS spending toward HCBS settings and supplying more options for people to live in and receive services in the community is a key goal for all states. Many states have specific rebalancing targets, as well as financial incentives for MLTSS plans to meet them. The number of plans used to administer MLTSS programs varies by state, a decision largely based upon the impacts on member choice and the administrative complexity the state is willing to accept. In states that have operated MLTSS programs for several years, and as the programs stabilize, their focus turns to monitoring health outcomes. Though increasing, states have focused much less on developing meaningful MLTSS quality measures, which has presented a challenge with the consistent data collection and benchmarks necessary to manage a VBP program. So far, most LTSS quality measures tend to focus on process rather than on measurement of quality of life, community integration, avoidance, or delay in need for institutional care appropriate for people experiencing chronic conditions, limitations in functional ability, or advancing age. States predict that successfully rebalancing LTSS toward HCBS will help to support other MLTSS program goals, including improved quality of life, expanded access to HCBS services, and lower costs.

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[60] Hinton E, Raphael J, Gifford K. KFF. Strategies to Manage Unwinding Uncertainty for Medicaid Managed Care Plans: Medical Loss Ratios, Risk Corridors, and Rate Amendments. April 10, 2023. Available at: https://www.kff.org/medicaid/issue-brief/strategies-to-manage-unwinding-uncertainty-for-medicaid-managed-care-plans-medical-loss-ratios-risk-corridors-and-rate-amendments/

[61] Breslin E, Di Paola S, McGeehan S, Kellenberg R, Maresca A. HMA. The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit Raising Rural Voices from New Mexico, North Dakota, and Tennessee to Create Action. January, 2023. Available at: https://www.healthmanagement.com/wp-content/uploads/RuralAccessToolkit_R6.pdf.

FIDE-SNP Rebalancing

The fundamental mechanics of a FIDE-SNP program support rebalancing when strategically structured, given that FIDE-SNP plans can be designed to bear full financial risk for Medicaid, Medicare, HCBS, and at least 180 days of institutional care. Minnesota, one of the earliest adopters of a fully integrated program, collaborated with actuaries to figure out the right formula for MCOs to bear full risk of institutional costs and ensure proper financial incentives towards prioritization of HCBS. This model has been in place for more than 25 years, has expanded to be statewide and has contributed to Minnesota's long-term success in having a rebalanced LTSS system. Beyond the alignment of financial incentives to influence a preference toward HCBS, the nature of the FIDE-SNP plan managing both Medicaid and Medicare benefit sets removes the risk for cost shifting between the programs.

As previously mentioned, states have multiple levers to influence FIDE-SNP program design through Medicaid contracts. In this regard, the value proposition for MLTSS plans to support rebalancing also applies to FIDE-SNP programs. States can include specific care coordination requirements in FIDE-SNP programs that further support rebalancing and community integration strategies. One example of this in the Minnesota model is requiring that care coordinators assigned to support participants living in the nursing homes are trained on HCBS and are qualified to conduct HCBS waiver assessments, efficiently supporting a move back into the community at the participant's request. FIDE-SNP models offer states a variety of policy and program levers that support rebalancing.

Extra Benefits

Additional MLTSS Benefits

Under federal rules, MCOs, including those that offer MLTSS, may incorporate value added benefits (VABs) into their plans. VABs are extra services that MCOs supply above or outside of what they are contractually required to provide. They are not built into MCO rate structures but are included in the numerator of MLR calculations as incurred claims or quality-related activities. Types of VABs that are often included in MLTSS plans are home repairs to reduce falls, cleaning to reduce asthma triggers, installing bathroom grab bars, and introducing exercise programs, among other examples.

Under certain federal authorities, states may give MCOs flexibility to offer in lieu of services (ILOS), i.e., services or settings that substitute for standard Medicaid benefits if medically appropriate and cost-effective. In January of 2023, CMS released new ILOS guidelines, setting guardrails for financing ILOS and clarifying that ILOS can also be preventive in nature and not simply an immediate replacement for other medical care.[62] Several states, such as California, Oregon, Kansas, and New York, have taken advantage of these new ILOS rules to allow MCOs to pay for more non-medical services that support participants' health-related social needs.

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[62] Hinton E, Diana A. KFF. Medicaid Authorities and Options to Address Social Determinants of Health. January 29, 2024. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/#endnote_link_610726-6. Accessed on February 26, 2024.

FIDE-SNP Extra Benefits

If sufficient financing is available (as determined annually during the Medicare bid process), MA plans may offer supplemental benefits. If CMS determines an MA plan has rebate dollars left after the bid process, the plan may use that money to offer benefits and services that go above and beyond those covered by traditional Medicare. For a FIDE-SNP, rebate dollars may be applied to benefits and services beyond Medicaid acute care and HCBS benefit coverage limits. In addition to price (premiums and cost-sharing) and plan network, supplemental benefits allow MA plans to differentiate themselves from their competitors.[63]

Nevada's D-SNPs offer a range of supplemental benefits not typically available through Medicare but are offered through Medicaid programs. For example, one plan offers an extra benefit card to help pay for everyday expenses like healthy foods, over-the-counter health products, and even rent According to Nevada's SMAC, the MA plan shall provide a listing of any of the following supplemental benefits, subject to the CMS Medicare Advantage bid review and approval process. This list[65] includes:

- Dental
- Vision
- Hearing aids
- Transportation to and from medical visits and pharmacies
- Personal emergency response system (PERS)
- Nursing hotline
- Telemedicine
- Meal services after acute care
- Fitness packages and plans

In a 2022 *Journal of the American Medical Association* article, Jin and colleagues reported that 41.1 percent of FIDE-SNP beneficiaries were enrolled in plans covering food and produce benefits, and 15.5 percent were offered non-medical transportation services.[66] Among dual-eligible enrollees, 14.4 percent of D-SNPs enrollees and 8.8 percent of general MA plan members were offered food and produce benefits. Nonmedical transportation was covered for 8.5 percent of dual-eligible enrollees in D-SNPs and for 5.8 percent in general MA plans. Benefits such as home-delivered meals, home modifications, and social services for individuals with chronic illnesses were offered to fewer than 10 percent of dual-eligible beneficiaries. Of the 42 supplemental benefits available, 22 were offered to fewer than 1 percent of dual-eligible beneficiaries and 8 percent were not offered by any plan.[67]

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[63] Faulhaber J, Ipakchi N. HMA. Medicare Advantage Supplemental Benefits: Current Landscape and Future Direction. Available at: https://www.snpalliance.org/wp-content/uploads/2020/05/faulhaber-ipakchi-hma-snpa.pdf.
[64] Aetna. Medicare Solutions. Available at: https://www.aetnamedicare.com/sites/mydsnp2024.html.
[65] State of Nevada. Dual Eligible Special Needs Program. Available at: https://dhcfp.nv.gov/Pgms/DSNP/Dual_Eligible_Special_Needs_Plans_(D-SNP)/.
[66] National Library of Medicine. Examination of Differences in Nonmedical Supplemental Benefit Coverage for Dual-Eligible Enrollees in Medicare Advantage Plans in 2021. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9539713/
[67] Ibid.

CMS has recently taken action to ensure that, by 2025, it will have the data needed to answer key policy questions related to supplemental benefits, including what services are offered, how much plans are spending, which enrollees use which services, the cost to enroll participants, and plan-level utilization.[68] CMS has conducted technical assistance calls to assist plans in reporting encounter data for supplemental benefits, including special supplemental benefits for people with chronic conditions. CMS is also collecting more data related to the MA value-based insurance design model, which evaluates how MA plans can more comprehensively address the medical and health-related social needs of participants, advance health equity, and improve care coordination for patients with serious illnesses.[69]

Care Coordination

MLTSS Care Coordination

Approaches to care coordination structures vary by state. Some states require one care coordinator to navigate across all the benefits included in an MLTSS contract, while others require MCOs to assign each member both a care manager (e.g., a registered nurse) and a service coordinator (e.g., a licensed practical nurse or a licensed clinical social worker). MCO care coordinators typically play a significant role in assessing HCBS waiver eligibility and subsequently offering support in service planning and coordination of HCBS providers.

The cadence of interventions (both face-to-face and virtually) also varies by state. CMS HCBS settings rules apply to all MLTSS programs, so models must be person-centered, with care planning and service decisions ideally made by the participant and/or a designee.

Some MLTSS care coordination models are highly delegated, meaning the MCO contracts with community-based organizations, healthcare systems, or county staff providing care coordination. Others have an MCO staff model, meaning all care coordinators are MCO employees. Some mix both models. MLTSS care coordination models often are enhanced further by other traditional MCO disease and case management programs, such as behavioral health case management or diabetes care management. These services generally are offered telephonically or in partnership with an MLTSS care coordinator. Caseload ratios vary and typically account for a participant's complexity, geography, setting, and other special healthcare or cultural needs. MCOs usually have greater success engaging their members when LTSS benefits are included.

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[68] CMS. Biden-Harris Administration Launches Effort to Increase Medicare Advantage Transparency. January 25, 2024. Available at: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-launches-effort-increase-medicare-advantage-transparency.

[69] ATI Advisory. New, Non-Medical Supplemental Benefits in Medicare Advantage in 2023. February 21, 2023. Available at: https://atiadvisory.com/resources/wp-content/uploads/2023/02/2023-New-Non-Medical-Supplemental-Benefits.pdf.

FIDE-SNP Care Coordination

All D-SNPs have basic care coordination requirements related to annual health risk assessments (assessing participants' functional, physical and psychosocial needs), development and implementation of care plans, the use of care teams, and an increasing focus on health-related social needs and caregivers. Beyond those basic expectations, FIDE-SNPs have other requirements to coordinate Medicaid and Medicare benefits and to align care management with key participant tools, such as directories, participant communications, and appeal, grievance, and other processes.

States have the ability to influence the FIDE-SNP care coordination model beyond Medicare requirements. In essence, a FIDE-SNP care coordination model is a state's Medicaid MCO and MLTSS care coordination model with other Medicare requirements that FIDE-SNP plans must deliver. Some states require MCOs to have one designated care coordinator for all benefit sets, whereas other state models require distinct roles be involved in certain aspects of the FIDE-SNP benefit set (e.g., a designated service coordinator for HCBS services only). Figure 27 illustrates how a FIDE-SNP model can be extremely robust for plans that must follow Medicaid MCO, MLTSS, and D-SNP requirements.

Figure 27. FIDE-SNP Care Coordination

Sample FIDE-SNP Care Coordination Model Attributes

States determine Medicaid Care Coordination/Case Management requirements and FIDE-SNP plans are required to additionally meet Medicare requirements.

Acute Care Medicaid MCO Contract Requirements	LTSS Medicaid MCO Contract Requirements	Medicare Model of Care MCO Contract Requirements
• Enrollee screening • Disease and Case Management • Behavioral Health Case Management • 24/7 Nurseline • Healthy Pregnancy programs • Health Coaching • Incentive programs for preventative health	• Intervention expectations, in person or virtual ○ Annually at a minimum, could be monthly • Person-centered assessments • HCBS waiver assessments • Assessments to determine need for custodial care (nursing home)	• Interdisciplinary Care Team, typically led by the Care Coordinator • Documented communication strategy • Health Risk Assessments • Development of Individualized Care Plan • Care Transition Protocols

As previously stated, states have different regulatory tools, such as the CMS MOC and the SMAC requirements, to direct plans in delivering certain types of care coordination models or to have a designated focus on a particular population or quality initiative. The MOCs also require FIDE-SNP plans to document in detail their approach to care coordination. The MOC requirements place notable emphasis on seamless coordination of care and within an interdisciplinary care team. The MOCs are scored and require a high standard for approval, ranging from one year for low scores to three years for higher scores. Once a MOC is approved, it becomes a regulatory document that functions as a contract. This ensures that the FIDE-SNP plan delivers what was submitted, requiring the FIDE-SNP plan to submit requests to CMS for review and confirmation of any significant model changes the plan may want to implement, prior to the MOC approval period ending.

Across the country, a wide and expanding range of SMAC provisions are being put in place to ease care coordination. Through a FIDE-SNP, Nevada would have significant new opportunities to better coordinate care for dual MAABD populations and to advance rebalancing through an MLTSS contract. The Nevada SMAC, which runs through the end of 2025, specifies several care coordination requirements as follows:

1. The MA plan shall provide care coordination.
2. The MA plan shall provide the following State Medicaid Agency services and related coordination when medically necessary and appropriate.
3. The MA plan shall provide a list of the following supplemental benefits, subject to the CMS Medicare Advantage bid review and approval process. The State Medicaid Agency will provide contact and resource information, including the sister agencies referenced within the Department of Health and Human Services above, to the extent available.[70]

Network Development and Access

PACE, MLTSS, and FIDE-SNP have varying policy requirements, funding strategies, and network adequacy expectations. Each model uses a capitated payment methodology that allow plans and PACE organizations to use financing more flexibly, supporting their ability to pay a higher rate for some services and in certain geographies when needed to meet adequacy requirements. Nonetheless, workforce shortages affect all these models as well as Medicaid FFS networks. The federal government continues to develop policies on network adequacy, and states are given flexibility to cultivate their own measurement approaches, thereby perpetuating variability across Medicaid nationally.

Nevada's largely rural geography presents unique challenges, which could benefit from new delivery models. How Nevada can support and build its provider network in rural parts of the state is a significant consideration. The challenges (a low volume of members across a large geographic area, limited numbers of providers of all types, difficulty recruiting and keeping a skilled workforce, and a lack of transportation options) are unchanging. However, each of the models has the potential to mitigate these concerns, depending on policy decisions.

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[70] Nevada 2025 State Medicaid Agency Contract. Document is confidential, please make any follow up requests to the Nevada DHCFP Agency.

