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Meeting Notes

Client: Nevada DHCFP

Meeting Date: September 2, 2020

Subject: Network Adequacy and SED Mandatory Enrollment Public Workshop

Location: WebEx

Notes

- **Network Adequacy Discussion**
  - Narrow networks or lack of providers generally for behavioral health providers, including SUD providers are a particular concern. This issue spans adult and pediatric populations.
  - Closed panel status poses access issues, using psychiatrists as an example, the MCO will assert there are a sufficient number of psychiatrics in network, but none of those providers serve the pediatric population.
  - Demonstrated need for an adequate array of home- and community-based providers serving the pediatric population.
  - Due to the shortage of providers, there needs to be a focus on diversity of the provider workforce, and if not diverse, at least culturally competent.
  - Lack of information on emergency room utilization (non-emergent and emergency) by members with behavioral health diagnoses or related-admissions; assertion is that utilization patterns are available under FFS, but not under managed care because the MCOs are not required to either track or publicly report that information. This utilization information would be useful to inform adequacy of the network.
  - Positive reception of provider-member ratios as a network adequacy measures; however, the simple ratio does not address the whole panel of patients (Medicaid and other payers) attributed to that provider type to understand if the needs of Medicaid members are met.
  - SilverSummit September 11 Public Comment
    - Asserts that current contractual access to care standards are reasonable and consistent with other state Medicaid programs. Silver Summit closely monitors compliance with appointment availability requirements. Advocates for use of NCQA's appointment access standards.

  - Due to known challenges in meeting appointment standards, may need to adjust specialist appointment standards for rheumatology, neurology, dermatology and pain management providers.

  - Supports consideration of telehealth visits towards adequacy standards; for example, include time-only requirements (e.g., access to a provider within 15 minutes). **Mercer note:** telehealth can be a factor in network development and such visits would satisfy time and distance standards; the contract would not need time-only measures to accommodate telehealth visits.

  - Regarding provider access for children with SED, SilverSummit works with Summit Behavioral Health to provide wraparound services, care coordination, and other integrated services and appointments are held exclusively for SilverSummit members. Designated case managers will work closely with the child and family to conduct social determinant of health screenings and schedule appointments.

- Nevada Psychiatric Association September 8 Public Comment

  - Current psychiatrist time and distance standard is 60 minutes/45 miles, recommends the same standard for board certified child and adolescent psychiatrists. **Mercer note:** DOI standard for psychiatrists is 45 minutes/30 miles and same standard will apply to pediatric psychiatrists in the 2022 contract.

- **Mandatory Managed Care Enrollment of SED Children Population Discussion**

  - FFS is the established delivery system for the population in DFS and the juvenile justice system. There are providers in FFS with the unique expertise to serve this population and the number of those providers is insufficient to meet needs. A second commenter advocated for foster care and juvenile justice involved children to remain in FFS to avoid disruption to continuity of care. Children return home and transition from FFS to an MCO and regress in their course of treatment. Suggested a transition of care period of six months when these children return home.

  - Commenter indicated work was needed to simplify the prior authorization process and measure the delivery of services by looking at claims and encounter data.

  - Theresa Carsten stated that when children return home, they would retain their eligibility code for a minimum of six months to aid in the transition. DHCFP will publish the eligibility codes for those children remaining in FFS and subject to mandatory enrollment.

  - Clark County's September 11 comment

    - Our concerns were (1) regarding network adequacy and the difficulty we have faced with our human services programming when managed care entities have closed or narrow behavioral health panels and only one entity available and (2) with enrollment into managed care by aid code given we have children in our child welfare system, children in our juvenile justice

system and some in both of our systems currently being case managed in a system of care we build under the FFS model. Clark Countysees the potential for disruption of care for this highly vulnerable population and we would like to work with the Division of Health Care Financing and Policy and Mercer on the research you will be conducting on how to ensure these kids, many of whom are receiving TCM services, can stay within our programming. We are opposed to mandatory enrollment that does not allow for protections or opt out for this highly vulnerable population.

- The following categories of children are of the utmost concern for mandatory managed care enrollment:
  - Child welfare kids in fictive kin placements — who may be associated with a TANF aid code because these kids are funded in part by TANF. They are still in our child welfare system.
  - Kids who may be in child welfare AND end up in juvenile justice — preliminary research is showing that we could have as many as 160 kids a year in this category and on average up to 60 kids at a time in this category.
  - Preliminary data shows that Clark County Department of Juvenile Justice Services has about 2,350 youth on formal probation living at home in the community — these kids are still under the Department's jurisdiction and in the provider system the county has built. Mercer had asked about an appropriate timeframe that would take into account continuity of care.
- SilverSummit September 11 Public Comment
  - Supportive of mandatory enrollment for children with SED status ensure a person-centered approach to care. Outlines number of evidence-based approaches to integrated care for this population, such as data analytic support for providers, alternative payment methodologies to incent screenings, use of telemedicine and telephonic integrated rounds.
  - To support mandatory enrollment of children with SED status, consider requiring a designated care manager with specialized training on trauma-informed and person-centered care; use of evidence-based screening tools; and use of standardized guidelines, such as the Child and Adolescent Service Intensity Instrument for RTC services.