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DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Care Financing and Policy
Helping people. It's who we are and what we do.

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Nevada Medicaid
Request for Public Engagement on Considerations to Enhance the Managed Care Model Program and Future Procurements

The Division of Health Care Financing and Policy (DHCFP or "the Division") is Nevada's single state Medicaid agency with responsibility for administering the State's Medicaid program and Children's Health Insurance program (CHIP), also known as Nevada Check Up. Medicaid services, both medical and dental, for recipients living in the urban Clark and Washoe counties are delivered by a Managed Care Organization (MCO) and a Prepaid Ambulatory Health Plan (PAHP). Nevada Medicaid currently has three (3) medical MCOs and one dental benefit administrator (DBA-PAHP). The current Medicaid managed care contracts will expire June 30, 2021. The Division intends to extend the current contracts by six (6) months, so the next contract cycle will begin and rotate on a calendar year as requested by the Centers for Medicare and Medicaid Services (CMS). The next managed care contract period will be January 1, 2022-December 31, 2025.

Since implementation in 1997, the Nevada managed care program has seen tremendous changes in the industry, as well as growth in MCO enrollment and covered services. Today, Nevada Medicaid's managed care enrollment stands at approximately 480,000 enrollees. The following are the Division's strategic goals:

- Promote health coverage for all Nevadans.
- Increase access to and use of primary care and preventative services.
- Improve the quality of and access to behavioral health services available to members.
- Ensure all pregnant women, children, and parents have the support they need for a strong start.
- Plan to support health aging for Nevadans.
- Develop a comprehensive strategy for prescription drug coverage and pricing.

In support of these goals, the Division is considering enhancing the managed care program with policy updates and new vendor requirements in the next MCO Request for Proposal (RFP). **The Division intends to issue the next Managed Care RFP in January 2021.** The purpose of publishing this notice is to request public engagement in the policy update and MCO RFP design process. Over the next couple months, the Division will gather stakeholder comments and feedback on initiatives that are being considered. The comments and feedback will aid in designing the "next generation" managed care model program. The Division's expectation with these efforts is that the new MCO model program will coordinate and integrate care beyond traditional managed care; will provide better quality services to Nevada Medicaid enrollees; will focus on improving care for populations with chronic and complex conditions; will align vendor payment incentives with performance goals; and build in accountability for the MCOs to provide high quality care to Nevada Medicaid enrollees.

The proposed items and initiatives under consideration by the Division are merely suggestions to be considered while developing a strategy for the Division to meet its strategic goals for the managed care program and are not final policy decisions or final RFP elements.

We invite your feedback and comments on the following initiatives and areas of interest.

1. **Dental Services Carve-In** – Currently, dental services are provided by the Dental Benefits Administrator (DBA) vendor. The Division is considering requiring dental services to be added to the requirements of the medical MCO vendor's scope of work. Dental services were previously covered under our managed care vendors but were carved out of the current MCO contract that began in July 2017.

2. **Skilled Nursing Facility (SNF) Services Carve-In** – The Division is considering requiring the MCOs to provide SNF service coverage as is medically necessary. Currently, the MCOs are only responsible for the SNF stay for 45 days.

3. **Residential Treatment Center (RTC) Services Carve-In** – Currently children that are approved to an RTC level of care are moved to the Fee-For-Service (FFS) delivery model. The Division believes that requiring the MCOs to continue coverage to children residing in an RTC will allow for better continuity of care. Children will be eligible for case management services under the MCO, the case manager can serve as part of the Inter-Disciplinary Team (IDT) and participate in meetings while the child is staying in the RTC, and the case manager can assist in the discharge planning as the child returns home. This assistance will ensure the child is connected to the required behavioral health providers within the MCO network upon returning home.