MLTSS Network

MLTSS plans must offer robust networks for the benefit sets outlined in their contracts with the state Medicaid agency. The Medicaid managed care regulation allows states to develop their own network adequacy standards, which can differ from the state's Medicaid FFS network adequacy requirements. States usually employ any number of methods, including time and distance standards, maximum travel times to provider locations, provider-to-participant ratios, wait times, and provider availability for new patients.[71] Federal regulation regarding Medicaid MCO network adequacy has evolved over the past decade. States must develop an approach to ensure MLTSS MCO network adequacy for at least seven distinct acute care provider types:[72]

- Primary care providers for adults and pediatrics
- OB/GYNs
- Behavioral health providers for adult and pediatric mental health and substance use disorders
- Specialists (as named by the state) for adults and pediatrics
- Hospitals
- Pharmacies
- Pediatric dental providers

Regulatory requirements are less prescriptive in terms for MLTSS plan and their LTSS networks, though the federal regulation does require states to develop a quantitative LTSS adequacy standard for MLTSS plans.

Developing network adequacy standards for LTSS and finding methods to effectively measure access, is challenging given the community-based nature of many of many long-term care services. Typically, MAABD enrollees have a high need for a diverse and robust provider network to address their medical, behavioral health, and LTSS needs. With acute care Medicaid, time and distance metrics typically are used, but these measures rarely translate well for the LTSS that direct care workers living in many different geographies often provide. Federal EVV requirements present new opportunities for states and MLTSS plans to use data in a new way to assess network adequacy. The federal government is finalizing two key rules that may bring more uniformity to the state of MLTSS network adequacy: Ensuring Access to Medicaid Services and Managed Care Access, Finance, and Quality.

Meanwhile, the benefits to an MLTSS plan for states is that they can tailor their MLTSS network adequacy requirements to drive MLTSS plans to focus on particular network areas by setting targeted adequacy expectations or measurement strategies. This approach should be implemented in tandem with workforce development requirements. When used strategically, MLTSS contracts provide states with an effective method to partner with Medicaid MCOs to address network challenges.

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[71] Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes. KFF. June 15, 2023. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/.
[72] National Archives and Records Administration. CFR 438.68 Network Adequacy Standards. Amended February 21, 2024. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68#p-438.68(b).

Improving access to providers for rural residents is a health equity goal for CMS and state Medicaid programs, both of which have created new policies to address provider shortages. For example, to expand access to behavioral health services, CMS established a policy that allows clinical staff in hospital outpatient departments to provide remote services. CMS first implemented this policy in response to the COVID-19 public health emergency (PHE). Telehealth and telemedicine have become solid solutions for addressing provider shortages in rural areas and are a key part of CMS's rural health strategy. Nonetheless, telehealth's application to rural residents with disabilities and the limitations of telehealth use (due to broadband and internet limitations) require further consideration. Nevada could partner with MCOs to implement innovative ways to deliver telehealth services and supports to people enrolled in the FE and PD waiver programs.

States also can use levers such as requiring MLTSS plans to be available in both urban and rural areas of the state. For example, if an MCO intends to have an MLTSS plan in a county with a sizeable member population, they also must commit to also serving people in a more rural county.

FIDE-SNP Network

State Medicaid programs can more meaningfully use Medicaid and Medicare plan expertise to address network gaps for dually eligible members. Network adequacy for a FIDE-SNP essentially involves meeting network adequacy requirements that differ for both Medicaid and Medicare. Medicare has set network adequacy requirements and formulas that apply nationally, as well as clearly defining cadence for when plans must submit network files for CMS to assess for adequacy. In addition, FIDE-SNP plans must satisfy the state's MLTSS network adequacy required in their Medicaid contracts, as described above. Hence, FIDE-SNP plans must monitor their networks closely to ensure compliance with different regulators.

Specific to the Medicare portion of a FIDE-SNP, CMS allows plans to submit a network exception request as part of the adequacy testing. The network exception accounts for patterns of care and the stark realization that many areas lack providers. An exception is not approved if the reason for the request is a plan being unsuccessful in executing a contract with an existing provider. The circumstances must be extenuating for CMS to consider approval. CMS's policy on network exceptions for FIDE-SNPs has been evolving and now includes collaboration with Medicaid state regulators to gather their input to consider a plan's request.

Approving and accepting a gap may overlook possibilities to offer innovative solutions and recommend policy changes. State Medicaid programs can play a more active role in addressing provider shortages in rural areas by partnering with Medicaid and D-SNP plans to fill network gaps. For example, through the SMAC, states may require plans with approved network exceptions to formulate and submit a gap-closure plan to the state, along with progress reporting expectations to ensure ongoing attention and accountability. Plan progress reports would help states better understand provider challenges and cultivate best practices on how plans can support provider access. Some states already benefit from this type of reporting with respect to recruitment and retention strategies for workforce development of direct support professionals. CMS network adequacy requirements, in tandem with the network exception request, offer a pathway to address provider shortages affecting dually eligible individuals at the federal, state, and plan levels.

SECTION 4: MAABD QUALITY

Introduction

Measuring the quality of Nevada's MAABD programs is important to ensure that Nevadans benefit from the Medicaid system of care. However, because Nevada lacks an overarching Medicaid quality framework, limited data on the quality of Medicaid services offered to people who are aged, blind, or have disabilities (ABD) and the program's quality exists.

Nevada's Medicaid Managed Care Quality Strategy is the most detailed approach in the state and falls under the purview of DHCFP. The Managed Care Quality Strategy does not drive quality for the Nevada MAABD population because this eligibility group is currently excluded from Medicaid managed care, and the majority of LTSS services are not included in the Medicaid managed care contracts.

- The quality measures that Nevada uses (e.g., population-level data, sentinel events, Patient Experience Survey) suggest that access to care and staff turnover are the MAABD program's biggest challenges.
- An aligned quality framework with short- and long-term goals will help Nevada track quality across all MAABD programs, even as the state's program offerings evolve.

Analysis of Nevada MAABD Quality Structure

A robust quality framework for Nevada's MAABD population and programs ensures that Nevadans benefit from high value care by identifying processes to improve care when services are of lower value. Nevada's MAABD population receives care across the Medicaid FFS system (i.e., Medical Assistance and the HCBS waiver), and for 70 percent of the MAABD population, also through Medicare. Nevada offers no Medicaid managed care coverage MA ABD populations, though the option is illustrated in this report.

In most aspects, the Medicaid programs in which MAABD operates lack a unified quality strategy. MAABD population enrollment in each system and existing quality frameworks/attributes are shown below.

Table 9: MAABD Population and Quality Frameworks/Attributes

Program Description	FFS Medical Assistance (Medicaid) only	MAABD HCBS Waivers for Frail Elderly and Physically Disabled people in FFS	Dual Eligible Special Needs Plans (D-SNPs)	Medicaid Managed Care
MAABD Population Enrollment	134,193	2,271	22,094	Exempt
Quality Frameworks	None	HCBS quality assurance and compliance required by 1915 C waiver requirements, NCI and HCBS measures in the future	As required by 42 CFR 422.162 Medicare: Model of Care, stars, CAHPs, HEDIS	As required by CFR 436 Medicaid Managed Care Quality Strategy 2022-2024 which does not include MAABD population

Using Nevada Medicaid MAABD Population Data for Quality Measurement

Limited data is available regarding the quality of care specific to Nevada's MAABD program participants. Common Medicaid quality frameworks are not implemented in Nevada for the MAABD population, and recent National Core Indicator (NCI) or National Quality Forum (NQF) quality reports are unavailable. The National Committee for Quality Assurance (NCQA) quality reports cannot stratify data by age or disability to delineate the unique experiences of the MAABD Medicaid subpopulation.

Nonetheless, the state can turn to population-level or program-level data to gain insights into the quality of care for the MAABD population, including information on sentinel events, ombudsman experiences, population composition, and staffing dynamics.

- The top two **sentinel events** in Nevada healthcare reports[73] are falls and pressure ulcers, which often occur among MAABD populations.
- Caseloads for long-term care **ombudsman** programs have increased dramatically, suggesting that more individuals are experiencing problems or concerns while[74] in long-term care.
- The Annual Statewide Consolidated HCBS FE/PD Waiver Review Final Report[75] showed that **staffing turnover** and staffing shortages will directly limit MAABD participants, limiting access to care and quality.

Quality Assurance in Nevada's FE/PD Waivers

Existing 1915(c) waiver requirements for quality assurance are regulatory and compliance-based, and less useful for driving improvements and favorably impacting participant experience measures. On July 21, 2022, the Center for Medicaid & CHIP Services released a letter to all state Medicaid directors outlining its intention to promote nationally standardized measures to drive improvement in quality of care and outcomes among people who are enrolled in HCBS. In alignment with CMS guidance, the Nevada ADSD staff interviewed shared their plans to pursue the nationally recognized NCI quality framework for the state's FE and PD waivers. DHCFP's HCBS FE and PD waivers recognize that many people at risk of placement in hospitals or nursing facilities can receive care in their homes and communities, preserving their independence at an average cost no higher than that of an institutional care.

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[73] Department of Health and Human Services Nevada Division of Public and Behavioral Health (DPBH). Sentinel Event Registry. Available at: https://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/.
[74] Elders Count Nevada. 2023. Available at: https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders_Count_2023-Final.pdf.
[75] State of Nevada Division of Health Care Financing and Policy. October, 2023. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/Grants/2022%20FE-PD%20Final%20Consolidated%20Report%20ADA.pdf.

Nevada's efforts to follow waiver requirements and other elements in the waiver application provide a foundation for a future MAABD population quality strategy. The annual statewide consolidated HCBS FE/PD waiver review final report, published in August of 2022[76] for the 2021 waiver review period, supported renewal of the FE/PD waivers, showed assurances of the health, safety, and welfare for HCBS program participants. The waiver quality assurances provided to CMS pertains to the effectiveness of HCBS service plans and shows the state's approach to monitor and ensure HCBS program participant health, safety, and welfare. States ensure the health, safety, and welfare of HCBS program participants through ongoing monitoring and improvements focused on the following:[77]

1. Level of care determinations
2. Individuals' plans and service(s) delivery
3. Provider qualifications
4. Recipient health, safety, and welfare
5. Financial oversight
6. Administrative oversight of the waiver

For Nevada's 2021 results, five components improved from the previous review period, including "frequency/duration/scope of each service is identified" at 97 percent, with a 4 percent increase, and "Plan Of Care (POC) revised as needed" at 99 percent, a 1 percent increase from the previous year. There were upward trends in monthly contacts, some health and safety issues, waiver service satisfaction, and assessment of personal goals, all improving at least one percent. Additionally, five elements that were at or above 98 percent remained consistent from the previous waiver year, including "Meets LOC," "LOC is accurate," "LOC completed annually," "POC completed annually," and "Monthly contacts."

The six patient experience questions with the lowest scores, indicating unmet needs, were:

- Access to care
- Choice in staff
- Changing staff
- Directing staff
- Contact for reporting staffing problems
- Equipment or modifications

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[76] State of Nevada Division of Health Care Financing and Policy. Annual Statewide Consolidated HCBS FE/PD Waiver Review Final Report. 2022. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/Grants/2022%20FE-PD%20Final%20Consolidated%20Report%20ADA.pdf.

[77] State of Nevada Division of Health Care Financing and Policy. Annual Statewide Consolidated HCBS FE/PD Waiver Review Final Report. 2022. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/Grants/2022%20FE-PD%20Final%20Consolidated%20Report%20ADA.pdf

COVID-19 restrictions, staff turnover, and staff shortages were found to be at the root of quality assurance deficiencies.[78] Participant Experience Survey (PES)

The PES is one way Nevada measures HCBS program participant satisfaction with their services, service quality, and outcomes. DHCFP quality assurance (QA) staff and the ADSD staff interview program participants using the participant experience 16-survey interview tool (PES interview tool). Staff select a random sample of HCBS FE and PD waiver program recipients to participate in the annual PES interviews from Carson City, Las Vegas, and Reno. They conduct PES interviews monthly (ADSD) and biannually (DHCFP QA). The most recent PES interviews took place July 2021−June 2022, and entailed 350 program participants and 167 PES completed interviews. The necessary COVID-19 pandemic precautions were in place during some of this time.

Staff mailed the PES interview tool with an accompanying cover letter. They then made follow-up calls to complete the interviews via telephone or inform participants of a survey option. During the reporting period, more than one-third of the 94 surveys mailed to HCBS program participants were completed. Critical or high-risk issues were promptly communicated to the proper ADSD office staff. The 12 questions with the highest recipient satisfaction ratings were:

- Staff time
- Case manager helpfulness
- Overall satisfaction with case manager
- Overall satisfaction with services
- POC development
- Respect from home care staff
- Careful listening from home care staff
- Respect from day program staff
- Careful listening by day program staff
- Respect from transportation staff
- Careful listening by transportation staff
- Community involvement

The six questions with the lowest scores, indicating negative responses about unmet needs, were reviewed on the previous page.

Inconsistencies in answers were noted in responses from the HCBS FE and PD waiver participants. For example, much of the state experienced staffing shortages for many types of providers, explaining why access to care, choice in staff, and changing staff were noted as high needs during the review period. Many recipients identified unmet needs as the result of staff shortages and often positively commented about the diligence of the case management staff in watching those situations. In addition to responding to questions, program participants clearly expressed their satisfaction with their case managers, as well as with their providers, and reported that they actively took part in the development of their POC.

