NEVADA MEDICAID DELIVERY MODEL RECOMMENDATION REPORT

Nevada Division of Health Care Financing and Policy

March 10, 2017

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Section 1: Executive Summary

In June 2015, Governor Sandoval approved Senate Bill 514, which allows the Department of Health and Human Services to enroll certain additional populations into Medicaid managed care organizations (MCOs). The Division of Health Care Financing and Policy (DHCFP) contracted with Navigant Consulting, Inc. to evaluate options for modifying Nevada's Medicaid delivery model, including expanding the MCO program to include additional populations, services and geographic areas.

Navigant's assessment considered a full range of Medicaid delivery model options that have a reasonable opportunity of effecting change and addressing challenges raised by stakeholders. These are:

1. Maintain current delivery systems
2. Expand the MCO program statewide
3. Carve in additional populations to MCOs
4. Contract with a managed long-term services and supports MCO
5. Contract with an administrative services organization
6. Develop accountable care organizations
7. Implement a patient-centered medical home (PCMH) program

We presented these potential options to stakeholders for input at listening sessions and specialized focus groups that were representative of populations under consideration for mandatory managed care enrollment. We also requested input from these stakeholders about what is working well and what is not working well in the Nevada Medicaid program.

A common theme expressed by stakeholders is that it is necessary to address issues with the current system, such as challenges with provider access, provider reimbursement rates, MCO performance and satisfaction measures and MCO compliance with State and federal requirements before expanding the MCO program to additional, more vulnerable populations. Interviews and stakeholder communications suggest that there may be managed care program features that could benefit additional Nevada Medicaid populations and service areas, if implemented appropriately. These program features include care and case management programs; an emphasis on integrated care across the physical health, behavioral health and long-term care settings; support to providers; and assistance in accessing the most appropriate care and services within a complex healthcare delivery system. Nevada's Medicaid MCOs noted that full-risk managed care also provides important services and benefits, such as calculating quality measures to understand and drive improvements in program performance, covering community resources and alternative services that are not available through fee-for-service (FFS) Medicaid and implementing new payment approaches and delivery models. Other stakeholders also expressed concern that other managed care program features might be detrimental to some Nevada Medicaid populations, particularly the most vulnerable.

Based on stakeholder input, available data about Nevada's Medicaid programs and experience with models used in other states, we recommend a phased approach to Medicaid delivery system changes in Nevada. This phased approach will allow DHCFP to implement program

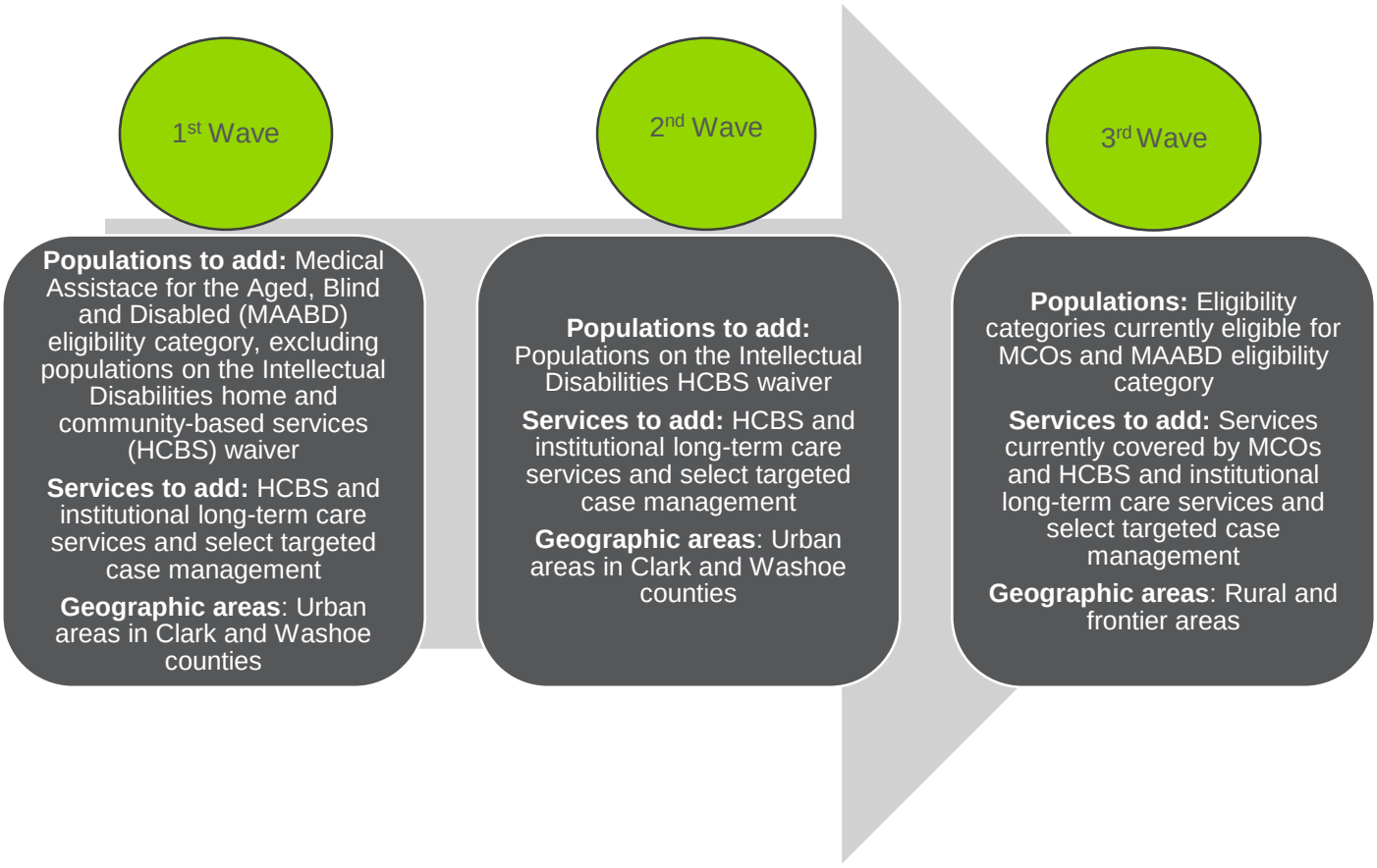
modifications gradually, while addressing a number of systemic issues identified by stakeholders and known by DHCFP. Such an approach will permit additional stakeholder involvement and time for adequate preparation of providers, Medicaid recipients, state divisions and other stakeholders regarding the program changes – a key element in successful implementations. The following recommended phases are designed to address performance, access and satisfaction issues that exist in the current program, and build upon positive program elements:

- **Phase 1.** Build state capacity for additional oversight to assure ongoing MCO compliance with State and federal requirements. Over the past several months, DHCFP has reallocated resources to focus on MCO oversight, and now has six positions with significant MCO oversight responsibilities. Given that an expanded MCO program could increase the number of MCO members by approximately 150,000, and given that many of these new MCO members have more complex healthcare and long-term care needs than the current MCO membership, the State needs to continue build additional capacity and provide training to these employees to monitor the additional populations and services. Central to this phase is implementing enhanced procedures to collect and analyze data on population sub-groups currently served by Nevada Medicaid MCOs and closely monitoring this data over time. These actions will support the State in having better information to oversee the MCO program in the future.
- **Phase 2.** Develop a strategy and implement changes to improve access to Medicaid services by making it easier for providers to actively participate in Medicaid. Evaluate Medicaid reimbursement rates and promote use of telemedicine to expand the reach of providers.
- **Phase 3.** Develop and enhance the capabilities of Nevada providers to offer high quality, integrated care to patients in the most appropriate setting by supporting primary care providers (PCPs) to become PCMHs and equipping providers to enter into value-based payment arrangements with payers.
- **Phase 4.** Offer care management, case management and support services to FFS populations, while creating an environment that is prepared for full-risk managed care, by developing a new managed FFS program. This managed FFS program would replace the existing care management program, the Health Care Guidance Program, and would build on lessons learned through that program. As one or more MCOs would serve as the managed FFS vendor, this program would be significantly different from other programs tested in Nevada, and would serve as pathway to prepare MCOs to take on full-risk for additional populations and services. The new managed FFS program would provide additional services to all FFS populations, without limiting their choice of providers or requiring providers to contract with MCOs, and would support other state and county case management services. The new managed FFS program would also impact some of the services provided by Hewlett Packard Enterprise (e.g., prior authorization).

Although Phase 4 is designed, in part, to prepare MCOs to take on full-risk in rural and frontier areas and for the aged, blind and disabled population in the future, we do not recommend that

DHCFP expand the scope of MCOs until there are sustained improvements in MCO performance measure rates, access and availability of appropriate providers and satisfaction among recipients and providers. If DHCFP sees sustained improvement in MCO performance measure rates, access and availability of appropriate providers and satisfaction among recipients and providers, we suggest the following sample strategy for expansion of populations and services into the MCO program.