4. **Pharmacy Services Carve-Out** – Currently, pharmacy services are provided by the MCO vendors for their enrolled members. The Division is considering contracting with a Pharmacy Benefits Manager (PBM) vendor to provide pharmacy services to Medicaid recipients statewide, drug rebates, program administration, and other pharmacy services to be determined. The Division will also be adding specificity related to physician administered drug services. This approach benefits the Division and members to reduce the Administrative burden and impact when switching between delivery models and plans. For example, if all pharmacy benefits are under one preferred drug list, then Medicaid members would have less trouble with transitioning drugs between health plans.

5. **NICU/PICU Services** - Improving health outcomes for NICU/PICU infants was heavily discussed during the 2019 legislative session and is a key priority for Nevada. The Division is considering adding a requirement for MCOs to perform case management services for their high-risk maternity population with NICU/PICU infants and NICU/PICU infants whose mother are not Medicaid eligible. The Division is also considering adding value or quality metrics specific to improving health outcomes for these populations.

6. **Serious Emotional Disturbance (SED) Determinants** – Currently, Medicaid eligible children with SED determinations may opt out of MCO enrollment. The Division is considering removing the allowance for those members to opt out of MCO enrollment solely due to the SED status. Children with an SED determination are not restricted by Federal law from being enrolled into managed care. The Division is interested in strengthening our integrated health model under the managed care benefit plan and believe that children with behavioral

health needs may be best served by a managed care entity that can provide case management services and assist in locating and scheduling appointments if necessary.

7. **Case Management** – The Division is considering adding and/or better defining case management expectations, which will include establishing language to define: case management versus disease management; the difference between case management, care management, and care coordination; and Division expectations for case management related to diagnosis, stratification, and face-to-face requirements.

8. **Increase Stop Loss Amount** – The Division's Fiscal Services unit is reviewing an appropriate increase to the Stop Loss amount, if applicable. Currently, the amount is $100,000, and the Division is responsible for reimbursing 75% of any inpatient hospital cost over that amount to the MCO vendor. The final analysis for increase will be reviewed by the Division's contracted Actuary vendor.

9. **New MCO Member Auto-Assignment Algorithm** – The Division is considering an update to the method used to assign new members to an MCO. The Division also recognizes the need for outlining how the existing MCO populations will be distributed or transferred after the procurement if a current MCO is selected under the new RFP, versus a new MCO vendor.

10. **Administrative Load** – Currently, the Administrative Load is established per vendor during the contract process. The Division is considering having the Medicaid Actuary vendor establish the MCO Administrative Load.

11. **Pay for Performance** – The Division utilizes an incentive referred to as Pay for Performance, whereby performance measures are selected that align with the Department's leading health priorities. The Division withholds a percentage of the managed care entities capitation payment, and if the managed care entity hits a prescribed measurement target for the year, then they can earn the withhold money. If the MCO misses the measurement target, then the State keeps the money that was withheld from the capitation payment. The withhold amount is currently 1.25%, and the Division is considering adjusting this amount to match national trending, which is currently ranging between 1.5% - 3% of the CAP payment. Any adjustments will be reviewed by our current Actuary vendor to ensure the capitated rates remain actuarily sound.

12. **Utilization Management** – Currently, the MCOs are free to utilize InterQual or MCG (part of the Hearst Health Network) care guideline criteria for first-level screening to determine if the proposed services are clinically indicated and provided at the appropriate level, or whether further evaluation is required. The Division is considering requiring the MCOs to use the same care guidelines as the designated quality improvement organization (QIO-like) vendor for Nevada Medicaid. Currently, the Division's QIO-like vendor, DXC, utilizes InterQual criteria only.

13. **National Claim Denial Codes** – The Division is considering requiring all Nevada Medicaid MCOs to use national claim denial codes to strengthen the encounter data and to ensure all providers across the state receive consistent explanations for denial of services.

14. **Provider Type and Taxonomy Codes** –. The Division is considering requiring the MCOs to use Nevada Medicaid provider types and taxonomy codes for reporting provider data to Division. This change will strengthen the State's ability to accurately report on Network Adequacy across all Medicaid programs and providers.