[78] Microsoft Power BI (powerbigov.us)

HCBS Quality Measures in Nevada's FE/PD Waivers

States and the federal government have taken steps over the past decade to assess HCBS quality, ensure access to services, and protect the safety of individuals in HCBS. Specifically, CMS has enhanced HCBS quality oversight, promoted interoperability standards, proposed new quality metrics, standardized assessment tools, and provided demonstration opportunities to assess innovation. These efforts culminated in CMS's release of an HCBS quality measure set in 2022.[79] The measure set is designed to bring national consistency to HCBS quality measurement and develop a comparative data set specific to HCBS. The 2022 HCBS quality measure set state Medicaid director correspondence outlined measures for inclusion and more guidance. The measure set was introduced as a voluntary possibility, with CMS stating the measures will be used to address the service plan Section 1915(c) waiver sub-assurances, and some of the health and welfare Section 1915(c) waiver sub-assurances.[80]

The HCBS Quality Measure Set used existing relevant quality frameworks and validated measures in place nationally. The measure set includes questions from surveys used to assess experience of care, which is an important aspect of quality and outcomes in HCBS. Some of the quality frameworks used for the experience of care surveys include:

- HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS)®
- National Core Indicators®-Intellectual and Developmental Disabilities (NCI®-IDD)
- National Core Indicators-Aging and Disability (NCI-AD)™
- Personal Outcome Measures (POM)®

Measure set domains include:

- **Access**, defined for the purposes of the measure set as the level to which the beneficiary, family caregiver, and/or natural support is aware of and able to access resources (e.g., peer support, respite, crisis support, information, and referral) that support overall well-being.
- **Rebalancing,** commonly defined as achieving a more equitable balance between the share of spending and use of services and support delivered in home and community-based settings compared to institutional care.
- **Community integration**, focused on ensuring self-determination, independence, empowerment, and full inclusion of children and adults with disabilities and older adults in all parts of society; and HCBS setting requirements.

The final CMS HCBS Settings rule requires that all HCBS settings meet the following qualifications:

- Is integrated in and supports full access to the greater community
- Is selected by the individual from among setting options
- Ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimizes autonomy and independence in making life choices
- Facilitates choice of services and who provides them

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[79] Medicaid. HCBS Measure Set SMDL. July, 2022. Available at: https://www.medicaid.gov/sites/default/files/2022-07/smd22003.pdf.
[80] Medicaid. HCBS Measure Set SMDL. July, 2022. Available at: https://www.medicaid.gov/sites/default/files/2022-07/smd22003.pdf.

Nevada's Medicaid Managed Care Quality Strategy

The most detailed Nevada Medicaid quality strategy is its Managed Care Quality Strategy. DHCFP has purview over Nevada Medicaid managed care programs. As described in the DHHS DHCFP Financing Policy 2022-2024 Quality Strategy,[81] CMS requires state Medicaid and CHIP agencies that contract with MCOs to develop and maintain a quality strategy to assess and improve the quality of healthcare and services that MCOs provide. These programs only offer Medicaid and CHIP benefits to members residing in Clark and Washoe counties, excluding MAABD and 1915 HCBS-eligible individuals.

The managed care quality framework does not drive quality for the Nevada MAABD population because this eligibility group is excluded from Medicaid managed care, and most HCBS services are delivered outside of the Medicaid managed care contracts. Therefore, the existing Medicaid Managed Care Strategy does not address the unique needs of the growing and diverse MAABD population in the state.

Even though the Medicaid quality strategy does not focus on the MAABD population, some goals are clearly applicable. The Medicaid Managed Care Quality Strategy supplies a solid foundation to identify key quality of care activities and initiatives, monitoring and compliance, a refined process for quality strategy development, and reviews and revisions that MAABD populations would benefit from, should they be applied to MAABD programs. Medicaid goals include:[82]

- Improve the health and wellness of Nevada's Medicaid population through increased use of preventive services
- Increase use of evidence-based practices for members with chronic conditions
- Reduce misuse of opioids
- Improve the health and wellness of pregnant women and infants
- Increase use of evidence-based practices for members with behavioral health conditions
- Increase use of dental services
- Reduce and/or end healthcare disparities for Medicaid members

The DHCFP mission aligns with the quality strategy in driving MCOs to focus on improving the quality of healthcare services. As noted in the quality strategy, "DHCFP's mission is to buy and provide quality healthcare services, including Medicaid services, to low-income Nevadans in the most efficient manner. Further, DHCFP seeks to promote equal access to healthcare at an affordable cost to Nevada

[81] State of Nevada Department of health and Human Services. Division of Health Care Financing Policy, Quality, and Strategy. 2022-2024. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Board/Quality_Strategy_2022-24.pdf.
[82] State of Nevada Department of health and Human Services. Division of Health Care Financing Policy, Quality, and Strategy. 2022-2024. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Board/Quality_Strategy_2022-24.pdf.

taxpayers, to restrain the growth of healthcare costs, and to review Medicaid and other State healthcare programs to maximize potential federal revenue."[83]

The quality strategy also is designed to align with the Nevada DHCFP strategic plan. The purpose of DHCFP's quality strategy is to:[84]

- Establish a comprehensive quality improvement system consistent with the National Quality Strategy and the CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs
- Provide a framework for DHCFP to implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system
- Find opportunities for improvement in the health outcomes of the enrolled population through preventive care services, chronic disease and special needs management, health promotion, and access to high-quality and culturally-appropriate care
- Identify best clinical practices and means of making healthcare more affordable
- Improve member satisfaction with care and services

The quality strategy outlines several different methods that DHCFP has selected to achieve the quality strategy goals, including:[85]

- Developing collaborative strategies among state agencies and external partners to improve quality of care, health education and health outcomes, and access to services for all Nevada Medicaid and Nevada Check Up members.
- Implementing performance measures, performance improvement projects (PIPs), contract compliance monitoring, member experience surveys, network adequacy and availability of services standards, clinical practice guidelines (CPGs), alternative payment methods (APMs), MCO quality assessment and performance improvement (QAPI) programs, and state-driven quality improvement initiatives to drive improvement in member healthcare outcomes
- Strengthening evidence-based prevention, wellness, and health management initiatives
- Enhancing member services and member satisfaction
- Improving health information technology to ensure that information retrieval and reporting are prompt, accurate, and complete.
- Revising MCO contracts to support Continuous Quality Improvement in all program areas

Of note, the Medicaid quality strategy covers many MCO quality initiatives, but does not detail every quality initiative MCOs have in place to support Medicaid members outcomes and experiences.

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[83] State of Nevada Department of health and Human Services. Division of Health Care Financing Policy, Quality, and Strategy. 2022-2024. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Board/Quality_Strategy_2022-24.pdf.
[84] State of Nevada Department of health and Human Services. Division of Health Care Financing Policy, Quality, and Strategy. 2022-2024. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Board/Quality_Strategy_2022-24.pdf.
[85] State of Nevada Department of health and Human Services. Division of Health Care Financing Policy, Quality, and Strategy. 2022-2024. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Board/Quality_Strategy_2022-24.pdf.

Opportunities for Alignment of Existing Quality Strategies

Program Description	FFS Medical Assistance (Medicaid) only	PACE	MAABD in Home and Community Based Services (HCBS) waivers for Frail Elderly and Physically Disabled (in FFS)	Dual Eligible Special Needs Plans (D-SNPs)	Medicaid Managed Care
Quality Committee required	No	Yes	No	No	Yes
Quality strategy required	No	Yes	No	Yes	Yes
Data	Adult core measure set (would need to be stratified for ABD)	Reporting requirements	Quality assurance data available now, NCI and HCBS measures in the future	Stars, CAHPS, and HEDIS	Adult core measure set (would need to be stratified for ABD)
Requirement of targeted activities for improvement	No	Yes	No	Yes	Yes

Quality Strategy Opportunities for Nevada's MAABD Population

Create a Statewide, Aligned Quality Strategy for the MAABD Population

Nevada has a comprehensive Medicaid Managed Care Quality Strategy in place. This framework can be used to create a separate quality strategy for the MAABD population. A strong MAABD quality strategy would focus on the core elements of a quality strategy:

- Establishing a governance structure or quality committee
- Analyzing data and information to establish quality of care baselines and trends
- Finding two to three priority areas to focus on for improvement across all programs
- Identifying and implementing evidence-based interventions
- Tracking outcomes through a statewide dashboard

The administrative effort needed to perform these tasks across programs varies and will require different resources. Under managed care, D-SNPs, and PACE, the state can shift the administration of these quality activities to the payer or provider, which would be reimbursed through the normal rate setting or fee schedule processes. State staff would undertake the managed care oversight of these activities. In the FFS program, the state would need to conduct most of these activities; however, aligning them across the programs would decrease the workload.

The MAABD quality strategy can have short- and long-term goals.

Examples of short-term MAABD quality goals include:

- For FFS Medicaid, extract the results for the mandatory reported adult core set measures for MAABD and present the information in a dashboard
- Create an interdepartmental/cross-functional quality committee charged with the production and analysis of quality data, prioritization of areas of focus, and collaboration across divisions and across funding sources to implement interventions
- Take the existing Medicaid Managed Care Quality Strategy and create a subsection for MAABD

The state should set goals to be reviewed annually that result in true quality improvements.

Examples of long-term MAABD quality goals include:

- If a PACE program is created and implemented, require sites to align their quality plan to the state's MAABD quality strategy and add PACE program data to the quality dashboard
- As the FE/PD waivers incorporate HCBS and NCI measures in the future, use the results to refine the quality strategy and drive corrective actions or PIPs
- If the state includes MAABD in its Medicaid managed care contracts, require stratified reporting of HEDIS measures by population, include some HCBS measures in required reporting, or require plans to receive the NCQA distinction for LTSS
- Make dashboards publicly available so provider or facility reports can inform individual choice

Elements of FE/PD Waiver Quality Framework to Consider for an Aligned Quality Strategy

The FE and PD quality strategies use data and information from:

- Case file reviews
- Financial reviews
- Participant experience surveys (such as CAHPS)
- Medicaid claims and utilization data
- Other surveys such as the NCI or POM

Care managers are at the center of quality assurance, compliance, and improvement in the FE and PD waivers. State staff report that this works well with high rates of waiver participant satisfaction. Care managers regularly monitor the health and welfare of waiver participants and review case files to ensure that needs are documented, plans are in place to address these needs, and that providers address risks. Care managers review critical incidents, unplanned hospitalizations, and any concerns related to abuse or neglect. They then follow up within five days and take proactive steps to mitigate risks.

Care managers arrange transportation for participants in rural areas so that they can access the services they need. However, the lack of providers that serve populations with disabilities is such an acute problem in Nevada that participants sometimes have had to travel out of state to have their needs met. All care managers are trained in cultural awareness and communications, many are multi-lingual, and the state supplies interpreters to meet the language access needs of participants.

Quality can also be improved through adequate access to services. Recently, the state has increased FFS rates for HCBS providers to address shortages, but the effects of this change have yet to be measured.

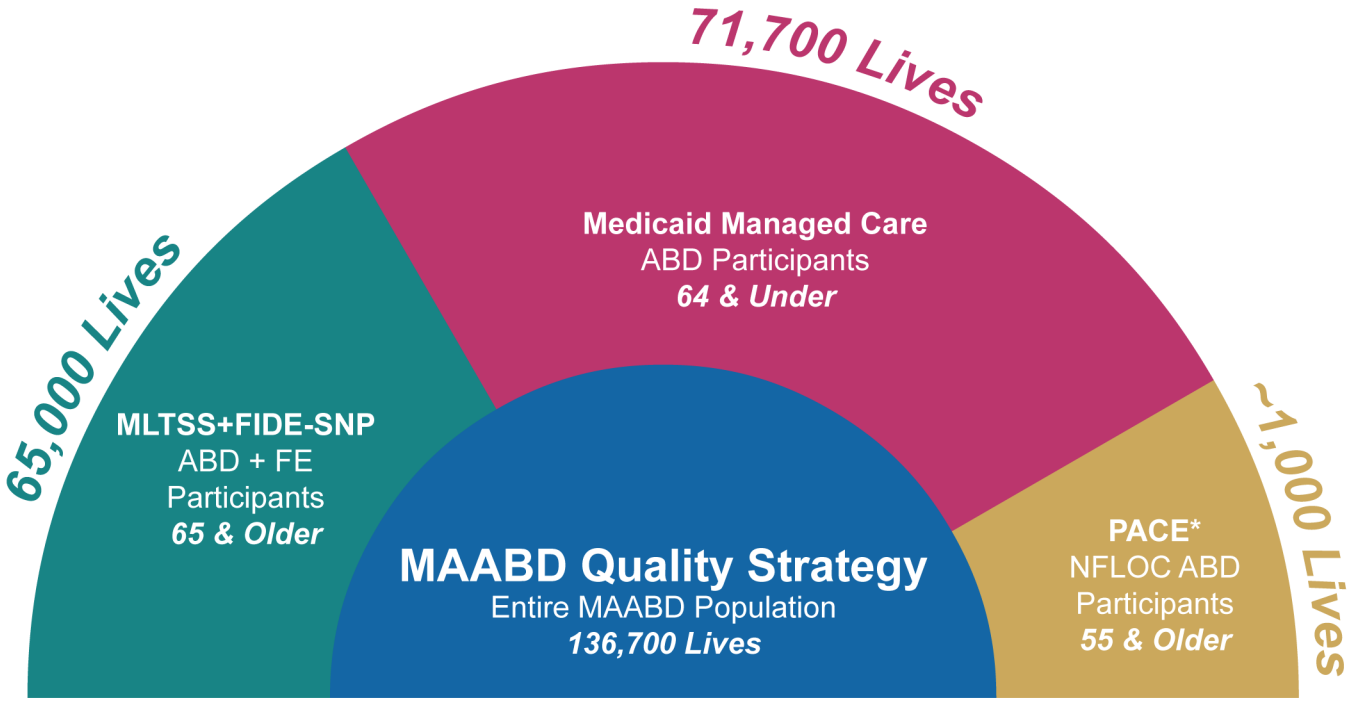
Elements of a Medicaid Managed Care Quality Framework to Consider for an Aligned Quality Strategy

Nevada has created a quality strategy for its Medicaid managed care program; however, it is exclusive of an MAABD population quality focus because MAABD is not covered by managed care. Elements of the Medicaid managed care program that can be used in the future to improve quality for the MAABD population include:

- A quality committee and the requirement of member input
- Quality reporting
- Performance improvement projects
- Incentive programs or alternative payment programs
- Value-added services
- Provider network adequacy
- Care coordination for MAABD
- Member services

SECTION 5: RECOMMENDATIONS

Nevada is uniquely positioned to implement changes that would drive significant improvements for the care, health outcomes, and quality of life of its MAABD population. To make optimal use of its current resources and infrastructure, HMA recommends that the state consider four programmatic recommendations over a six-year period, with new approaches to delivering and ensuring improved quality of care. The recommendations do not have interdependency; meaning, Nevada could implement any or all of the recommendations. However, implementing all recommendations will yield the most significant improvement for all MAABD Nevadans.