Example Progression of MCO Expansion



To develop this phased recommendation, Navigant assigned a rating to an unmanaged FFS program, a managed FFS program, and a full-risk MCO program, based on how well each approach is positioned to achieve Medicaid strategies identified by the State and other stakeholders. We found that the MCO program, followed by the managed FFS program, were the best equipped to achieve the identified strategies, when implemented with the appropriate infrastructure and contract oversight in place. Although the MCO program received the highest score, there is significant concern from stakeholders about the readiness of the State for an expanded MCO program at this time. For example, stakeholders have named timely access to appropriate providers, adequate provider capacity, sufficient State oversight for an expanded MCO program and lack of familiarity among FFS Medicaid recipients with managed care elements as issues. We suggest that moving forward with an expanded full-risk MCO program

before addressing these and other concerns could mitigate the benefits that the expanded MCO program can bring. As the managed FFS program shares many of the same program elements of the MCO program, it is well positioned to provide case and care management and integrated care to the FFS population while preparing the environment for expanded full-risk managed care.

The recent *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule* strengthens regulations for network adequacy and access to care and includes new regulations specific to the inclusion of managed long-term services and supports. Given these new regulations and given the populations that Nevada is considering for managed care expansion are particularly vulnerable populations, we expect that CMS will look closely at Nevada and its timetable for managed care expansion. Stakeholder concerns (providers and recipients) regarding managed care have been of utmost importance to CMS. Other states, in their implementation and expansion of managed care have experienced issues with MCO provider network development, MCO/member communications about obtaining services and care management, among other areas, and Nevada's timetable will have to address these concerns.

Expansion of the MCO program will have significant impacts on the State divisions, and to a lesser extent, the county agencies providing case management services, and may result in some job losses or reassignments. In addition, expansion of the MCO program will have a financial impact on providers participating in supplemental payment programs and certified public expenditure programs. This report provides a summary of those impacts. Although there are options available to diminish the effect of MCO expansion on the supplemental payment programs, DHCFP will need to weigh the advantages in budget predictability and potential improvements in quality outcomes and integrated care that an expanded MCO program can bring, with the potential negative financial impact to State division revenue, county revenue and provider revenue. The report also recognizes the additional funding that the State will need to provide to support implementation.

For any delivery system modification, DHCFP will need to conduct a planning process to further determine all key design features. Continued use of a deliberate decision making strategy, combined with thorough planning and robust communication with stakeholders, will help DHCFP prepare for and implement modifications to the Nevada Medicaid delivery system to achieve its objectives.

Section 2: Overview of Report Objectives

Governor Sandoval approved Senate Bill 514 on June 11, 2015. Among other changes, this Bill allowed for the transfer of funds between DHCFP and the Aging and Disability Services Division (ADSD) for the purpose of implementing a managed care program for the waiver population. Prior to the establishment of such a program, the Bill requires an analysis of the impact of transitioning the waiver population to a managed care program.

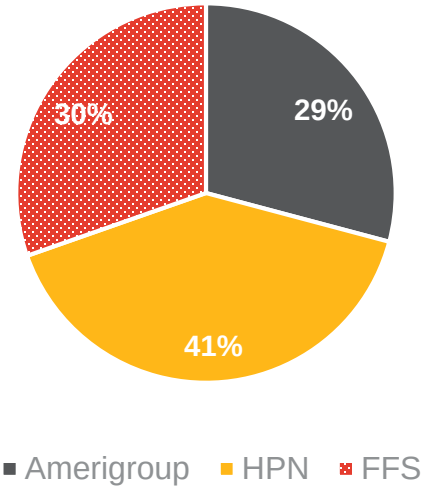
DHCFP contracted with Navigant Consulting, Inc. to evaluate options for modifying Nevada's Medicaid delivery model. This includes not only implementing a managed care program for the waiver population as described in Senate Bill 514, but also expanding the managed care program for other populations receiving services through the FFS system. We also considered other modifications to Nevada's Medicaid delivery system to address challenges identified in the current system and build upon successful program components.

This report first presents an overview of the current Medicaid delivery systems in Nevada and special considerations that impact the way Medicaid services are delivered and financed in the State. Next, the report summarizes input from providers, Medicaid recipients and their families, advocacy organizations, State divisions and county agencies regarding the current systems and suggestions for modifications. Finally, the report provides a recommended "go-forward" approach for addressing stakeholder considerations and meeting DHCFP objectives related to the Medicaid system.

Section 3: Current Medicaid Delivery Systems in Nevada

DHCFP serves as the lead division in Nevada for healthcare planning and purchasing, operating a Medicaid program that serves nearly 650,000 low-income individuals. DHCFP administers the Medicaid program through a combination of MCOs and FFS providers. Two MCOs, Amerigroup and Health Plan of Nevada (HPN), jointly enroll approximately 450,000 Medicaid recipients, or 70 percent of all Medicaid recipients. Beginning in July 2017, two more MCOs – Aetna Better Health of Nevada and SilverSummit Healthplan – will also join the MCO program. The addition of two more MCOs will create more options for recipients and could also help promote competition among the MCOs.

Figure 1. Medicaid enrollment by MCO and FFS (as of March 2016)



In addition, DHCFP oversees the Health Care Guidance Program (HCGP), a care management program for recipients with designated chronic diseases. Appendix A provides a comparison of select program features across the MCO, FFS and Health Care Guidance Programs.

Other state divisions – namely ADSD, the Division of Public and Behavioral Health (DPBH) and the Division of Child and Family Services (DCFS) – are also involved in the financing and care delivery for certain Medicaid populations. In addition, Clark and Washoe counties provide some direct Medicaid services and also play a role in the financing of the Medicaid program. These relationships are discussed more within Section 4: Special Considerations for Nevada.

MCO Program

DHCFP has contracted with MCOs to deliver Medicaid services since 1997. The MCO program operates in the urban areas of Nevada's two most populous counties – Clark and Washoe counties. Within the urban areas of these counties, MCOs enroll most children, pregnant women and low-income adults on a mandatory basis. Individuals in the Medical Assistance for the Aged, Blind and Disabled (MAABD) eligibility category are excluded from MCO enrollment. In addition, the following groups have the option to enroll in MCOs if they live in the urban areas of Clark or Washoe counties – otherwise they receive services through the FFS program:

- Native Americans
- Children receiving foster care or adoption assistance
- Children with special healthcare needs
- Children defined as Severely Emotionally Disturbed
- Adults defined as Seriously Mentally Ill (unless they are part of the Medicaid expansion population, in which case they must enroll in an MCO)

MCO Covered Services

Most physical, behavioral health and pharmacy services are covered through the MCO program, while long-term care services are generally excluded and instead provided through the FFS program. In addition, non-emergency transportation (NET) services are excluded from the MCO program and provided by two vendors – MTM and Paratransit. Beginning in July 2017, dental services will be excluded from the MCO program and provided through a dental prepaid ambulatory health plan.

As illustrated in Table 1, for some excluded services, individuals are not eligible for MCO enrollment if they need that service. For example, if a Medicaid recipient has a nursing facility stay over 45 days, he will be disenrolled from his MCO and will receive his Medicaid services through the FFS program. For other excluded services, individuals remain enrolled in their MCO, but receive those excluded services through the FFS program.

Table 1. Services Excluded from the MCO Program

Excluded Services (if individual requires these services, he is excluded from MCO enrollment)	• Long-term care services
	  – Home and community-based waiver services
	  – Hospice
	  – Intermediate care facility for individuals with intellectual disabilities
	  – Nursing facility stays over 45 days
	  – Residential treatment center (for Medicaid recipients only)
	• Swing bed stays in acute hospitals over 45 days

Excluded Services (individual remains in MCO, but service is paid for through FFS)	• Long-term care services – Adult day healthcare • Targeted case management • NET • School-based child health services • Orthodontic services • Dental services (beginning in July 2017 to be provided by a dental prepaid ambulatory health plan)

MCO Compliance

Federal regulations require a state or its external quality review organization to conduct one review within every three-year period to determine Medicaid MCOs' compliance with federal standards and standards established by the state for access to care, structure and operations and quality measurement and improvement. As part of this review, DHCFP's external quality review organization reviews the following:

- **Internal Quality Assurance Program (IQAP) Standards** to assess compliance with state and federal managed care requirements
- **Checklists** to assess outreach and educational materials associated with member rights and responsibilities, the member handbook, medical record standards and the provider manual
- **File reviews** to assess operational compliance for credentialing, recredentialing, service denial, grievances and appeal processing and case management activities

Table 2 below provides results from these reviews for State Fiscal Year (SFY) 2014–2015.[1]

Table 2. Compliance Results for Nevada MCOs

Compliance Activity	Amerigroup	HPN
IQAP Standards Score	98.7%	97.3%
File Review Score	96.5%	99.1%
Checklists Score	100%	98.7%
Overall Score	**97.3%**	**98.6%**