15. **National Committee on Quality Assurance (NCQA) Accreditation** – Currently, the Division requires that MCO vendors be accredited by any nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor The Division is considering requiring future Nevada Medicaid MCO vendors to be accredited by NCQA.

16. **Enhance Network Adequacy and Access Standards** - The Division is considering enhancements to the program to improve network adequacy, as well as the standards for timeliness and availability of appointments for certain types of care. The Division is interested in hearing from different providers on what a standard of care or best practice is for your specific specialties. For instance, timeframes for what an urgent or routine visit is for a Primary Care Physician (PCP) should be may greatly differ than what a Physical Therapist would consider is necessary for an urgent or routine visit. Currently, our contract outlines the following:
    a. Emergent - Emergency services should be provided immediately on a 24-hour basis, seven days per week, with unrestricted access, to enrolled members who present at any qualified provider.
    b. Urgent - PCP urgent care appointments should be made available the same day as the inquiry. Urgent appointments for specialty care should be made available within three calendar days.
    c. Routine - Routine appointments for PCP services should be made available within two (2) weeks. Routine appointments for specialty care should be scheduled within 30 calendar days of the referral.
    d. The Division is looking to secure best practices for appointment standards by provider types, so that the best medical outcome can be achieved.

17. **Referral Management Process** – The Division is considering program enhancements to Close the Referral Loop (CRL) between primary care and specialist physicians, with the goal being to increase the percentage of patients with referrals for which a referring provider receives a report from the provider to whom the patient was referred.

18. **Improving Patient Experiences** – The Division is considering enhancing the MCO RFP requirements for how Secret Shopper compliance surveys are conducted. The Division is interested in how results from these surveys could be used by the MCOs to improve patient care and experience.

19. **Promote Population Health** – The Division is considering managed care program improvement opportunities such as those discussed by the Center for Health Care Strategies (CHCS) that foster delivery system innovation and improve health outcomes such as:
    a. Member engagement strategies to motivate participation in their health.
    b. Federally Qualified Health Center (FQHC) utilization for delivering high-quality patient centered medical care with a focus on care coordination and management.
    c. Medicaid Clinic Models developed and operated by MCOs designated as PCP walk in clinics
    d. Social Determinants of Health (SDOH) standardized screenings for members.
    e. Food Prescriptions or Food Security Requirements to promote Medicaid recipient healthy behaviors.
    f. Incentives for the prevention of chronic illness.

Compared to past procurements, the Division's expectations have increased for successful bidders of MCO RFP. The Division is looking for vendors experienced with the managed care delivery model with which it can partner to realize

the Division's mission and program objectives through improving access to care, providing quality care, and ultimately improve the health of Medicaid managed care enrollees in Nevada.

Feedback on this notice in general and specifically these items should be submitted to the Division in writing by 5:00pm June 30, 2020, via MCORFPfeedback2021@dhcfp.nv.gov. There will be no acknowledgement by the Division of receipt of the comments. Acceptance of comments places no obligations of any kind upon the Division. Furthermore, when submitting comments and feedback to this notice, commenters should clearly identify themselves and their affiliation, the item to which their comments are referring, and applicable program policy and/or requirements to which they are responding. Commenters are not required to address all the items in this notice. The Division may publish feedback received to the public at-large via the Division's internet website.

To solicit oral comments, the Division will hold a series of public workshops in various locations across the state while the RFP and policies are being developed. The schedule will be published on the Division's website at the following location: http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/.

Providing comments in response to this letter will not prohibit interested parties from responding to any future procurements.

Sincerely,

Suzanne Bierman, JD, MHP
Administrator

cc: Health Plan of Nevada, Inc.
Silver Summit Healthplan, Inc.
Amerigroup Nevada, LLC
Liberty Dental of Nevada, Inc.