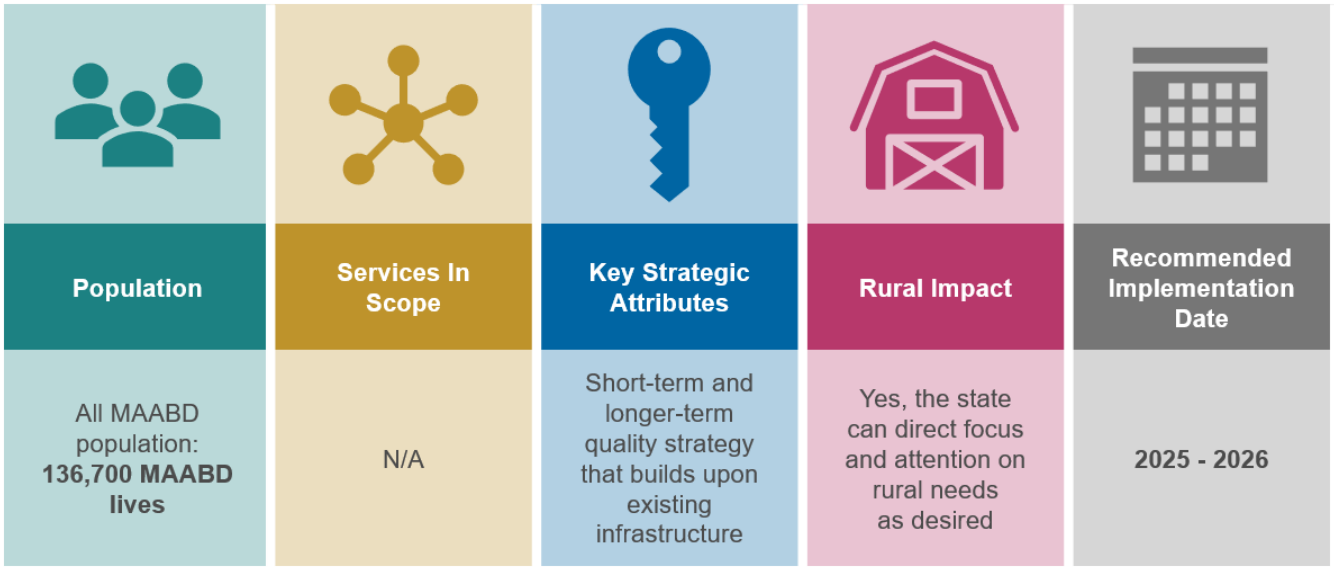


*PACE site enrollment is up to 300 participants.
Numbers in the graphic are an estimate of potential impact.

These recommendations are intended to offer Nevada shorter term and longer-term options for structural and operational changes. They could favorably affect not only the lives of Nevadans enrolled in Medicaid under MAABD eligibility, but also offer the state more reliable budget predictability, improve quality and outcomes, and create smoother coordination of care across complex programs, payers, and systems.

Change is rapidly occurring at the federal and state levels. HMA's recommendations are intentionally aligned with the programmatic and regulatory initiatives and infrastructure currently underway, including the D-SNP SMAC procurement, the planned statewide expansion of Nevada Medicaid managed care, increased CMS HCBS quality requirements, and the forthcoming CMS rules on Access to Medicaid and Improving Access to Care in Managed Care. Nevada is encouraged to embrace this dynamic time of reform, be strategic and proactive, and drive its MAABD program toward making a greater difference in the lives of Nevadans.

Recommendation A: Implement Aligned Short and Long-Term Quality Strategies for the MAABD Population



Population	Services In Scope	Key Strategic Attributes	Rural Impact	Recommended Implementation Date
All MAABD population: **136,700 MAABD lives**	N/A	Short-term and longer-term quality strategy that builds upon existing infrastructure	Yes, the state can direct focus and attention on rural needs as desired	**2025 - 2026**

Quality strategies are important guideposts for state Medicaid programs, indicating state priorities, action steps, timing, and means of tracking effectiveness. A quality strategy can also serve as a governance plan, outlining who is informed of program quality and who makes decisions about actions to improve program quality.

A quality strategy plan is a living document to be revised annually, if not more frequently. It should incorporate lessons learned from measuring the effectiveness of interventions, overall program quality, and emerging areas of concern. As noted earlier, Nevada has no overarching quality strategy plan for the MAABD population, though it does have a quality strategy plan for its managed care population, which is exclusive of MAABD. In part, this oversight is the result of a federal requirement to have a Medicaid managed care quality strategy but no parallel requirement for FFS.

Nevada can build upon its Medicaid Managed Care Quality Strategy to design a parallel and aligned strategy for the MAABD population, as well as including PACE programs, which already have a quality infrastructure built into their requirements. The MAABD population is especially vulnerable and having providers, payers, and state resources collaborate to improve quality of care for this population would be a powerful and effective step. Creating and implementing a quality strategy for the MAABD program will require administrative resources, such as matching funding from sister agencies and community programs.

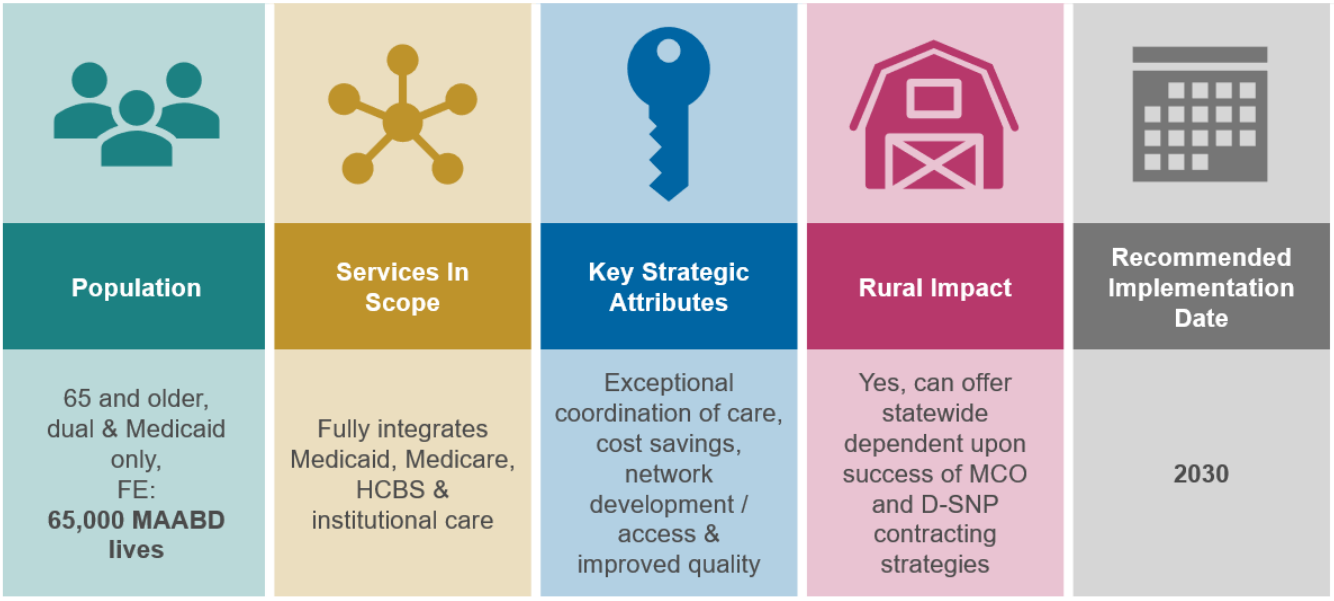
An overall quality strategy would support Nevada's priority areas across all programs. For example, if the state decides to focus on ensuring that its MAABD population has access to good nutrition, it might consider the following action steps by program:

- **For D-SNPs and Medicaid managed care**, the state's quality strategy could require plans to provide VABs focused on delivering meals to MAABD members, with a PIP centered on nutrition for MAABD members through relationships with HCBS providers, or senior centers that serve the MAABD population.
- **For FFS programs**, the quality strategy could direct sister agencies or community organizations to connect MAABD enrollees with community food banks or the Supplemental Nutrition Assistance Program (SNAP) and encourage eligibility and enrollment specialists to assess Medicaid applicants for SNAP, then monitor SNAP use for MAABD participants.
- **For PACE programs**, the quality strategy could require part of the quality governance and data to focus on nutrition. PACE organizations often have excellent relationships with community organizations and can help refer participants to them.

It would be efficient and effective for the state to map out a multi-year quality strategy to incorporate other program changes and to learn from those experiences. A short-term strategy would allow Nevada to take immediate action towards improved MAABD quality and position itself well in preparation for the potential of larger-scale Medicaid service delivery model changes for the MAABD population. The longer-term quality strategy could focus on alignment with other quality frameworks that may be applicable to the MAABD population several years from now, dependent upon how Nevada proceeds with changes to the MAABD delivery system.

An overall quality strategy would leverage much of the quality work underway related to FE and PD waivers as well as other quality initiatives in D-SNPs and Medicaid managed care. The final sections of Section Four of this report provided additional recommendations for how Nevada could develop an MAABD quality strategy through alignment and building upon existing quality and compliance work.

Recommendation B: Implement Separate MLTSS and FIDE-SNP Programs for Adults Aged 65 and Over, Including the FE HCSB Waiver



A total of 24 states have contracted with MCOs to deliver a limited or full range of MLTSS for older adults and individuals with physical disabilities through a capitated managed care program. Some states launch their MLTSS programs as standalone programs; others redesign their existing managed care programs to include new populations and LTSS. This approach creates a comprehensive service continuum for the focus populations by providing access to all services, including medical, behavioral health, LTSS, and any other health-related social needs through a single MCO.

Many states with MLTSS also have required their MLTSS health plans to develop Medicare Advantage (MA) and dual-eligible special needs plans (D-SNPs) to complement their MLTSS plans with more focused efforts for dually eligible individuals who need a higher degree of coordinated care. FIDE-SNPs offer the highest degree of Medicaid and Medicare integration, and Nevada is well positioned to build upon current program changes to implement a FIDE-SNP program. MLTSS and FIDE-SNPs offer robust care coordination across the continuum and have effectively lowered Medicaid costs through decreasing rates of emergency department and hospital care and fewer nursing facility (NF) placements.

Nevada's Medicaid program could establish a statewide, comprehensive MLTSS program for MAABD participants ages 65 and older who are Medicaid-only and dually eligible. These programs would provide all members with access to managed LTSS. The MLTSS program and a companion FIDE-SNP program for dually eligible MAABD participants could be operationalized through a separate DHCFP Medicaid managed care Older Adults contract. A separate contract would ensure older adults get the targeted care they need and set the programs apart from the existing Medicaid managed care program, which does not include the full LTSS benefit set. HMA recommends that Nevada consider a more comprehensive design for participants by creating these two new sister programs, available for all Nevadans who are Medicaid-eligible and aged 65 and older, so they have access to a more person-centered and integrated care experience.

Program Option #1: Available to Medicaid-Eligible Participants

Nevada is currently expanding the existing managed care program for Medicaid-only, non-MAABD participants to be offered statewide. The state contracts with and pays MCOs a capitated rate. Nevada's managed care program excludes the MAABD population and HCBS. Nevada is well positioned to use the statewide expansion experience and a multi-year implementation road map to support successful implementation of a new MLTSS program. Oversight of the Medicaid managed care expansion to statewide, coupled with intentional data collection to drive a continual process improvement effort, would allow Nevada to build on its experience and be mindful and intentional about launching MLTSS in 2030.

For all Medicaid participants aged 65 and older, the state could follow suit of current managed care enrollment policies by requiring mandatory enrollment into an MLTSS-only program as an entry point. This program would be where existing MAABD participants aged 65 and older, as well as newly eligible 65+ MAABD Nevadans enroll and have support and options to access a more robust FIDE-SNP, if desired. Both the Medicaid-only MLTSS and the FIDE-SNP programs could be implemented through one Older Adults MLTSS contract.

Key Features

1. *Enrollment and Eligibility.* This possibility assumes that all MAABD enrollees aged 65 years and older with Medicaid would have the option to enroll in one or more MLTSS plan providing Medicaid covered services, and therefore, qualifying MAABD populations would be mandated to enroll in managed care. Ensuring enough enrollment into a limited number of MLTSS plans would support economies of scale at the MLTSS plans and likely make the bid for business more attractive to the MLTSS plans.