MCO Program Performance

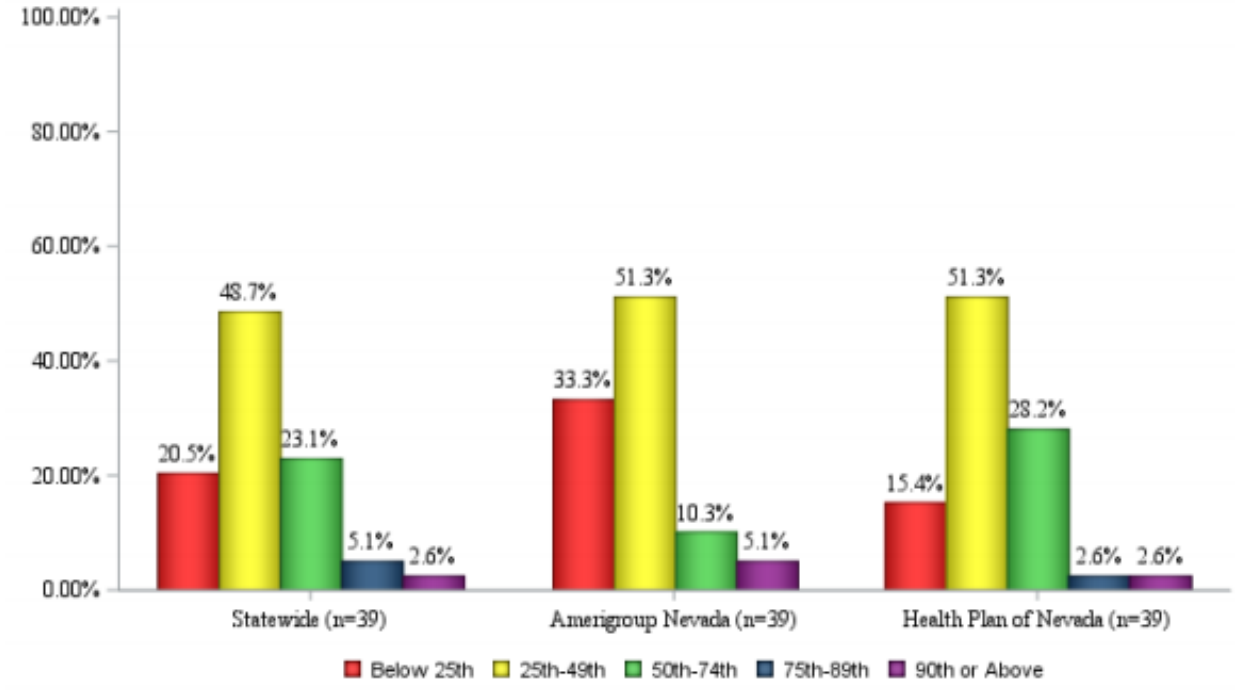
MCOs are required to report on select Healthcare Effectiveness Data and Information Set (HEDIS) measures on an annual basis.[2] In 2016, DHCFP's external quality review organization found that Amerigroup and HPN demonstrated mixed performance on HEDIS measures. While MCOs performed above the national 50th percentile for several HEDIS measures, the majority of HEDIS measures were below the national 50th percentile. Most of the MCOs' performance measure rates from HEDIS 2015 to HEDIS 2016 remained relatively stable (i.e., decreased or increased by fewer than five percentage points), although both MCOs experienced increases of more than five percentage points for several HEDIS measures. The following figure shows the performance for Amerigroup and HPN, as well as the statewide performance (Amerigroup and HPN combined) on the measures, as compared to HEDIS national Medicaid percentiles.[3]

[1] Health Services Advisory Group. (October 2015). *Division of Health Care Financing and Policy State Fiscal Year 2014–2015 External Quality Review Technical Report.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/FY2015_EQR_Technical_Report.pdf.

[2] See Section 5 of the *Division of Health Care Financing and Policy State Fiscal Year 2015–2016 External Quality Review Technical Report* for a list of the HEDIS measures and the individual HEDIS performance measure results for Amerigroup and HPN. The report is available at: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2015-16_EQR_TechRpt_F1.pdf.

[3] Health Services Advisory Group. (October 2016). *Division of Health Care Financing and Policy State Fiscal Year 2015–2016 External Quality Review Technical Report.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2015-16_EQR_TechRpt_F1.pdf.

Figure 2. Comparison of Nevada MCO Medicaid Performance Measures to HEDIS Medicaid National Percentiles, 2016



Source: Health Services Advisory Group. 2016.

In Section 7: Recommended Improvements to Nevada's Medicaid Delivery System, we provide recommended steps to support improved performance on HEDIS measures.

MCO Member Satisfaction

MCOs also are required to conduct member satisfaction surveys on an annual basis. The surveys ask MCO members to report on and evaluate their experiences with healthcare, and cover topics such as the communication skills of providers and the accessibility of services. In 2016, the MCOs' rates were lower than the Medicaid national averages for the majority of satisfaction measures, however some satisfaction rates increased over the previous year. Results from the 2016 survey are summarized below.

Table 3. MCO Member Satisfaction among Amerigroup and HPN Members, 2016

	Amerigroup		HPN	
	Adults	Children	Adults	Children
Composite Measures				
Getting Needed Care	77.6%	77.5%	73.1%	80.6%
Getting Care Quickly	76.4%	83.3%	70.4%	85.9%
How Well Doctors Communicate	87.5%	88.5%	86.5%	89.5%
Customer Service	84.7%	87.2%	NA	90.1%
Shared Decision Making	80.0%	77.3%	NA	78.4%
Global Ratings				
Rating of All Health Care	44.2%	68.6%	44.6%	68.5%
Rating of Personal Doctor	58.6%	69.2%	54.3%	74.4%

	Amerigroup		HPN	
	Adults	Children	Adults	Children
Rating of Specialist Seen Most Often	58.6%	80.0%	NA	NA
Rating of Health Plan	45.9%	64.5%	52.5%	74.9%

Note: A minimum of 100 responses is required for a measure to be reported as a survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA)

Source: Health Services Advisory Group. 2016.

In Section 7: Recommended Improvements to Nevada's Medicaid Delivery System, we provide recommended steps to support improved member satisfaction.

MCO Quality Initiatives

Nevada's Medicaid MCOs have initiated a number of strategic quality initiatives and value-added services to improve care for their members. A limited sample of these initiatives and value-added services are:[4]

- Continued My Advocate Program, which provides text and verbal messaging as vehicles for proactive and culturally appropriate communication and coaching to pregnant women
- Continued a transition care program in which a team of nonclinical coordinators serves as surrogate family members to individuals who were hospitalized and assists members with obtaining medications, setting appointments for follow-up care, coordinating transportation and coordinating housing to promote stabilization for the member after discharge from the hospital
- Facilitated medical director one-on-one meetings with physicians to discuss missed opportunities and approaches to improve performance measure rates
- Issued Citibank cards to incentivize children to receive well-care visits and seek medical attention at the pediatrician's office
- Implemented Now Clinic, a telemedicine service where recipients may see a provider face-to-face through a mobile device
- Conducted the Willing Hands Program, an 11-bed facility designed to support homeless members' post-discharge care by providing home health, a social worker, case manager and others
- Included PCMHs in their provider networks and supported enhancement of practice capabilities

FFS Program

Individuals not enrolled in an MCO are considered part of the FFS program. The FFS program serves many of Nevada's Medicaid members with the most complex needs, including individuals who are aged, blind or have disabilities and children receiving foster care. In addition, all Medicaid recipients in areas other than the urban areas of Clark and Washoe counties receive their Medicaid services through the FFS program. Below, we briefly describe the subpopulations served by the FFS program.

[4] Health Services Advisory Group. (October 2016). *Division of Health Care Financing and Policy State Fiscal Year 2015–2016 External Quality Review Technical Report.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2015-16_EQR_TechRpt_F1.pdf.

Medical Assistance for the Aged, Blind and Disabled

Medical Assistance for the Aged, Blind and Disabled (MAABD) is the name of a Nevada Medicaid eligibility category. Individuals in this category include those who are eligible for and/or may be receiving Supplemental Security Income (SSI), persons who qualify for home and community-based services (HCBS) waivers, certain persons who qualify for Medicare coverage in addition to Medicaid coverage and certain disabled children who would be eligible for nursing facility placement but who receive care in their home, referred to as Katie Beckett eligibility option participants.

Below we provide brief descriptions of three of the groups within the MAABD eligibility category: HCBS waiver participants, persons who qualify for Medicare and Medicaid coverage and Katie Beckett eligibility option participants.

HCBS Waiver Participants

Nevada has three HCBS waiver programs, as shown in Table 4 below. These HCBS waivers allow a greater portion of recipients needing long-term care services to receive services in non-institutional settings as opposed to nursing facilities. DHCFP has oversight responsibility of the HCBS waiver slots, while ADSD is responsible for all HCBS waiver operations. Individuals receiving services through HCBS waivers typically have case managers. ADSD has a unique billing protocol for providers working with consumers on the Waiver for Persons with Intellectual Disabilities and Related Conditions to ensure that services come in a timely and effective manner, so that there is no lapse in care for this vulnerable population.

Table 4. HCBS Waiver Participation

HCBS Waiver	No. of Members	No. on Waiting List
Waiver for Persons with Physical Disabilities	755	119
Waiver for Persons with Intellectual Disabilities and Related Conditions	2,081	825
Waiver for the Frail Elderly	1,924	214

Persons who Qualify for Medicare and Medicaid Coverage

Approximately 75 percent of individuals in the MAABD eligibility category are eligible for both Medicare and Medicaid.[5] This population is sometimes referred to as “dual eligibles.” Medicare is the primary payer and covers most of the acute care costs for this subpopulation.

Katie Beckett Eligibility Option Participants

Under the Katie Beckett eligibility option, DHCFP provides Medicaid benefits to children with disabilities who would not ordinarily qualify for SSI benefits because of the parents’ income or resources. These children must require a level of care that would make them eligible for

[5] Division of Health Care Financing and Policy. (April 4, 2015). *Executive Agency Fiscal Note AB 310.*

institutional placement, but instead receive services in the home.[6] There are approximately 600 children who receive services under the Katie Beckett eligibility option in Nevada.