2. *Provider Network.* This option assumes that MCOs would build a provider network to provide all covered services, and support a smooth transition, with a continuity of care period for members with any providers not part of the MCO's network.

3. *Comprehensive Care Model.* This choice assumes that members would have a person-centered care model, person-centered coordination, access to a care manager and assessment process to support the development of a person-centered care plan. The models would be comprehensive, including support and coordination across Medicaid, LTSS and behavioral health services.

4. *Financing.* This option assumes that MCOs would receive a capitated payment from the state's Medicaid program for all Medicaid-covered services (including LTSS) for each enrolled participant on a per member per month basis.

Program Option #2: Dually Eligible Participants

For enrollees covered under both Medicare and Medicaid or who are dually eligible, the state could create a comprehensive integrated care program by leveraging the MA D-SNP platform. This program could be an option for dual participants to select as an alternative, or an "upgrade" from the MLTSS program. Nevada's current landscape includes D-SNPs, which serve dually eligible individuals in a fragmented way. This program would build upon efforts underway to develop an intentional D-SNP strategy in Nevada. This program would significantly further coordination across Medicaid and Medicare and provide the state with options to explore around MCO alignment across Medicaid MCOs, MLTSS plans, and D-SNP plans across the state. The alignment of plans would support smoother transitions when Nevadans need to change programs and would decrease administrative burden to the entire system.

Currently, MAABD, dually eligible D-SNP enrollees receive their Medicaid covered services, including LTSS, on a FFS basis. Nevada could require current D-SNPs to become FIDE-SNPs with a companion MLTSS plan covering all Medicaid services, including LTSS, to continue serving dually eligible individuals. FIDE-SNPs would contract with CMS to administer Medicare Parts A, B, and D. The state would require the plans to have a Medicaid contract outlining all state Medicaid requirements for FIDE-SNPs and support a SMAC.

Key Features

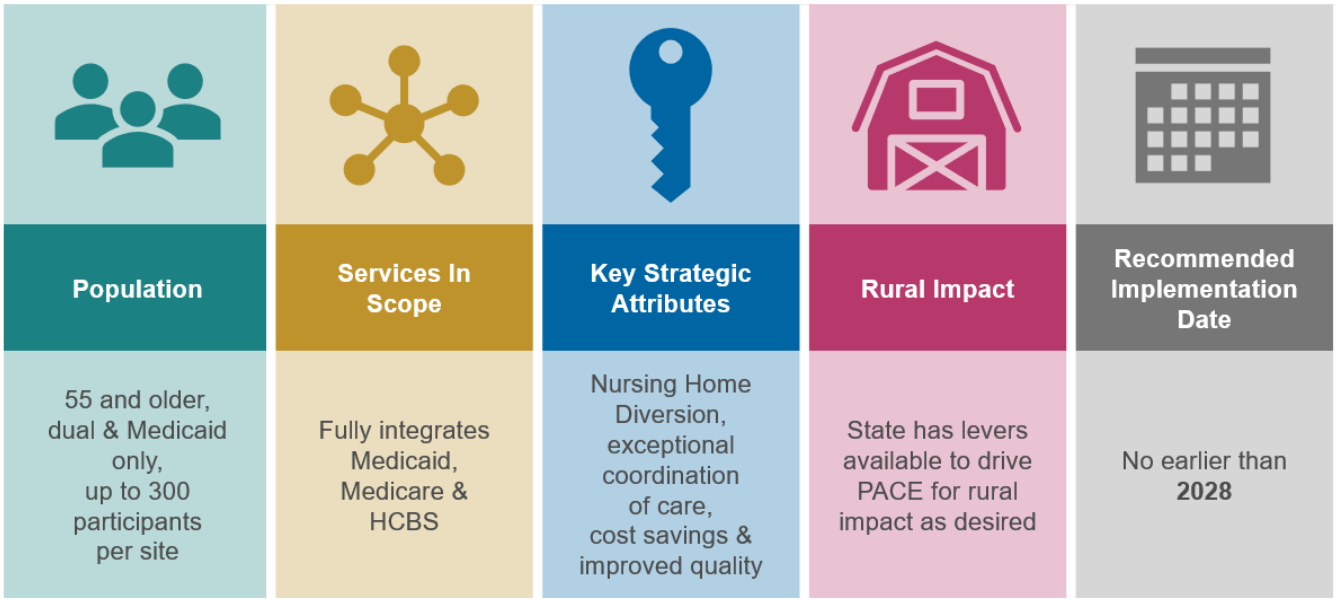
1. *Enrollment and Eligibility.* This option assumes that all MAABD participants aged 65 years and older and the dually eligible have the choice to enroll in a FIDE-SNP plan that provides Medicare and Medicaid covered services. Upon enrollment, members would have to receive all services through a single plan.

2. *Provider Network.* This option assumes that each FIDE-SNP would build a provider network to deliver all covered services and support a smooth transition, with a continuity of care period for members with providers that are outside the FIDE-SNP network. A benefit of a FIDE-SNP network is the high bar of adequacy it must meet (Medicaid, LTSS, and Medicare), which would ideally drive improved access for MAABD populations, and the population-specific annual training required of the FIDE-SNP provider network.

3. *Integrated Care Model.* This option assumes that members would receive person-centered care and person-centered care coordination. They would have access to a care manager, an assessment process, and an interdisciplinary care team (ICT) to support the development of a person-centered care plan. The model would be comprehensive and fully integrated, including support and coordination across Medicaid, Medicare, LTSS, and behavioral health services.

4. *Financing.* This option assumes that FIDE-SNPs would receive a capitated payment from CMS for all Medicare-covered services and a capitated payment from the state's Medicaid program for all Medicaid-covered services including LTSS, for each enrolled member on a per member, per month (PMPM) basis. In this model the plan could assume full risk and manage both Medicaid and Medicare benefits, thereby removing the risk of cost shifting while aligning financial incentives to drive outcomes and quality.

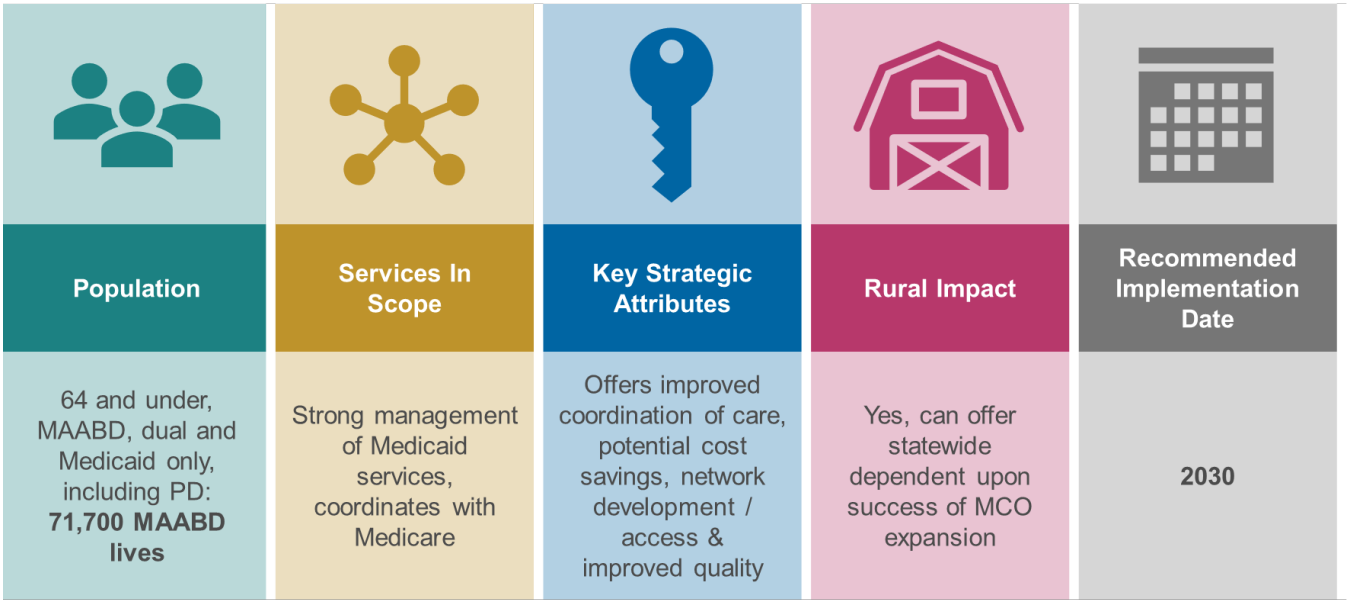
Recommendation C: Implement PACE Model of Care



Since it was first developed in San Francisco, CA, in the late-1970s, the PACE model has spread to 32 states and the District of Columbia to serve 70,000 individuals through 155 PACE programs. The model is a proven, effective, local solution for helping medically complex, nursing home-eligible adults aged 55 and older remain in their homes. The key to its success includes PACE organizations that receive capitated payments for supplying comprehensive services to a discrete number of individuals through a dedicated, integrated care team of healthcare and social service professionals. PACE program participants have increased social interaction, decreased depression, and encouraged better health and longer lives.

The implementation of the PACE model is an appealing opportunity for Nevada for several reasons. The model can serve as an intentional nursing home diversion strategy for populations that need more focus in terms of system rebalancing. Additionally, the PACE model will enable the state to target comprehensive services to geographic areas where access to MAABD HCBS services is limited. This would be helpful in urban, rural, and frontier communities where providers are in short supply. Because of the composition of its multidisciplinary team, PACE provides fully integrated and coordinated services to individuals with complex challenges that require clinical, functional, social determinants of health, and other supports. The PACE model would yield improved coordination and health outcomes for some of Nevada's higher need MAABD population, including those with and without dual eligibility.

Recommendation D: Enroll the 64 and under MAABD Population into Medicaid Managed Care Contracts Upon 2030 Contract Renewal



Population	Services In Scope	Key Strategic Attributes	Rural Impact	Recommended Implementation Date
64 and under, MAABD, dual and Medicaid only, including PD: **71,700 MAABD lives**	Strong management of Medicaid services, coordinates with Medicare	Offers improved coordination of care, potential cost savings, network development / access & improved quality	Yes, can offer statewide dependent upon success of MCO expansion	**2030**

Managed Medicaid has been associated nationally with increased access to services, improved care coordination, and robust data gathering and analysis to track the quality of Medicaid services. Nevada is already providing these higher levels of care through contracts with MCOs for the non-MAABD Medicaid population. These service improvements would greatly enhance supports for the MAABD population as well, especially since accessing services in a timely manner, coordinating care across settings, and ensuring service quality are challenges for the current MAABD program.

Requiring Medicaid MCOs to cover the MAABD population would build upon the Medicaid managed care infrastructure and processes to better align and coordinate services and reduce fragmentation of care. It could provide MAABD participants with innovative MCO programs and benefits. It could also result in cost savings for the state. This recommendation provides the state with options to explore around MCO alignment across Medicaid MCOs, MLTSS plans, and D-SNP statewide. The alignment of plans would support smoother transitions when Nevadans need to change programs and would decrease administrative burden to the entire system.

Rural Considerations

For each of the recommendations listed above, the state will need to plan carefully how to work with current and new partners to address the significant differences and disparities between its urban and rural MAABD populations. Workforce challenges remain critical across all models; however, each model allows for different kinds of flexibility in financing, which creates prospects for expanding new types of providers, including community health workers and peer support specialists for behavioral health needs. These types of roles are especially important in rural communities because they allow new career opportunities for residents who may lack the education or skills needed to fill higher-level, licensed clinical roles, but who know their communities and resources. This paradigm has the double benefit of both supporting MAABD members and rural economic development and can encourage individuals on a longer-term career path toward clinical practice.

PACE

- Require PACE providers to launch a rural center within three years of starting an urban PACE center as a condition of participation.
- Leverage existing community resources for inclusion in the PACE network, such as local public health offices and other CBOs.
- ICT support for all aspects of care.

MLTSS

- Require MCOs to participate in rural counties if they want to serve urban counties.
- MCOs meet network adequacy and access requirements can be good partners to support building provider access in rural areas.
- Require MLTSS plans to create workforce development plans and report on progress to the state.
- Consider requirements of MLTSS plans to align and simplify on provider operational components to reduce provider burden if shifting HCBS to MCO payers.

FIDE-SNP

- Leverage the SMAC to establish additional, targeted care coordination requirements for members in rural areas.
- Align Medicare and Medicaid to reduce administrative burden for providers, especially those in rural areas.

Implementation Considerations

State Structure and Training

The recommendations in this report intentionally build upon existing programs in Nevada and leverage new opportunities available as a result of changes that the state has already set in motion for a strengthened Nevada Medicaid program. To that end, many of the staffing needs for the recommendations have a foundation upon which the state can build. Implementation of a PACE MLTSS program and FIDE-SNP program is complex work that will require new skill sets at the state level and likely changes in existing staff functions. With the exception of the state-employed FE and PD waiver case managers, the recommendations in this report would not result in a reduction of state staff and would likely require new staff to make administration effective. Most state staff roles would require a change in focus to regulate payers and providers and deliver on a new vision for Nevada Medicaid that provides strengthened coordination, drives better outcomes, and cultivates provider access and cost savings to the state for the MAABD population. Some key considerations are noted below.

Significance of the State Medicaid Agency Cultivating Medicare Expertise

One well-known barrier to states pursuing fuller integration of Medicare within state Medicaid programs is the complexity of these programs, which were created to work independently. Demands on state staff are significant just to manage Medicaid, let alone to learn the intricacies of Medicare; however, Medicare expertise is necessary to understand how integration options might work in the state and to incite change.