Children Receiving Foster Care

Nevada DCFS is responsible for supervising and administering child protective and welfare services, including targeted case management, in the 15 rural and frontier counties in Nevada, while the Washoe County Department of Social Services and the Clark County Department of Family Services do so in their respective counties.[7] As of December 2015, there were 4,632 children in out-of-home foster care placements.[8] Since July 2016, children receiving foster care have had the option to enroll in a MCO if they live in the urban areas of Clark and Washoe counties, however this option has not yet been implemented or requested.

Other Populations with an Option to Participate in Medicaid Managed Care Programs

Other populations that may choose to receive services through the FFS program or the MCO program include:

- Native Americans
- Children with special healthcare needs
- Children defined as Severely Emotionally Disturbed
- Adults defined as Seriously Mentally Ill (unless part of Medicaid expansion population, in which case they must enroll in an MCO)

FFS Program Performance and Quality Initiatives

DHCFP monitors FFS utilization and FFS recipient complaints and grievances.[9] However, DHCFP does not conduct quality measure monitoring or recipient satisfaction surveys for FFS recipients, therefore there is limited data available about FFS program quality performance as a whole. There is data available through the HCGP on the specific populations enrolled in that program.

DHCFP has engaged in a number of quality initiatives over the past several years including:[10]

- **State Innovation Model**. A grant from 2015-2016 that provided financial and technical support to design multi-payer healthcare payment and service delivery models. Nevada did not receive federal funding to implement its designed models.

[6] Division of Health Care Financing and Policy. (February 2016). *Katie Beckett.* Retrieved from: http://dhcfp.nv.gov/Pgms/LTSS/LTSSKatieBeckett/.
[7] Division of Child and Family Services. *Nevada's Child Welfare and Child Protective Services.* Retrieved from: http://dcfs.nv.gov/Programs/CWS/.
[8] State of Nevada, Department of Health and Human Services. (February 2016). *DHHS Fact Book.* Retrieved from: http://epubs.nsla.nv.gov/statepubs/epubs/31428003093214-2016-02.pdf.
[9] Division of Health Care Financing and Policy. *Quality Assessment and Performance Improvement Strategy: 2016-2017.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2016-17_QAPIS_Report_F1.pdf.
[10] Division of Health Care Financing and Policy. *Quality Assessment and Performance Improvement Strategy: 2016-2017.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2016-17_QAPIS_Report_F1.pdf.

- **Balancing Incentive Payments Program.** A Centers for Medicare and Medicaid Services (CMS) grant-funded program, with the goal of making structural changes to the way individuals access long-term services and supports to rebalance institutional care with HCBS.
- **Money Follows the Person.** A CMS grant-funded program, with the goal of rebalancing and redesigning long-term care systems and transitioning individuals from qualified institutional settings to qualified residences in communities.
- **Medicaid Incentives for Prevention of Chronic Disease.** A grant to perform a study to measure how incentives for the Medicaid population affected achievement and maintenance of health outcomes.

Health Care Guidance Program

DHCFP launched the HCGP on June 1, 2014. The HCGP is a care management program available to select FFS Medicaid recipients to help them better manage their health. The program is mandatory for eligible recipients. To be eligible for HCGP, recipients must have one or more of 11 qualifying diagnoses, such as asthma, heart disease, HIV/AIDS or a mental health disorder. Even if recipients have a qualifying diagnosis, they are excluded from the HCGP if they are:

- Enrolled in an MCO
- Adults included in the Medicaid expansion population
- Eligible for Medicare and Medicaid
- Receive targeted case management
- Receive case management services through HCBS waivers
- In Nevada Check Up
- In the juvenile justice or foster care programs
- Receive emergency Medicaid
- Residents of intermediate care facilities for individuals with intellectual disabilities

The HCGP is authorized by a Section 1115(a) research and demonstration waiver, which is approved through June 30, 2018. Under the Section 1115(a) demonstration, CMS mandates care management services be provided to between 37,000 and 41,500 chronically ill beneficiaries. Using a monthly claims stratification process that identifies beneficiaries as “low” (risk level 1), “moderate” (risk level 2), “high” (risk level 3) and “complex” (risk level 4), the program design requires strategic targeting of beneficiaries in risk levels 2, 3 and 4. Beneficiaries in risk levels 2, 3 and 4 average 7,300 a month.

HCGP Performance

The HCGP reports performance data to DHCFP quarterly for monitoring purposes. DHCFP evaluates the HCGP program using both savings targets and HEDIS performance measures as compared to a baseline. HCGP tracks a total of 94 performance measures. Thirty of the performance measures are pay for performance (P4P) measures, while the remainder are not tied to payments. If the vendor achieves savings and meets quality improvements specified in the contract, the vendor is eligible for a bonus. For HCGP’s first year (June 1, 2014 to May 31, 2015), the program reduced costs by the guaranteed amount (a net reduction in costs of at least

$5,100,000), but did not achieve the contracted quality improvements that would make them eligible for the P4P bonus.

An evaluation of the program completed in November 2016 found that the HCGP reduced costs by approximately $9.9 million, after accounting for management fees associated with the contract. Further, although not P4P measures, the HCGP vendor reported meeting performance targets for the acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for hospital admissions, avoidable emergency room visits, members receiving well-child visits and children receiving select immunizations, among several other measures.[11]

The number of beneficiaries "touched" by the HCGP is expected to continue to increase over time. Because the Section 1115(a) demonstration covers a five-year period, results from the final evaluation will not be available until after the demonstration expires.

In Section 7: Recommended Improvements to Nevada's Medicaid Delivery System, we provide recommendations to support improved performance for FFS populations through a managed FFS program, to replace the HCGP.

Section 4: Special Considerations for Nevada

There are a number of unique issues in Nevada that must be considered relative to any changes in its Medicaid delivery system. These include:

- Frontier nature of the State and limited provider access
- Relationships with State divisions and counties
- Supplemental payment programs
- Certified public expenditure programs
- Provider payment issues

We discuss each of these considerations below.

Frontier Nature of the State and Limited Provider Access

Fourteen of the 17 counties in Nevada are considered rural or frontier. According to the National Center for Frontier Communities, frontier areas are the most remote and geographically isolated areas in the United States, and are usually sparsely populated and face extreme travel time to services of any kind.[12] The rural and frontier nature of the State contributes to challenges accessing healthcare providers.

The federal Health Resources and Services Administration designates Health Professional Shortage Areas (HPSAs). HPSAs may be designated as having a shortage of primary medical

[11] AxisPoint Health. (November 3, 2016). *Program Year 1 Non-P4P Clinical Rate Observations (July 2014 – May 2015).*
[12] University of Nevada School of Medicine. (January 2015). *Nevada Rural and Frontier Health Data Book.* Retrieved from: http://med.unr.edu/Documents/unsom/statewide/rural/data-book-2015/Nevada_Rural_and_Frontier_Health_Data_Book_2015DraftEmbedOpt.pdf/.

care, mental health or dental providers.[13] The table below illustrates how many Nevada residents live in an HPSA, as well as the number of counties considered single-county HPSAs.[14]

Table 5. HPSAs in Nevada

Type of HPSA	Population Living in HPSA Number (percent of residents in area)		Counties with Single County HPSA Designation
	Rural/Frontier	Urban	
Primary Care HPSA	142,476 (50.6%)	911,684 (33.7%)	9
Mental Health HPSA	286,251 (100%)	1,500,000 (53.3%)	16
Dental HPSA	145,426 (51.4%)	903,241 (31.7%)	8

Approximately 75 percent of Nevada physicians participate in the Medicaid program, which was the 21st highest rate compared to other states. However, Nevada ranks 49th out of 50 states when considering the number of Nevada physicians accepting Medicaid per 100,000 population.[15] Because there is a lower number of physicians per capita in Nevada, it ranks poorly compared to other states when considering both Medicaid participation rates and the per capita number of physicians. Further, input from stakeholders suggests that some Medicaid providers no longer actively accept Medicaid patients, or only accept very limited numbers of Medicaid patients.

DHCFP Medicaid Access Study

According to DHCFP's commissioned evaluation of the Nevada Medicaid provider network, Medicaid MCOs had lower (i.e., better) provider-to-recipient ratios compared to the general population, but higher (i.e., worse) ratios compared to the Medicaid FFS ratio. The Nevada Medicaid study also found that the MCOs' PCP ratios far exceeded the standards established in the MCO contract (Amerigroup and HPN had ratios of 1:211 and 1:228 respectively, compared to the Medicaid MCO contract requirement of 1:1,500).[16] It is important to note that the study of provider-to-recipient ratios did not consider whether a provider is accepting new Medicaid patients or how active the provider is in the Medicaid program, so it is possible that these ratios overstate the availability of providers. In addition to assessing provider-to-recipient ratios, DHCFP also evaluated appointment availability, as described below.

DHCFP's access study also identified a few areas where at least one of the MCO's ratios was higher (i.e., worse) than that for the general Nevada population. This occurred for:

- Dentists
- Mental health outpatient services

[13] Primary care HPSAs are based on a physician to population ratio of 1:3,500. Mental health HPSAs are based on a psychiatrist to population ratio of 1:30,000. Dental HPSAs are based on a dentist to population ratio of 1:5,000.
[14] University of Nevada School of Medicine. (January 2015). *Nevada Rural and Frontier Health Data Book.* Retrieved from: http://med.unr.edu/Documents/unsom/statewide/rural/data-book-2015/Nevada_Rural_and_Frontier_Health_Data_Book_2015DraftEmbedOpt.pdf/.
[15] Sommers, B.D. & Kronick K. (January 5, 2016). Measuring Medicaid Physician Participation Rates and Implications for Policy. *Journal of Health Politics, Policy and Law.*
[16] Health Services Advisory Group. (July 2015). *Division of Health Care Financing and Policy State Fiscal Year 2014–2015 Provider Network Access Analysis.* July 2015. Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/2014-2015%20Network%20Adequacy%20Report.pdf.

- Pediatric mental health specialists
- Home health providers
- Psychiatric inpatient hospitals[17]

Because the Medicaid MCO program does not cover most HCBS and nursing facility services, the study did not evaluate availability of most of these provider types.

As the number of providers in a network does not always provide a full picture of access, DHCFP's access study also evaluated appointment availability by conducting "secret shopper"[18] telephone surveys of contracted MCO and FFS providers' offices. The surveys evaluated the average length of time it takes for a Medicaid recipient to schedule an appointment with a Nevada-licensed provider. Across the four categories evaluated in the study (i.e., PCPs, prenatal care providers, specialists and dentists), nearly 50 percent of the calls ended without a scheduled appointment. For the calls that ended in a scheduled appointment, less than three-quarters of the appointments were scheduled within contract timeliness standards.

Urban and Frontier/Rural Provider-to-Recipient Ratios

DHCFP's access study did not break out provider-to-recipient ratios separately for urban and frontier/rural areas of the State. This is likely due in part to the fact that MCOs currently only enroll Medicaid recipients in the urban areas of Clark and Washoe counties. The Nevada Rural and Frontier Data Book illustrates that provider ratios are generally higher (i.e., worse) in rural areas as compared to urban areas. Below are ratios for a sample of licensed provider types in rural vs. urban areas of Nevada.

Table 6. Provider Ratios in Nevada Rural and Urban Counties

Licensed Health Professional	Number per 100,000 Population	
	Rural Counties	Urban Counties
Allopathic Physicians (MDs)	72.8	183.4
Osteopathic Physicians (DOs)	15.8	21.6
Primary Care Physicians (MDs and DOs)	49.6	90.4
Dentists	38.0	56.8
Psychiatrists	0.7	7.0
Psychologists	6.0	14.0

Source: Nevada Rural and Frontier Data Book. 2015.

Telemedicine

In 2015, DHCFP modified its telemedicine reimbursement policies to apply to all qualified providers for all appropriate services.[19] DHCFP employs a broad policy to encourage use of

[17] CMS generally does not provide federal funding for services for Medicaid recipients in an Institution for Mental Disease (IMD). States have the option to authorize IMD services through their managed care contracts, and Nevada has exercised this option more recently.
[18] A secret shopper is a person employed to pose as a shopper, client or patient to evaluate the quality of customer service or the validity of information. The study's secret shopper telephone survey allowed for objective data collection from healthcare providers without potential biases introduced by knowing the identity of the caller.
[19] Division of Health Care Financing and Policy. (November 12, 2015). *Medicaid Services Manual Changes – Chapter 3400 Telehealth Services.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C3400/MSM_3400_12_01_15.pdf.

telemedicine and allows for the originating site (i.e., the location of the patient) to be anywhere the patient is located. This includes a provider's office, as well as a patient's home through technology such as an iPad or Smartphone or home computer via a Health Insurance Portability and Accountability Act-compliant platform at both locations.[20] In interviews, DHCFP staff report that uptake in telemedicine utilization has been slower than expected.

The Nevada State Office of Rural Health reports that the telemedicine technology has allowed for over 100 hours of contact time for specialty consults with University of Nevada, Reno School of Medicine physicians on behalf of rural Nevadan's and between 70 and 180 classes and training programs.[21]

Relationships with State Divisions and Counties

Case Management Services

In Nevada, State divisions and counties agencies provide waiver or targeted case management services and a few other direct services for select populations. Revenue generated from providing targeted case management services plays a large role in funding county programs.

Targeted case management is defined as services which assist individuals in gaining access to needed medical, social, educational and other services.[22] Currently, there are eight target groups eligible to receive this service in Nevada, which are listed in Table 7 below, along with the State division and county agencies responsible for providing those services. State and county providers of targeted case management certify their costs through a cost reporting process that allows them to receive the federal share of the difference between their Medicaid cost and the interim rates paid for targeted case management services.[23]

Table 7. Groups Receiving Medicaid Targeted Case Management and Responsible State and County Providers

Target Group	Responsible State Division	Responsible County Agencies
Children and adolescents who are Non-Severely Emotionally Disturbed with a mental illness*	DPBH (rural counties) and DCFS (urban counties)	NA
Children and adolescents who are Severely Emotionally Disturbed	DPBH (rural counties) and DCFS (urban counties)	NA
Adults who are Non-Seriously Mentally Ill with a mental illness*	DPBH	NA
Adults who are Seriously Mentally Ill	DPBH	NA

[20] Division of Health Care Financing and Policy. (May 2016). *DHCFP Telehealth Policy Legislative Update.* Retrieved from: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/PCO/DHCFP%20Telehealth%20Policy%20Legislative%20Update.pdf.
[21] Nevada State Office of Rural Health. *Telehealth.* Retrieved from: http://med.unr.edu/rural-health/telehealth.
[22] State of Nevada Purchasing Division. (July 1, 2016). *Request for Proposal 3260 for Managed Care Organizations.*
[23] Nevada Medicaid State Plan Attachment 4.19-B. Medicaid State Plan current as of June 6, 2016.

Target Group	Responsible State Division	Responsible County Agencies
Persons with intellectual disabilities or related conditions	ADSD	NA
Developmentally delayed infants and toddlers under age three	ADSD	NA
Juvenile Probation Services	NA	Clark County Juvenile Justice Washoe County Juvenile Services Any rural county
Child Protective Services	DCFS	Clark County Family Services Washoe County Social Services Any rural county

* Private providers may also provide targeted case management services these target groups.

In addition to State divisions and county agencies providing targeted case management, state divisions and counties also serve in the following roles related to the Medicaid program:

- **ADSD** provides case management services to individuals on HCBS waivers
- **ADSD** operates three facilities that provide services for persons with intellectual disabilities and persons with related conditions (Desert Regional Center, Sierra Regional Center, Rural Regional Center)
- **DPBH** operates and provides clinical behavioral health services through Southern Nevada Adult Mental Health, Northern Nevada Adult Mental Health and Rural Counseling and Supportive Services[24]
- All of the **17 counties in Nevada** reimburse DHCFP the non-federal share of expenditures for recipients that meet an institutional level of care whose income is at 142 percent to 300 percent of the Federal Benefit Rate up to the budgeted maximum cap
- **Washoe County Senior Services** provides an adult day health program, called Daybreak Adult Services; this is a licensed adult day program that supports the needs of frail, disabled and cognitively impaired adults 18 years and above by providing social, nursing and community support and serves as an alternative to institutional care[25]

Supplemental Payment Programs

Nevada's supplemental payment programs are important to consider, as recent Medicaid managed care regulations severely limit a state's ability to continue distributing supplemental payments for services covered under a MCO program. Nevada has several supplemental payment programs that provide revenue to providers. If Nevada expands the reach of its MCO program to cover additional services and populations, it will no longer be able to consider those services and populations in the supplemental payment calculations. Without identifying replacement programs, this would reduce funding to providers, and impact funding to DHCFP

[24] Division of Public and Behavioral Health. (April 7, 2016). *Clinical Behavioral Services.* Retrieved from: http://dpbh.nv.gov/Programs/ClinicalBehavioralServ/Clinical_Behavioral_Services_-_Home/.
[25] Washoe County Nevada. *Adult Day Health.* Retrieved from: https://www.washoecounty.us/seniorsrv/adult_day_health/index.php.

as well. The following provider types receive payments from DHCFP in addition to claims payments:

Table 8. Summary of Supplemental Payment Programs

Provider Type/ Service	Qualifying Criteria	Payment Distribution Methodology
Public Hospitals, Inpatient Services	All non-State government owned or operated acute hospitals	• Payments based on Medicaid FFS days
Public Hospitals, Outpatient Services	Acute care hospitals that are non-State governmentally owned or operated	• Payments based on Medicare cost to charge ratio and Medicaid FFS outpatient adjudicated claims
Private Hospitals	Private hospitals affiliated with a state or unit of local government through a Low Income and Needy Care Collaboration Agreement	The payment methodology is based on the lesser of: • Difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services processed for FFS recipients • For hospitals participating in the Nevada Medicaid Disproportionate Share Hospital (DSH) program, the payment distribution methodology is based on the difference between the hospital's total uncompensated costs, less the hospital's DSH payments, less all inpatient supplemental program payments
Indigent Accident Fund (IAF)	Acute care hospitals that are not the following: critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities or long-term acute care hospitals	• Payments made based on a pre-determined total pool of money • A portion of the pool is divided between trauma centers, with Level I and Level II trauma centers receiving a higher weight than Level III trauma centers • Remaining portion of pool is distributed on a per diem basis based on the total days for each hospital adjusted by the hospital's Medicaid case mix
Free-Standing Nursing Facilities	All free-standing nursing facilities except for nursing facilities owned by the State of Nevada or any of its political subdivisions	Calculated to ensure that: • 50 percent of the supplemental payment is based on Medicaid occupancy, MDS accuracy and quality measures • 50 percent of the payment is based on acuity
Practitioner Services Delivered by the University of Nevada School of Medicine	Select practitioners employed by the University of Nevada School of Medicine	• The payment methodology is based on an enhanced Medicare rate less Medicaid payments

Source: Nevada Medicaid State Plan Attachment 4-19.