These roles are needed to effectively partner with CMS for more meaningful integration and to leverage key coordination opportunities that will further state Medicaid goals, while likely yielding cost savings. The state Medicaid agency should invest resources in Medicare expertise from policy, operations, data, and financial perspectives. Medicare knowledge will be necessary to ensure PACE and FIDE-SNP success. As the need for Medicaid agencies to fully comprehend Medicare becomes more apparent, so does funding, and so do training opportunities, such as integration grants from Arnold Ventures, CMS technical support from the Integrated Care Resource Center (ICRC), and data access and support made available by the State Data Resources Center (SDRC).

Analysis of Current State Structure

HMA recommends that the state invest resources in a formal evaluation of state staffing and organizational structure. As programs change, organizational frameworks need to adapt. Some of the report recommendations affect staffing, as well as where programs should reside. For example, DHCFP LTSS manages D-SNP contracts, though several D-SNPs also work with DHCFP managed care area as contracted Medicaid MCOs. Should Nevada pursue a more integrated programs, decisions will need to be made about where programs reside and what staffing model will be most effective.

Another example is PACE and whether the program should be managed in the Aging and Disability Services Division (ADSD) or the Medicaid LTSS unit of DHCFP. State experts interviewed shared concerns about workforce shortages for waiver case managers. How might implementation of an MLTSS and FIDE-SNP program affect FE and PD waiver public case management, potentially opening up additional access for state-employed case managers to support I/DD waiver case management needs? This question and others must be addressed in order for the state to be most effective at implementing and administering expanded and/or new programs for the MAABD population.

Conclusion

Through its long history, Nevada's MAABD program has accomplished a great deal, but still faces increasing challenges of fragmentation of services for a growing population of older adults and individuals with disabilities. It is an opportune time for the state to improve MAABD through new supports in geographically underserved areas, a more comprehensive quality strategy, and closer alignment with ongoing and planned revisions of Nevada Medicaid. Through these bold changes, the MAABD program can become the prime driver of state efforts to empower some of its most vulnerable Nevadans to live as they wish, safely and contentedly within their own communities.

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GLOSSARY OF ACRONYMS

AARP: American Association of Retired Persons

ABD: Aged, Blind, or Disabled

ACAP: Association for Community Affiliated Plans

ADA: Americans with Disabilities Act

ADL: Activities of Daily Living

ADSD: Aging and Disability Services Division

APM(s): Alternative Payment Method(s)

ARPA: American Rescue Plan Act; enacted during COVID-19 pandemic to provide additional funding for healthcare providers and other businesses

AWOP: Amount that Would Otherwise be Paid

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CBO(s): Community-Based Organization(s)

CFR: Code of Federal Regulations

CHIP: Children's Health Insurance Program

CLAS: Culturally and Linguistically Appropriate Services

CMS: Centers for Medicare & Medicaid Services; payer of publicly funded healthcare programs

CPGs: Clinical Practice Guidelines

DCW: Direct Care Workforce

D-SNP: Dual-eligible special needs programs; programs for people who eligible for both Medicare and Medicaid because have complex health/social needs

DHCFP: Division of Health Care Financing and Policy

DHHS: Department of Health and Human Services

DHHS OCR: Department of Health and Human Services, Office of Civil Rights

DME: Durable Medical Equipment

DWIP: Disabled Waiver Initiative Program

EVV: Electronic Visit Verification

FBDE(s): Full-Benefit Dual Eligible(s)

FE: Frail Elderly

FFS: Fee for service; traditional Medicare and Medicaid payment model

FIDE-SNP(s): Fully Integrated Dual Eligible Special Needs Plan(s)

FY: Fiscal Year

HCBS: Home and Community Based Services

HCC: Hierarchical Condition Category

HCP-LAN: Health Care Payment – Learning and Action Network

HEDIS: Healthcare Effectiveness Data and Information Set

HHS: Health and Human Services (see also DHHS; Department of Health and Human Services)

HMA: Health Management Associates, Inc.

HRA(s): Health Risk Assessment(s)

ICRC: Integrated Care Resource Center

IDD: Intellectual and Developmental Disabilities

IDT: Interdisciplinary care team

ILOS: In Lieu Of Services

KFF: Kaiser Family Foundation; now known as KFF exclusively

LOC: Level Of Care

LTC: Long-Term Care

LTSS: Long-Term Services and Supports

MA: Medicaid Advantage

MAABD: Medical Assistance for the Aged, Blind, and Disabled

MCO: Managed Care Organization

MLR(s): Medical Loss Ratio(s)

MMLR(s): Minimum Medical Loss Ratio(s)

MOC: Model of Care

MLTSS: Managed Long-Term Services and Supports

NCI: National Core Indicator

NCQA: National Committee for Quality Assurance

NF: Nursing Facility

NQF: National Quality Forum

OB/GYN: Obstetrician Gynecologist

PACE: Program of All-Inclusive Care for the Elderly; provides transportation, homemaker, respite, grocery shopping, and other services to aging populations who want to receive in-home and community-based services

PD: Physical Disability

PES: Participant Experience Survey

PHE: Public Health Emergency

PIP(s): Performance Improvement Project(s)

POC: Plan Of Care

POM: Personal Outcome Measures

QA: Quality Assurance

QAPI: Quality Assessment and Performance Improvement

QIAs: Quality Improvement Activities

SDOH: Social Determinants Of Health

SFY: State Fiscal Year

SMAC: State Medicaid Agency Contract

SNF: Skilled Nursing Facilities

SNP(s): Special Needs Plan(s)

VAB(s): Value-Added Benefit(s)

VBP: Value-Based Purchasing

APPENDICES

Appendix A: AARP LTSS 2023 Scorecard for Nevada

Every three years, AARP releases a comprehensive scorecard that describes how state long-term services and supports (LTSS) systems are performing. This scorecard aggregates LTSS services in Nevada to inform rating and state performance. Therefore, results are not specific to the ABD LTSS population, but still provide valuable information in assessing the ABD LTSS population quality experience and opportunities.

The 2023 Scorecard, released on September 28 of that year, is a compilation of state data and analysis based on a "new vision of a high-performing state long-term services and supports (LTSS) system," and includes 20 new indicators. The scorecard is based on the following five dimensions: (1) affordability and access, (2) choice of setting and provider, (3) safety and quality, (4) support for family caregivers, and (5) community integration. Nevada ranked 44th out of 50 states and Washington, DC in overall LTSS performance. AARP groups all states into five tiers, from best to worst (1-5). Nevada is ranked 44th in the nation, falling into Tier 4, which includes states ranked 36−46. Nevada's scores by the five dimensions[86] are shown below.

	State Ranking			
Dimensions and Measures	Overall	Improved	Declined	No Credit
Ranking by Dimension				
Affordability and Access	49			
Choice of Setting and Provider	48			
Safety and Quality – 48	48			
Support for Family Caregivers – 19	19			
Community Integration – 33	33			
Rankings for Select Measures by Dimension				
Affordability and Access	49			
Medicaid for Low-Income People with Disabilities:		42		

[86] AARP. LTSS 2023 State Scorecord Report for Nevada. Available at: https://ltsschoices.aarp.org/scorecard-report/2023/states/nevada.

	State Ranking			
Dimensions and Measures	Overall	Improved	Declined	No Credit
Percentage of people with Activity of Daily Living (ADL) disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance, ages 21+. (53%, still performing near last compared to national average of 59%)				
Home Care Costs: *Median annual home care private pay cost as a percentage of median household income ages 65+.* (81%, still performing slightly above national average of 83%)			22	
Medicaid HCBS Presumptive Eligibility: State policies that allow presumptive eligibility for Medicaid HCBS.				No credit.
Choice of Setting and Provider	48			
Adult Day Service Supply: *Adult day services total licensed capacity per 10,000 population ages 65+* (45, compared to national average of 54)		18		
Home Health Aide Supply: *Home health and personal care aides per 100 population with an Activity of Daily Living (ADL) disability, ages 18+.* (13, performing close to last compared to national average of 25)		45		
Medicaid LTSS Balance: Spending: *Percentage of Medicaid LTSS spending going to HCBS for older people and adults with physical disabilities.* (33.5%, below the national average of 53%)			31	
Self-Directed Program Enrollment: *Number of people enrolled in a self-directed HCBS program per 1,000 population with disabilities.* (2.3, performing nearly last compared to national average of 36)			48	

	State Ranking			
Dimensions and Measures	Overall	Improved	Declined	No Credit
Community Integration	33			
Employment Rate for People with Disabilities: *Rate of employment for adults with ADL disabilities ages 18-64 relative to rate of employment for adults without ADL disabilities ages 18-64.* (19%, performing somewhat below national average of 22%)			42	

Appendix B: Analysis of Program Attributes of Recommendations

Program Name	PACE	MLTSS Stand-Alone	MLTSS + FIDE SNP
State Goals			
Statewide coverage	Targeted	Statewide possible	Statewide possible
State budget predictability	All options give the state Medicaid program greater budget predictability.		
	Highest	Depends upon financing provisions.	Depends upon financing provisions.
Rebalancing incentives	All options create incentives to rebalance care from facilities to community as a result of capitation's incentives.		
	PACE organizations have the greatest incentives of all programs because PACE operates at full risk which preserves capitation's incentives.	Depends upon financing and quality oversight.	Depends upon financing and quality oversight.
Integrate care	Yes		
Upstream services and supports to address social drivers and health-related social needs	Yes. PACE organizations and plans may use capitated funds to address social drivers.		
Program Descriptions			
Eligibility			
Age	Be 55+	Be 65+	Be 65+

Program Name	PACE	MLTSS Stand-Alone	MLTSS + FIDE SNP
Criteria	Acuity level requirement: must meet nursing facility level of care	No limit based on acuity level. Live in the community, at home or in a nursing facility.	No limit based on acuity level. Live in the community, at home or in a nursing facility.
Coverage	Have Medicaid only; or Have Medicaid and Medicare Part A and Part B	Have Medicaid only; or Have Medicaid and Medicare Part A and Part B	Have Medicaid and Medicare Part A and Part B
Choice	Voluntary or self-selected enrollment	Voluntary or self-selected enrollment	Voluntary or self-selected enrollment
Continuity of care period	No continuity of care period	Continuity of care period	Continuity of care period
Network access	Access to PACE providers employed directly or contracted with PACE	Must maintain access to adequate network to provide all enrollees with access to all covered services	Must maintain access to adequate network to provide all enrollees with access to all covered services
Out-of-network	Access to out-of-network providers for urgent care and after an emergency medical condition	Access to out-of-network providers for urgent care and after an emergency medical condition	Access to out-of-network providers for urgent care and after an emergency medical condition
Additional services covered within the capitation rates	PACE organizations may provide additional services within the capitation rate.	Plans may provide additional services within the capitation rate, to address social services and supports.	Plans may provide additional services within the capitation rate, to address social services and supports. FIDE-SNPs are required to provide supplemental benefits.
Person-centered care model	Yes	Yes	Yes
Assessment	Initial and on-going	Initial and on-going	Initial and on-going
Care team	Interdisciplinary care team (11 members)	Interdisciplinary care team	Interdisciplinary care team

Program Name	PACE	MLTSS Stand-Alone	MLTSS + FIDE SNP
Person-centered care plan	Yes	Yes	Yes
Capitation rates	Capitated Medicaid and Medicare payments on a monthly basis.	Capitated Medicaid payments on a monthly basis.	Capitated Medicaid and Medicare payments on a monthly basis.
Risk adjustment	Medicare rate is risk adjusted. Frailty adjuster applied to Medicare adjusted rate. Medicaid rate is not risk adjusted.	Medicaid rate is risk adjusted.	Medicare rate is risk adjusted. Frailty adjuster applied to Medicare adjusted rate. Medicaid rate risk adjusted.
Risk corridors	Does not apply	State decision to establish corridors around Medicaid capitation rates.	State decision to establish corridors around Medicaid capitation rates.
Medical loss ratio (MLR)	MLR does not apply	State sets the Medicaid MLR	Applies to Medicaid and Medicare, separately; plan is subject to 85% MLR
State requires remittance	MLR does not apply	State determines	Yes Medicare; State decides for Medicaid

Appendix C: Cultural Considerations

States must carefully consider the cultural and linguistic needs of individuals using HCBS to advance equity for this population, as all population groups require culturally and linguistically appropriate services. In Nevada, MAABDs are diverse in race, ethnicity, language, and disability type. Approximately 60 percent of the MAABD population enrolled in the FE or PD waiver is made up of communities of color, including Black or African American, American Indiana or Alaskan Native, and Hispanic communities. Approximately 40 percent are White.

PACE, MLTSS, and FIDE SNP programs can raise the bar on providing culturally and linguistically appropriate care, and an opportunity to reduce racial and ethnic disparities in access to and quality of HCBS for individuals of color.

"In 2013, the U.S. Department of Health and Human Services (HHS) released National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, which states that its principal standard is "to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."[87]

Unfortunately, the MAABD population aged 65 years and older often experience significant disparities in access to culturally and linguistically appropriate care. They face the confounding effects of ageism, ableism, and racism. There are also additional confounding access impacts due to the lack of accessible equipment to match different disability types, and lack of communication access for those who are hard-of hearing or have a vision impairment.

Perceptions. According to an article by lead author, Dr. Lisa Iezzoni, "More than sixty-one million Americans have disabilities, and increasing evidence documents that they experience health care disparities. Although many factors likely contribute to these disparities, one little-studied but potential cause involves physicians' perceptions of people with disability. In our survey of 714 practicing US physicians nationwide, 82.4 percent reported that people with significant disability have worse quality of life than nondisabled people. Only 40.7 percent of physicians were confident about their ability to provide the same quality of care to patients with disability, just 56.5 percent strongly agreed that they welcomed patients with disability into their practices, and 18.1 percent strongly agreed that the health care system often treats these patients unfairly. More than thirty years after the Americans with Disabilities Act of 1990 was enacted, these findings about physicians' perceptions of this population raise questions about ensuring equitable care to people with disability. Potentially biased views among physicians could contribute to persistent health care disparities affecting people with disability." [88]

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[87] U.S. Department of Health and Human Services, Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at: https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf.

[88] National Library of Medicine. Iezzoni L, Rao S R, Ressalam J et al. Physicians' Perceptions Of People With Disability And Their Health Care. February, 2021. Available at: https://pubmed.ncbi.nlm.nih.gov/33523739/

Access to HCBS. A recent study from LeadingAge LTSS Center in Boston, Community Catalyst, Institute for Community Health, entitled "Improving HCBS Access and Outcomes for Dual-Eligible Beneficiaries of Color" identified racial and ethnic disparities in access to and quality of HCBS for dually eligible HCBS beneficiaries of color. While people of color are more likely to have long-term supports and services (LTSS) needs, they are also less likely to receive help from informal care and/or HCBS and have lower HCBS utilization and expenditures.[89]

Higher rates of nursing home use. "Black older adults are less likely to move to assisted living and are more likely to move to a nursing home compared to older white adults. Black-white disparities in moves to nursing homes are explained by black-white differences in enabling and need factors, whereas black-white disparities in moves to assisted living remain even after adjusting for enabling and need factors." [90] There are several reasons why people of color do not use sufficient HCBS to meet their needs. Communities of color are under-resourced, often due to historical racism and segregation. Barriers to accessing HCBS include concerns about immigration status and language access. Information about the availability and location of HCBS may not be provided in an accessible manner, accounting for health literacy levels, language needs, and cultural preferences. Structural barriers include long waiting lists, fragmented delivery system, and limited transportation to service locations. Finally, subtle, and overt racist interactions with HCBS care managers and care givers leave HCBS participants slow to trust caregivers. Finally, all of these barriers to accessing HCBS can contribute to poorer health outcomes, which in turn can create or exacerbate inequities for people of color.[91]

These inequalities can be significantly worse for people with disabilities, and especially for people of color with disabilities, who live in rural communities. These communities already face major challenges with provider access, limited services availability, and workforce shortages. Many rural providers simply do not have adequate knowledge, training, or resources to support the needs of this very vulnerable population.

People living in rural areas face acute supply shortages—from direct care and primary and mental healthcare to hospital and nursing facility closures— and infrastructure problems, such as inadequate transportation and limited access to broadband internet. The nation's shortage of direct care workers for in-home care is more acute and immediate in rural areas, worsened by low wages, unpaved roads, and limited transportation.

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[89] Community Catalyst. Improving the Access and Outcomes of Home and Community-Based Services (HCBS) Use Among Older Adults of Color Enrolled in Both the Medicare and Medicaid Program: A Summary of Findings and Policy & Practice Recommendations. September, 2023. Available at: https://communitycatalyst.org/wp-content/uploads/2023/10/CC_HCBS_Report_10.11-FOR-WEB.pdf.

[90] Morales M J, Robert S. National Library of Medicine. November, 2020. Black–White Disparities in Moves to Assisted Living and Nursing Homes Among Older Medicare Beneficiaries. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7566960/.

[91] Community Catalyst. Improving the Access and Outcomes of Home and Community-Based Services (HCBS) Use Among Older Adults of Color Enrolled in Both the Medicare and Medicaid Program: A Summary of Findings and Policy & Practice Recommendations. September, 2023. Available at: https://communitycatalyst.org/wp-content/uploads/2023/10/CC_HCBS_Report_10.11-FOR-WEB.pdf

Federal and state policymakers must partner with rural communities to help build and fund a local infrastructure at the county level to develop a Comprehensive Access and Rural Equity (CARE) Plan that prioritizes dually eligible individuals' needs. The CARE Plan development and implementation process will benefit from a local infrastructure with staffing at the county level (or community level) to engage diverse stakeholders, develop supply-side solutions, and coordinate with larger federal and state efforts to address barriers to access to healthcare, health-related social needs, and social services, resulting from supply shortages and capacity issues in rural areas.

Appendix D: Stakeholder Report

Grounded in Stakeholder Feedback

An integral part of this project was to gather feedback from stakeholders to inform the research and recommendations of this project. Meaningful stakeholder participation ensures that the perspectives, knowledge, and concerns of stakeholders are taken into account when making decisions that will affect program participants. This process helps build trust and credibility, and uncovers hidden risks, opportunities, and innovative ideas that could otherwise be overlooked. HMA and DHCFP collaborated over several months in early 2023 regarding the need to ensure that relevant voices were invited to the discussion and that their feedback was captured, shared, and incorporated during the subsequent stages of this project.

The Nevada MAABD Needs Assessment project stakeholder engagement process included focus groups with key stakeholders from the MAABD advocacy community, state and local agencies, providers, and community-based organizations. These stakeholders – in addition to program participants – were invited to the initial stakeholder kickoff meeting that occurred on July 17, 2023.

HMA conducted three focus groups, structured by topic: PACE Program, Value Based Payment, and MLTSS. Across the PACE, MLTSS and VBP focus groups, a total of 55 individuals participated. Given the volume of participants, each topical session was split into breakout rooms to support smaller group discussion in the interest of all participants having an opportunity to share observations and feedback.

A high-level summary of the key themes from the focus groups is provided below:

High Level Themes from Project Stakeholder Feedback

1. There are significant barriers to MAABD service access

- Under-resourced Nevadans under-utilize MAABD services because of barriers
- Waiting lists for FE and PD HCBS waivers
- Low reimbursement rates lead to workforce shortages, particularly in rural areas
- Unaligned MCO administrative procedures slow referrals
- Transportation challenges, other SDOH factors

2. Implementing new models of care can help rebalance MAABD services

- PACE is associated with improved coordination of care; decreased ED and hospital admissions, depression, social isolation; increased medication adherence
- MLTSS offers more comprehensive care, greater system efficiencies, and enhanced case management but may face challenges with network adequacy; needs standardization of processes across MCOs to reduce administrative burden for providers

3. Value-based payment programs could bolster provider network

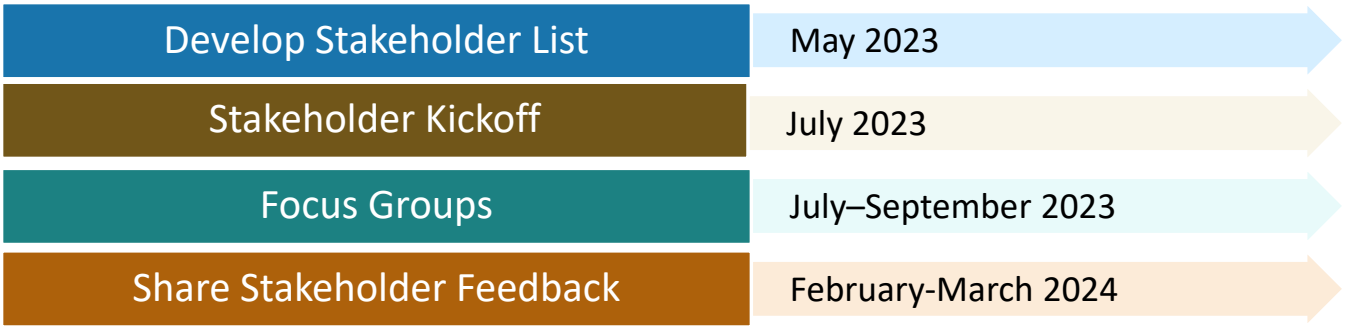
- Offering a continuum of VBP programs could incentive different types of providers
- Global capitation has most improved health outcomes/quality performance but takes time, administrative capacity, and financial stability
- Providers need initial incentives, such as technology upgrades and increased capacities to develop workforce, to adopt VBP
- Bidirectional data sharing and HIE/HIT data availability are critical elements for success

4. MAABD quality measures need to be identified and widely adopted

- There are no real industry benchmarks in HCBS to measure provider performance
- Intermediary software should be identified so multiple systems can become interoperable and share common metrics

Stakeholder Engagement Plan

In coordination with the DHCFP, Health Management Associates (HMA) developed a stakeholder engagement plan with a phased implementation strategy:



Development of Stakeholder List

HMA worked closely with DHCFP throughout the stakeholder engagement selection process. The process included HMA completing state-specific research to identify stakeholders and stakeholder groups. HMA then shared and reviewed the research with DHCFP, who managed the final email distribution list, including stakeholders who are part of other existing DHCFP LISTSERVs. More than 2,500 stakeholders, representing program participants, providers/payers, community organizations, waiver providers, government entities, advisory groups, and other associations, were included in this initial mailing. In addition to the stakeholder kickoff outreach going to the DHCFP cultivated distribution list, the Aging and Disability Services Division (ADSD) sent notifications to the entities and individuals on their distribution lists. All stakeholders were invited to the project kickoff meeting via email and in compliance with all accessibility, open meeting, and public notice requirements.

Stakeholder Engagement Kickoff Meeting

On July 17, 2023, DHCFP and HMA hosted a project kickoff meeting. Participants had the option to attend in-person or virtually. The purpose of this event was to inform stakeholders about the ABD Needs Assessment project and share opportunities for participation during the various stages of the process. The agenda included:

- Project Background and Vision
- The rationale Behind the Needs Assessment
- Overview of Current ABD Services and Structure
- Vision for the Future of ABD Services
- Project Goals, Description, and Overview
- Overall Project Timeline
- Stakeholder Engagement Plan
- Opportunities for Engagement
- Questions/Open Discussion

A total of 107 participants (98 virtual and nine in-person) attended this meeting and had the opportunity to sign up for upcoming focus groups.

Focus Groups

NEVADA MEDICAID ABD NEEDS ASSESSMENT
INTERVIEW GUIDE FOR FOCUS GROUP: PACE
AUGUST 21, 2023, AT 1:00 P.M. PST

Facilitator PACE Questions

1. Does your organization/entity currently operate in Nevada?
2. What are some of the things working best now in Nevada when you think about current programs and services the ABD population accesses?
3. What are the greatest opportunities for improvement when you think about Nevada's ABD programs and benefits?
4. Please talk about the key, Nevada-specific ABD population issues you believe PACE in Nevada would address.
5. What Nevada-specific challenges would you anticipate should the state launch a PACE program(s)?
6. What health, and other types of outcomes should the state expect should PACE be implemented in Nevada?
7. Please talk a little about your organization's commitment to PACE Principles.
8. Please talk about your organization's approach to building relationships and community partnerships if Nevada pursues a PACE mode.

9. Please describe your current organization's experience working with dually eligible Medicaid and Medicare populations if not a current PACE sponsoring organization.

10. Please discuss your organization's experience in providing Primary, Acute, Behavioral Health and/or Long-Term Care Services to Medicaid and dual-eligible populations.

11. Please talk about any relevant PACE experience in other states that would be helpful for Nevada DHCFP to be aware of.

PACE Focus Group Feedback

Current waivers

- Home and community-based waivers have waiting lists and are not readily available to all who require these waivered services
- Waiver carries with it high regulatory burden and low reimbursement
- Some providers have pulled out of certain geographic areas because of high costs
- Waiver services would benefit from increased and improved care management
- Waiver participants would benefit from medication management services

Workforce shortages and reimbursement rates

- Current non-profit service providers are unable to operate in all needed service areas because of low reimbursement rates and workforce shortages
- Areas outside of Clark (Las Vegas) and Washoe (Reno) Counties are experiencing service shortages
- Personal care agencies often do not participate as they cannot make the economics work with current reimbursement
- PACE organizations would need to develop means of offsetting workforce challenges

Barriers to accessing services

- Under-resourced communities underutilize; the need for services is greater than what is being presented or is known by the state agency
- Additional barriers to accessing services are common in the rural areas
- PACE could address most access to care issues, including transportation

Managed care organizations

- The three MCOs have different authorization processes, slowing access to services
- Three of the MCOs have capitated rates for occupational and physical therapy, so there are limited providers for individuals in need of these services

PACE could have the following impacts on its Medicaid program

- A 10 percent or higher reduction in nursing home spending
- A reduction in ED visits and the need for chronic disease management
- PACE experienced a 24 percent reduction in hospitalizations compared with the FFS population
- Fewer slips and falls
- Reduction in depression, social isolation, and psychosocial conditions
- Increases in medication adherence

Miscellaneous

- The need to develop a level of care process that works well for PACE organizations and the state
- Should not have LOC decisions awaiting approval from the state
- Better coordination of care can help reduce overall cost of care

NEVADA MEDICAID ABD NEEDS ASSESSMENT

INTERVIEW GUIDE FOR FOCUS GROUP: MLTSS

AUGUST 22, 2023, AT 1:00 P.M. PST

Facilitator MLTSS Questions

1. Please share what organization you work with and how you work with Nevada ABD populations currently.
2. What, if any, program or service improvements do you think the state should focus on for Nevada ABD populations?
3. What do you think the greatest opportunity for improvement would be for Nevada to consider an MLTSS program, with the goal of strengthening the experience and outcomes of Nevada's ABD population served through Medicaid?
4. Are there any risks or concerns about moving towards an MLTSS program in Nevada?
5. How might an MLTSS model enhance Nevada's current FE/PD waiver process?
6. What are some of the things working best now in Nevada when you think about Medicaid managed care and the existing D-SNP plans in Nevada? How might these apply to MLTSS?
7. What are the greatest opportunities for improvement when you think about Medicaid managed care and the existing D-SNP plans in Nevada? How might this apply to MLTSS?
8. What type of support do you think Nevada's HCBS provider network needs to grow and sustain? Do you believe there may be unique strategies MLTSS could offer to achieve these results?
9. If the state were to further explore MLTSS for Nevada, do you have recommendations for the most effective way to conduct a planning process?
10. If the state were to further explore MLTSS for Nevada, what key features do you think would be most important to obtain stakeholder feedback on?
11. What are some of the most meaningful performance and outcomes measures the state should consider if they further explore MLTSS in Nevada?