Appendix B provides a summary of State, county and provider revenue associated with the supplemental payment programs. In Section 7: Recommended Improvements to Nevada's

Medicaid Delivery Model, we provide an analysis of the impact of MCO expansion scenarios on supplemental payment programs and a discussion of possible alternatives.

Certified Public Expenditure Programs

Nevada's certified public expenditure (CPE) programs are also important to consider, as these programs can also be impacted by expanding the scope of MCOs. Under Nevada's CPE programs, governmental providers may certify that they expend public funds to support the full cost of providing Medicaid-covered services or program administrative activities. In turn, these expenditures are eligible for federal financial match.[26] Nevada's CPE programs include government units that provide:

- Targeted case management
- Adult day healthcare
- Public and mental health services
- Developmental services
- Emergency transportation services
- Paratransit services

In general, CPE providers certify their costs through a cost reporting process that allows the providers to receive the federal share portion of the difference between their Medicaid cost and the interim rates paid for services provided. The providers may also require DHCFP to either recoup total computable expenditures where interim rates exceed Medicaid cost or off-set future claims until the amount of the federal share has been recovered.[27] The CPE provider incurs the total cost of the service on behalf of DHCFP. CMS pays the federal share of the CPE to DHCFP.

If the CPE services bulleted above are carved in the MCO benefit package and paid for by MCOs, federal regulations do not allow Nevada to maintain these CPE programs, which would impact revenue to the government units that provide these services.

Appendix C provides a summary of State, county and provider revenue associated with the CPE programs. In Section 7: Recommended Improvements to Nevada's Medicaid Delivery Model, we provide an analysis of the impact of MCO expansion scenarios on CPE programs and a discussion of possible alternatives.

Provider Payment Issues

Critical Access Hospitals

There are thirteen hospitals in Nevada that have been designated by Medicare as Critical Access Hospitals (CAHs).[28] CAHs must meet specific federal criteria, for example, they must be located in a rural area, maintain no more than 25 inpatient beds and furnish 24-hour emergency

[26] Medicaid and CHIP Payment and Access Commission (MACPAC). *Non-federal financing*. Retrieved from: https://www.macpac.gov/subtopic/non-federal-financing/.
[27] Nevada Medicaid State Plan Attachment 4.19-B. Medicaid State Plan current as of June 6, 2016.
[28] Flex Monitoring Team. (April 6, 2016). *List of Critical Access Hospitals.* Retrieved from: http://www.flexmonitoring.org/data/critical-access-hospital-locations/.

care seven days a week.[29] DHCFP reimburses these hospitals under Medicare's retrospective cost reimbursement methodology, as follows:

- On an interim basis, each hospital is paid for certified acute care at the lower of 1) billed charges, or 2) the rate paid to general acute care hospitals for the same services[30]
- The reasonable allowable costs of inpatient acute hospital services are "cost-settled," – their costs are determined using the Medicare cost report and hospital-specific retrospective Medicare principles of reimbursement

Most CAHs are located in the rural and frontier regions of Nevada, areas that are not covered by MCO contracts. Therefore, CAHs have generally not had to contract with MCOs and receive a very limited proportion of payments from MCOs. If managed care were expanded statewide, MCOs would need to contract much more widely with CAHs to have sufficient hospital coverage.

Rural Health Clinics

There are ten rural health clinics (RHCs) in Nevada.[31] RHCs are required to be staffed by a team that includes one mid-level provider that must be on-site to see patients at least 50 percent of the time the clinic is open, and a physician to supervise the mid-level provider. RHCs are required to provide outpatient primary care services and basic laboratory services, and must be located within non-urban rural areas that have healthcare shortage designations.[32]

RHCs are located in the rural and frontier regions of Nevada, areas that are not covered by MCO contracts. Therefore, RHCs have generally not received payments from MCOs. If managed care were expanded statewide, MCOs would need to contract with RHCs to have sufficient networks and RHCs would receive a much greater proportion of their payments from MCOs.

RHCs are unique among providers because federal law specifies the way they are to be reimbursed and sets a floor for payment. Medicare and Medicaid programs pay a facility-specific all-inclusive per visit payment that covers all services provided to a single patient on a single day of service.[33] [34] DHCFP reimburses RHCs based on a prospective payment system and sets the baseline rate based on the reasonable and allowable costs of services. DHCFP annually updates the rate by applying the Medicare Economic Index for primary care services. Consistent with federal requirements, DHCFP makes additional adjustments as needed to

[29] Centers for Medicare and Medicaid Services. *Critical Access Hospitals*. Retrieved from: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/cahs.html.
[30] Nevada Medicaid State Plan Attachment 4.19-B. Medicaid State Plan current as of June 6, 2016.
[31] Nevada Rural Hospital Partners. (May 7, 2014). *Rural Health Clinics.* Retrieved from: http://www.leg.state.nv.us/Interim/77th2013/Exhibits/HealthCare/E050714G.pdf.
[32] Health Resources and Services Administration. *What Are Rural Health Clinics?* Retrieved from: http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html.
[33] Section 702 of the Benefits Improvement and Protection Act of 2000 states that Medicaid programs provide payments to FQHCs and RHCs in an amount based on a per-visit basis equal to the reasonable cost of services documented for a baseline period (with adjustments) or based on an alternative payment methodology to reimburse for these services.
[34] Centers for Medicare and Medicaid Services. (2001). *New FQHC/RHC Payment Provisions*. Retrieved from: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011901d.pdf.

account for any increase or decrease in the scope of services provided by an RHC during the fiscal year.

CMS provided guidance related to RHCs under a State Health Official letter related to network sufficiency and wraparound payments under Medicaid managed care.[35] The letter states that RHC services "furnished through Medicaid managed care programs, requires that state plans provide for supplemental [wraparound] payments from states to FQHCs and RHCs equal to the amount or difference between the payment under the prospective payment system (PPS) methodology and the payment provided under the managed care contract." The use of the wraparound payment approach allows states to comply with Social Security Act §1902(bb)(5) regardless of the Medicaid delivery system.

Nevada's Medicaid State Plan states that RHCs that provide services under contract with an MCO will receive quarterly or monthly (as agreed upon between the provider and the state) wraparound payments for furnishing services. The wraparound payments are a calculation of the difference between the MCO payments and the payments the RHC would have received under the FFS methodology. At the end of each payment period, the total amount of MCO payments received by the RHC would be reviewed against the payments that the RHC would have received under the FFS methodology, based on the actual number of visits provided. If the amount exceeds the total amount of MCO payments, DHCFP would pay the RHC the difference, and if the amount is less, the RHC would refund the difference to DHCFP.[36]

Impact on Drug Rebates

DHCFP currently carves in pharmacy into the MCO benefit package, but requires MCOs to submit all pharmacy encounters and outpatient administered drug encounters to DHCFP. DHCFP then submits these encounters to drug manufacturers to collect rebates. If DHCFP were to expand the populations and geographic areas enrolled in MCOs, MCOs would be responsible for paying for prescriptions for a greater proportion of Nevada's Medicaid recipients.

Expanding MCOs to cover these additional populations could reduce the pharmacy rebates that DHCFP collects, however evidence from other states suggests that overall costs for pharmacy may decrease as well. A 2015 study found that states that carved-in pharmacy experienced a net savings of $6.33 per prescription compared to states that carved out pharmacy, due in part to the lower pre-rebate prescription costs for states that carved-in pharmacy.[37] This suggests that DHCFP could experience reduced pharmacy costs for populations newly covered by MCOs, despite potentially collecting less rebates.

[35] Vikki Wachino. (April 26, 2016). *RE: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care*. *SHO #16-006.*
[36] Nevada Medicaid State Plan. Medicaid State Plan current as of June 6, 2016.
[37] The Menges Group. (April 2015). *Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States.* Retrieved from: https://www.ahip.org/wp-content/uploads/2015/04/Medicaid-Pharmacy-Carve-In-Final-Paper-The-Menges-Group-April-2015.pdf.