MLTSS Focus Group Feedback

Area's stakeholders identified to strengthen ABD programs:

- Improved coordination of care
- Workforce shortages (recruitment and retention)
- Rebalancing of ABD; maintenance of people in the community plus reintegration into communities

Opportunities MLTSS offers for ABD program improvement

- Comprehensive and holistic care
- Person-centered care and improved equity
- Better Medicaid and Medicare integration drives comprehensive care and system efficiencies

Risk and barriers to MLTSS in Nevada

- Network adequacy
- Direct care workforce concerns, particularly in rural and frontier areas
- Ensuring adequate and sufficient stakeholder engagement throughout any transition process

How MLTSS might enhance Frail Elderly (FE) and Physically Disabled (PD) processes

- MLTSS may deliver better results on rebalancing and increasing community awareness around LTSS
- Case management benefits

Strengths of current Medicaid MCO and DSNPs in state

- Additional benefits
- Investment in community relationships
- High quality and satisfaction scores

Opportunities for current Medicaid MCO and DSNPs in state

- Better integration of services and benefit coverage
- Better leverage MCO flexibilities with respect to benefit design and care management
- Increase use of specialty care, particularly for ABD populations

Types of support HCBS providers need

- Standardized MCO processes to reduce administrative burden if implementing MLTSS
- A lot of education and training to successfully transition to an MLTSS program
- Effective rates
- Additional flexibilities
- Provider workforce capacity programs

Most effective way to conduct MLTSS planning process

- Learning from other states with MLTSS programs
- Provide stakeholders with enough time to prepare
- Consideration and coordination of important timelines (procurement, contracting, CMS Medicare bids)
- Streamlining and standardizing

Key features to obtain stakeholder feedback regarding MLTSS

- Provider feedback including process to understand MCO contracting needs and requirements
- Needs for supporting transitions including housing and home modifications

Most meaningful performance measures for MLTSS

- Integration of care
- Medicare quality measures
- Transitions of care
- HCBS network provider performance measures

NEVADA MEDICAID ABD NEEDS ASSESSMENT

INTERVIEW GUIDE FOR FOCUS GROUP: VBP
AUGUST 23, 2023, AT 1:00 P.M. PST

Facilitator VBP Questions

1. Please tell us/confirm your name, role, and what program/agency you are with.
2. Please describe the clients you serve and what type of services you offer.
    a. What are your client's needs?
    b. What strategies to approach and engage your clients have been effective?
3. Is your organization currently billing Medicaid for any HCBS or other services?
4. What are some of the things working best now in Nevada when you think about current programs and services the ABD population accesses?
5. What are the greatest opportunities for improvement when you think about Nevada's ABD programs and benefits?
6. Please describe your experience to date, if any, with value-based contracting arrangements (ex. pay for reporting, capitation, risk-bearing arrangements, etc.).
    a. Do you have any VBP experience specific to HCBS services?
    b. Do you have any VBP experience with other programs, such as Medicare, D-SNP, etc.?
7. Are you familiar with Health Care Payment Learning & Action Network (HCP-LAN) alternate payment methodologies?
8. For those with knowledge of or experience with value-based or alternative payment models, what are some examples of the type of support you and your organization would need to effectively implement these types of programs?
    a. Are there differences in your needs when you think about VBP for traditional medical services versus VBP for HCBS and/or behavioral health services?

9. Please describe your current data and reporting capabilities (ex. ability to take in and process eligibility files, report out HEDIS or other health outcome data, etc.).
    a. What data and reporting capabilities do you have specific to HCBS?
10. How do you keep track of the clients you serve, and the services provided to them?
    a. Do you have a health record system or something similar?
    b. Does each person who performs the service enter their own notes/record of client interaction?
    c. How do you differentiate your HCBS clients from your Medicaid population that does not receive HCBS?
11. Tell us about your current administrative workforce and any existing/anticipated staffing challenges should Nevada pursue a VBP strategy for the ABD population.
12. Are there any particular types of HCBS VBP that you believe would strengthen the program experience and health outcomes for Nevada's ABD population?

VBP Focus Group Feedback

Offering a continuum of VBP programs

- Reach different types of providers
- Meet their readiness to adopt
- Meet their financial situation for risk
- VBP for HCBS is different than it is for physical and behavioral health services

Capitation arrangements

- Strong results where the Health Care Payment Learning & Action Network (HCP-LAN) alternative payment methodology (APM) framework has been adopted
- Global capitation has produced the strongest results for health outcome/quality performance
- Global capitation models take time, administrative capacity, and financial stability to sustain
- Larger delivery systems with the necessary infrastructure will be key targets for this type of model
- Balance between the number of visits and ensuring quality outcomes for patients is critical
- Incentives cannot reward providers for minimizing patient visits
- Capitation arrangements can limit the availability of practitioners
- Before limiting the providers, it needs to be verified that the patients can get the best medical care
- Capitation should not be awarded to a practice that does not treat the entire eligible population

Data sharing

- Bidirectional data sharing and health information exchange/health information technology (HIE/HIT) data availability are critical elements for success
- Everybody (payers and providers) has its own system that tracks data slightly differently
- It is difficult for any of those systems to become interoperable
- Consistency in VBP performance tracking is a challenge

Incentivize moving to VBP

- An initial incentive needs to be offered for moving to VBP
- Providers must demonstrate progress in improving health outcomes against benchmarks
- Readiness assessment is required to ensure providers can proceed on the HCP-LAN APM continuum
- Support providers in acquiring the technology, tools, and staffing needed to administer VBP
- Incentivize capacity to develop and strengthen the workforce
- Incentivize enhancing technology capabilities to support the workforce

Performance measures and benchmarks

- No real industry standards or benchmarks in HCBS to measure provider performance
- Recommend intermediary software so multiple systems can become interoperable and share common metrics
- Highly utilized “in-lieu of” services could lead to value-based contracting by demonstrating savings

Appendix E: Data Methodology & Limitations

Data Methodology

Health Management Associates (HMA) collaborated with the Nevada Department of Health Care Financing and Policy (DHCFP) to conduct a thorough analysis of the state's Medical Assistance for the Aged, Blind, and Disabled program (MAABD). The objective was to evaluate and improve the effectiveness of the MAABD program in providing Medicaid coverage to aged, blind, and disabled individuals.

HMA's analysis relied on a blend of publicly available data from the Nevada Office of Analytics and de-identified data provided by DHCFP. DHCFP supplied comprehensive datasets spanning State Fiscal Years (SFY) 2018 through 2022, sourced from its data warehouse, which aggregates information from numerous Medicaid providers nationwide. This dataset included patient counts of Medicaid ABD enrollees based on paid claims and enrolled providers with paid claims.

This data facilitated HMA's analysis of the MAABD population, including subsets such as the MA ABD population on the Waiver for the Frail Elderly and the MA BD population on the Waiver for Persons with Physical Disabilities. To stratify these populations, HMA utilized specific MA ABD Codes. For the Waiver for the Frail Elderly, codes included Home & Community Based Waiver Assisted Living (AL1A and AL1S) and Home & Community Based Waiver for the Elderly (HC1A, HC1B, HC1C, and HC1D). For the Waiver for Persons with Physical Disabilities, codes included Home & Community Based Waiver Aged (DWIP) (HD1), Home & Community Based Waiver Blind (DWIP) (HD3), and Home & Community Based Waiver Disabled (DWIP) (HD9). Further analyses provided insights into demographic factors such as age, gender, race, and zip code distribution within these populations. Additionally, the analysis assessed the percentage of individuals in these populations with dual eligibility status based on their Medicare status.

HMA also conducted an analysis of the MAABD population's utilization, providing insight into the number of MA ABD individuals receiving services through the Waiver for the Frail Elderly and Waiver for Persons with Physical Disabilities. Publicly available data from the Nevada Office of Informatics informed our analyses of the state's actual caseload, budgeted caseload, and waitlist for each of these Waiver programs. Leveraging data from DHCFP, we examined Personal Care Services (PCS) and Case Management utilization, identifying individuals receiving PCS from Provider Agencies (Provider Type 30) or Intermediary Service Agencies (Provider Type 83), as well as those receiving case management (T1016). Additionally, Medicaid spending for the MAABD Population, the MA ABD population on the Waiver for the Frail Elderly, and the MAABD population on the Waiver for Persons with Physical Disabilities was assessed.

Furthermore, an assessment of the network of providers serving the MAABD population on the Waiver for the Frail Elderly and Waiver for Persons with Physical Disabilities was conducted. This involved identifying active providers based on Provider Type Codes, including Waiver for the Frail Elderly (Provider Type Code 48) and Waiver for Persons with Physical Disabilities (Provider Type Code 58).

Data Limitations

It's essential to highlight several inherent limitations within the data provided by both the Nevada Office of Analytics and DHCFP for analysis. While DHCFP diligently validates data accuracy through provider education and audits, reliance on providers to submit complete and precise information on Medicaid patients introduces potential discrepancies. Users of DHCFP reports on disease morbidity and patient health should understand that these reports are solely based on patient claims data, which may not offer a comprehensive health record. Moreover, the data from the Office of Analytics is publicly available and not under DHCFP's purview, thus DHCFP cannot provide additional context on the data.

Moreover, accurately accounting for patient counts by payment sources (FFS/MCO) presents challenges. Patients may be counted under each payment source, resulting in mutually exclusive patient counts by payment sources from the total count of patients.

Additionally, a notable percentage of Medicaid claims show paid amounts of $0. This occurrence may be due to various reasons such as services provided without prior authorization, services deemed non-covered by the Medicaid program, or issues with provider enrollment status. Medicaid programs often impose limits on the frequency or duration of certain services, leading to claims for additional services being denied or paid out at $0 if patients exceed these limits.

These limitations emphasize the necessity for careful interpretation of the data and acknowledgment of potential gaps and biases inherent in claims-based analyses. Users should exercise discretion and consider these limitations when drawing conclusions or making decisions based on DHCFP reports and data.

Appendix F: D-SNP Care Coordination Requirements

D-SNPs must have contracts with CMS and each state in which they operate, to ease the coordination on behalf of dually eligible individuals who enroll in D-SNPs. As described by the Integrated Care Resource Center: (1) CMS requires that they must, at least, coordinate Medicaid benefits for their enrollees. They must have a Model of Care describing how DSNPs will meet the needs of dually eligible population being served. (2) In addition to the CMS contract, they must have a State Medicaid Agency Contract (SMAC). State contracts with D-SNPs must include minimal contract elements, but states may include additional requirements to improve administrative, clinical, and financial integration for enrollees. The requirements vary based on D-SNP type. See Table 11.

CMS requires D-SNPs to "coordinate" Medicaid benefits for their enrollees, and CMS has noted that "coordination" may encompass "a wide range of activities that a D-SNP may engage in for their dual[ly] eligible members." For example, for enrollees identified through health risk assessments and/or individualized care plans as having functional limitations and/or mental health needs, D-SNPs could collaborate with the enrollees to: (1) verify eligibility, (2) determine access, and (3) coordinate services.

State Medicaid Agency Contracts (SMACs)

States can also require D-SNPs to implement state-specific provisions aimed at better coordinating Medicare and Medicaid services by: "specifying certain care coordination requirements within the state's SMAC(s) with the D-SNP(s); and/or specifying in the SMAC that the D-SNP(s) must include certain content within their MOC(s)." ICRC offers this example: A state could require its D-SNPs to describe within the MOC how the D-SNPs will coordinate specific Medicaid services covered in the SMAC, and how they will operationalize coordination with various entities within the state.

State Medicaid programs have significant flexibility in setting up SMACs. HMA understands that Nevada has been working to strengthen its SMAC and D-SNP strategy.

Spotlight on Current SMAC

The Integrated Care Resource Center, offers states SMAC language examples, which are an important resource for states. As ICRC highlights, states must address minimal elements, but can also add elements to facilitate coordination and integration.

CMS Requirements

According to 42 CFR 422.101(f)(1-3), CMS requires that all Medicare Advantage Special Needs Plans, including D-SNPs, to meet these essential requirements:

1. Assess enrollee's physical, psychosocial, and functional needs through initial and annual health risk assessments (HRAs).
2. Develop and implement individualized care plans for each enrollee
3. Use interdisciplinary care teams (ICTs) to address enrollee's health and functional needs
4. Use a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA) to "assure an effective care management structure."

In addition, FIDE SNPs have the added requirement: “[Coordinate] the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries.”

Table 11: CMS Requirements by D-SNP Type

D-SNP Type	CMS Requirements
CO D-SNP	• Must meet CMS requirements for D-SNPs. • Must notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for at least one designated group of “high-risk,” full-benefit dually eligible (FBDE) enrollees.
HIDE SNP	• Must cover Medicaid behavioral health benefits, long-term services and supports (LTSS), or both. • Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP’s parent company, or another entity owned and controlled by the D-SNP’s parent company. • In 2025, a HIDE SNP’s capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP.
FIDE SNP	• Must cover Medicaid primary and acute care services and LTSS, including at least 180 days of nursing facility coverage. • Must use specialized care management and network methods to coordinate care for high-risk beneficiaries. • Entity contracted to cover Medicaid benefits must be the same legal entity that holds the D-SNP contract with CMS. • In 2025, must operate with exclusively aligned enrollment and cover more Medicaid benefits. The capitated contract with the state Medicaid agency must also cover the entire service area of the D-SNP.