Section 5: Stakeholder Input

DHCFP has held dozens of listening sessions and focus groups since January 2016, to receive input about a possible expansion of the MCO program and the unique considerations for Nevada, including those listed above. DHCFP first held a series of stakeholder meetings between January and May 2016 to introduce the concept of MCO expansion and hear comments from the public. When Navigant's contract with DHCFP began in summer 2016, we conducted interviews with staff from DHCFP, other State divisions and the Governor's office to gather information about the current MCO and FFS programs and considerations for potential modifications to the delivery system. Following these meetings, Navigant identified seven potential delivery system options for Nevada:

1. Maintain current delivery systems
2. Expand the MCO program statewide
3. Carve in additional populations to MCOs (e.g., MAABD population)
4. Contract with a managed long-term services and supports MCO
5. Contract with an administrative services organization
6. Develop accountable care organizations
7. Implement a PCMH program

We presented high-level descriptions of these options at a series of listening sessions and focus groups in September and October 2016 and requested input into how these options may work in Nevada, noting that options could be combined in different ways. Stakeholders providing input included providers, Medicaid recipients and their families, advocacy organizations and representatives of State divisions and county agencies. Appendix D provides a list of the stakeholder meetings.

Below, we provide a summary of stakeholder comments. ***Stakeholders commonly expressed that it is necessary to address issues with the current system (e.g., provider access; reimbursement rates; accountability and collaboration structures) before expanding the MCO program to additional, more vulnerable populations.***

- **Provider access.** Provider access was repeatedly named as a major concern across the State for both the Medicaid FFS and MCO programs. Specific comments include:
  - Some services are only available out-of-state, while others have waiting lists or require long travel distances
  - Patients sometimes cannot be discharged to a less intensive setting because there are no beds available (e.g., cannot be discharged from an acute care hospital to a rehab facility)
  - Some FFS Medicaid recipients are unaware of how to find a participating Medicaid FFS provider; contact information for both FFS and MCO Medicaid providers is sometimes out-of-date or they are not accepting new Medicaid patients
  - Concern that provider access issues will intensify with MCO expansion, since MCOs choose not to contract with some providers and some providers elect not to not contract with Medicaid MCOs

  - FFS Medicaid recipients and their families are concerned that they will have a limited choice of providers and will not be able to see their current providers under an MCO model
  - Stakeholders are concerned that MCOs sometimes exclude community providers from their network and instead use providers employed by the MCO
  - Stakeholders expressed that they have experienced reliability and service issues with the Medicaid transportation providers; MCOs report that they sometimes cover transportation services for their members even though they are not paid to do so to ensure their members have transportation
  - Individuals commented that telemedicine should be part of any Medicaid program going forward to increase access to providers and support PCPs by connecting them with specialists
- **Provider reimbursement.** Stakeholders expressed concern with reimbursement rates and potential delays in payment under MCOs and suggest that more provider payments be tied to value
  - Stakeholders expressed that reimbursement rates are not sufficient and have not been increased in over ten years for some provider types; some are also concerned that if managed care is expanded without first increasing FFS rates, MCO rates will also be too low
  - Providers are concerned that MCOs will take longer to pay them than the FFS system, and that more staff will be required to confirm that providers receive correct payments from MCOs
  - For both the FFS and MCO programs, stakeholders suggested that more payments to providers need to be based on quality and value, as opposed to the volume of services delivered
  - Stakeholders are concerned that the introduction of managed care will impact supplemental payment and CPE programs (and therefore funding) for a variety of provider types, as well as impact county funding
  - Some provider types, such as CAHs, RHCs and hospital-based nursing facilities are reliant on cost-based reimbursement, and are concerned that if the reimbursement method changes under MCOs, providers will not be able to sustain operations and access issues will worsen
- **Navigating the system.** The Medicaid system is complex, and recipients and providers may be challenged in understanding and adhering to DHCFP and MCO materials and policies
  - Both Medicaid FFS and MCO recipients sometimes have difficulty understanding what providers they may see and who to call with issues
  - For some providers and recipients, the MCO process to obtain prior authorization has been a negative experience
  - Providers feel it is expensive to become an MCO provider due to the rigorous credentialing process; several providers reported that it took more than one year to become enrolled with an MCO

- **Evidence-based models.** Stakeholders commented that the Medicaid program and providers should more widely incorporate evidence-based models, such as PCMHs, Health Homes and complex care management
- **Supportive housing, long-term supports and other services.** Stakeholders reported that there needs to be more community-based programs and programs offering supportive housing, employment, crisis intervention and stabilization centers and long-term supports; stakeholders also expressed the need for enhanced coverage of dental services, prescriptions and durable medical equipment for adults
- **Appropriate use of emergency departments.** In both urban and rural areas of the State, providers noted that there are challenges with Medicaid recipients using the emergency department for non-emergent needs
- **Data and performance monitoring.** Stakeholders noted that strong state oversight is essential and there is currently limited ability to measure and monitor the quality and satisfaction of the Medicaid programs
  - There needs to be strong state oversight to ensure MCOs are compliant with federal regulations and State requirements, with enforceable sanctions if MCOs are not compliant
  - Contact information for Medicaid recipients is sometimes inaccurate, leading to challenges reaching Medicaid recipients for case management and care delivery
  - Stakeholders requested that more information be publicly available regarding both the Medicaid FFS and MCO programs to increase transparency
  - Individuals suggested that more performance measures are needed to evaluate care and outcomes for special populations, such as individuals with developmental disabilities, individuals with behavioral health conditions and children receiving foster care
  - Stakeholders want to see more information on network adequacy for certain provider types, such as behavioral health providers, substance use providers and autism services providers and request that this information should include community experience of accessing various types of providers
- **Customer service and communications.** Stakeholders are concerned that Hewlett Packard Enterprise and MCO customer service are not always responsive to providers' and recipients' questions and sometimes provide incorrect responses; materials can be difficult to understand and interpret
- **State employees.** State employees are concerned that changes to the delivery system will impact their jobs and they wish to continue working for the State
- **Stakeholder involvement.** Regardless of the Medicaid delivery model selected, stakeholders emphasized the need for robust involvement of a wide array of stakeholders in the design, implementation and monitoring of Medicaid programs to assure the model meets the needs of all populations

In addition to the comments above, stakeholders also provided considerations for specific populations, such as children receiving foster care and individuals receiving long-term services. Appendix E provides a summary of these considerations.

In January 2017, DHCFP and Navigant held town hall meetings in Las Vegas, Reno and Carson City to answer questions and solicit comments on the draft *Nevada Medicaid Delivery Model Recommendation Report*. In response to the comments received, Navigant made several edits and clarifications to the report. Appendix F provides a summary of the other key comments received during the town hall meetings or through written comment.

Section 6: Objectives and Evaluation Criteria for Delivery System Options

Considering DHCFP's Medicaid program goals and the stakeholder feedback summarized above, we identified objectives for enhancing the Nevada Medicaid program and strategies for achieving those objectives. We also consolidated the seven delivery model options discussed with stakeholders and assessed how well each option could accommodate the strategies.

Objectives and Strategies for Enhancing the Medicaid Program

Table 9 below provides a list of the objectives and associated strategies for enhancing the Medicaid program.

Table 9. Objectives and Strategies for Enhancing the Medicaid Program

Objective	Strategy
Ensure appropriate use of healthcare services	• Connect Medicaid recipients with a dedicated PCP • Provide targeted outreach to frequent emergency department users and other high utilizers • Provide transition support to beneficiaries when changing care settings • Provide coaching, education and support for patient self-management • Help individuals access and use home and community-based services rather than institutional services, if desired
Enhance access to quality care for Medicaid recipients	• Create incentives to increase the number of providers participating in Medicaid • Hold providers to higher quality standards • Maintain or increase choice of Medicaid providers compared to current state • Reduce the length of time between scheduling an appointment and seeing a provider • Evaluate increase in provider reimbursement rates • Increase use of telemedicine to support PCPs and connect recipients with services
Maintain access to, and viability of, safety net providers	• Assist safety net providers in developing financially sustainable models • Support full choice of safety net providers, including community-based providers • Maintain supplemental payment programs to safety net providers
Streamline Medicaid provider administrative responsibilities	• Streamline provider credentialing process across entities • Streamline prior authorization process across entities
Improve the ability of Medicaid recipients to navigate the healthcare system	• Provide more resources to help recipients find providers and services • Provide more resources to help recipients manage their health conditions

Objective	Strategy
	• Provide enhanced support to recipients when they experience problems with quality, access or level of services provided
Increase use of evidence-based practices	• Increase education and technical assistance to providers regarding evidence-based practices • Require providers to use evidence-based practices as a condition of model participation
Allow for integrated delivery of services and person-centered planning, particularly for complex populations	• Require development of a person-centered plan and regular updates • Use interdisciplinary care teams, including family members • Provide a dedicated case manager for high risk individuals • Integrate physical, behavioral and long-term services • Provide support for recipients' social needs (e.g., housing, employment)
Improve ability to monitor quality measures for all Medicaid recipients	• Dedicate resources for data collection, measure calculation and auditing
Achieve a sustainable business model for the State	• Maintain funding streams to finance the Medicaid program • Provide budget predictability to the State
Support operational feasibility from a State administrative and oversight perspective	• State staff monitor the program and enforce accountability of vendors/providers • Allow for phased implementation • Allow for modifications to model based on implementation experience • Realign jobs for State employees to improve efficiency
Align provider and/or vendor payments with the value generated for the State and Medicaid recipients	• Increase the percentage of Medicaid providers that have payments based on quality improvements (incentives) • Increase the percentage of Medicaid providers whose payments include down-side risk (e.g., capitated payments, bundled arrangements) • If using vendors, condition a portion of vendor payment on agreed-upon outcomes

Consolidated Options

For the purposes of evaluating Medicaid delivery model options, we consolidated the seven Medicaid delivery model options presented at the September/October 2016 stakeholder meetings into three major program approaches and two models for coordinating care among providers. The three major program approaches are:

- Unmanaged FFS program (most similar to Nevada's current FFS program, with limited numbers of recipients eligible for case management services)
- Managed FFS program (most similar to Nevada's HCGP; administrative service organizations can fit into this category)
- MCO program (most similar to Nevada's current MCO program)

For the managed FFS program and the MCO program approaches, we assume strong contracts between DHCFP and the vendor; we also recommend the implementation of robust monitoring,

oversight and enforcement activities, which we discuss in more detail in Section 7: Recommended Improvements to Nevada's Medicaid Delivery Model.

In addition to these three program approaches, we evaluated how well two popular models for coordinating care among providers – PCMHs and accountable care organizations (ACOs) – could achieve these strategies. Both PCMHs and ACOs can be used in conjunction with an unmanaged FFS program, a managed FFS program and a MCO program. See Appendix G for a description of other Medicaid delivery system options considered.

Rating Approach

We assigned a rating to each program approach and provider-level model based on how well positioned it is to achieve each strategy. If, with the appropriate contracts and oversight in place, the program approach or provider-level model could generally achieve the strategy we assigned three points, if it would have a limited impact, we assigned two points and if it would have little or no impact we assigned one point. Based on this analysis, we found that the MCO program, followed by the managed FFS program, were the best equipped to achieve the identified strategies for the Nevada Medicaid program.

Although the MCO program received the highest score, the score assumes that the MCO program is implemented with strong contract oversight and monitoring infrastructure and practices, which will require increased funding and take time to achieve. Therefore, in Section 7: Recommended Improvements to Nevada's Medicaid Delivery Model, we suggest implementing a new managed FFS program as an interim step, followed by expansion of the MCO program in a phased approach, assuming DHCFP has implemented the contract oversight and monitoring changes and MCOs experience improved performance and satisfaction measures. As the managed FFS program shares many of the same program elements of the MCO program, and would be run by MCOs, it is well positioned to provide case and care management and integrated care to the FFS population. We discuss this recommendation in more detail in the next section. The PCMH and ACO models had similar ratings to each other. Appendix H provides more information on this evaluation.

Section 7: Recommended Improvements to Nevada's Medicaid Delivery Model

Based on interviews conducted with State staff, dozens of listening sessions and focus groups and the results of the evaluation described above, we recommend a phased approach to modifying Nevada's current Medicaid FFS and MCO programs.

This phased approach will allow DHCFP to implement program changes gradually, to allow for additional stakeholder involvement and time for adequate preparation of providers, Medicaid recipients, state divisions and other stakeholders regarding the program changes. Rather than implementing a number of large changes at once, a phased approach will allow DHCFP to address challenges with the current systems and build upon positive program aspects, while preparing for more significant modifications in the future. Further, the recommended approach would only expand MCOs to additional populations and geographic areas if there are sustained improvements in performance (e.g., HEDIS measures), access and availability of appropriate providers and satisfaction among recipients and providers.

Interviews and stakeholder communications suggest that there may be managed care program features that could benefit additional Nevada Medicaid populations and service areas. These program features include care and case management programs; an emphasis on integrated care across the physical health, behavioral health and long-term care settings; support to providers; and assistance in accessing the most appropriate care and services within a complex healthcare delivery system.[38] Although there are advantages to implementing many managed care features, there are a number of systemic issues that the State should address before moving forward with MCO expansion; stakeholders have also noted many of these issues as areas of concern, particularly in regard to vulnerable populations.

We recommend that Nevada take a series of steps to prepare for the implementation of additional managed care program features, working in collaboration with Medicaid providers, Medicaid MCOs, the Nevada Legislature, Medicaid recipients and advocacy organizations. These steps are designed to address performance, access and satisfaction issues that exist in the current program. In developing these recommended steps, we looked at all options, regardless of funding issues; however it is important to note that a number of the recommendations will require additional funding. The recommended steps fall into four primary phases:

- **Phase 1:** Build state capacity for additional oversight to assure ongoing compliance on the part of MCOs with State and federal requirements. Given that an expanded MCO program could increase the number of MCO members by approximately 150,000, and given that many of these new members have more complex healthcare and long-term care needs than the current MCO membership, the State needs to build additional capacity to monitor the additional populations and services. Stakeholders report both positive and negative feedback about MCOs, and without more in-depth monitoring and reporting, it is difficult to identify what is fact versus anecdote.

- **Phase 2:** Develop a strategy and implement changes to improve access to Medicaid services by making it easier for providers to actively participate in Medicaid, evaluating Medicaid reimbursement rates and promoting use of telemedicine to expand the reach of providers. Provider access was repeatedly raised by stakeholders as a barrier to quality care in the State. While DHCFP can implement program changes to help alleviate some access concerns, it seems evident that additional workforce development policies are needed to increase the number of providers in the State and account for the unequal geographic distribution of providers.

[38] For the purposes of this report, we define care management and case management using definitions from the Technical Assistance Collaborative, Inc. Care management is defined as a set of activities by which a system of care assures that every person served by the system has a single approved care plan that is coordinated and not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. Care management is often done intermittently, when the individual first comes into the system of care and at critical treatment junctures. In contrast, case management is a clinical service focused on higher need individuals. Case management is provided continuously, even if there is no immediate need for services, so long as the individual is determined to need the assistance from a case manager.

- **Phase 3:** Develop and enhance the capabilities of Nevada providers to offer high quality, integrated care to patients in the most appropriate setting by supporting PCPs to become PCMHs and equipping providers to enter into value-based payment (VBP) arrangements with payers.

- **Phase 4:** Offer care management, case management and support services to FFS populations, while creating an environment that is prepared for full-risk managed care, by including MCO(s) in a managed FFS program. This managed FFS program would provide additional services to these FFS populations without limiting their choice of providers or requiring providers to contract with MCOs. As one or more MCOs would serve as the managed FFS vendor, this program would be significantly different from other programs tested in Nevada, and would serve as pathway to prepare MCOs to take on full-risk for additional populations and services.

Phase 1: Build State Capacity

DHCFP does not currently have enough resources devoted to managed care monitoring, particularly when considering an expansion of the MCO program. In 2015, DHCFP paid MCOs over $1.2 billion in capitation payments.[39] With contracts of this size, it is essential that states be effective monitors to confirm contracted services are provided in accordance with contract requirements and generate value to the State and other stakeholders. Effective monitoring can also lead to program improvements and measurable savings. This requires staff to have sufficient time, resources and training to conduct strong oversight and enforcement activities.

Over the past several months, DHCFP has reallocated resources to focus on MCO oversight. Navigant recommends continuing to build capacity in this area to monitor and enforce Medicaid contracts and equipping these staff with the appropriate training and tools. It is also important that these staff have the authority to enforce contract requirements, such as imposing sanctions. It is our experience that when states move to enroll nearly all Medicaid recipients in some type of managed care program, states can retrain existing resources to carry out the managed care oversight and monitoring functions.

A sample of suggested activities for DHCFP includes:[40]

- **Implement managed care oversight team.** We recommend that DHCFP use a multi-disciplinary team to oversee MCOs. This team may consist of an operations manager, as well as a support team that works across all MCOs. The operation manager's primary responsibility would be to oversee the performance of all MCOs and provide comparative information to identify issues that impact all MCOs. The support team would be responsible for reviewing MCO reports and data in functional areas, such as quality, clinical management, operations and finance. All members of the managed care oversight team will require sufficient training and resources. Currently, DHCFP does not have a formal managed care oversight team.

[39] DHCFP data. Received July 12, 2016.
[40] Navigant is contracted with DHCFP to recommend further revisions to DHCFP's MCO oversight process, and this activity will be conducted outside the scope of this report.

- **Update reporting requirements.** As managed care programs evolve, reporting needs sometimes change. Some reports may no longer be needed (or may be needed at a reduced frequency), while other reports may need to be added. We recommend reviewing the reports MCOs are currently required to submit and assessing whether each one provides DHCFP with the information necessary to monitor and enforce contract requirements that are most meaningful to program success and improvements in recipient outcomes. In addition, we recommend assessing whether there are any gaps in reporting. For example, from our high-level review of reports, it did not appear that MCO reports provide data to understand utilization or performance outcomes or issues for special populations (e.g., adults with serious mental illness, children with autism) or reports to assess operations or outcomes associated with MCO case management activities.[41]

  DHCFP currently provides report instructions and templates for many of its required reports. Navigant recommends reviewing these report instructions and templates to ensure they provide comprehensive instructions and easy-to-use formats. For example, our high-level review of selected reports found that some reports requiring calculations were in Word templates, which makes it harder to input numbers and analyze data. In addition, some reports only included very high-level instructions, and lacked specific details on what should be included in particular fields. We also recommend providing training to MCOs on the updated reporting requirements, to ensure that, when completed by MCOs, the reports will provide the required information.

- **Develop standard operating procedures for reviewing reports.** Standard operating procedures can help ensure that DHCFP staff reviewing reports do so in a consistent manner. The standard operating procedures would provide a set of designated steps, specific to each report, to confirm that the reports are not only complete, but also to identify potential performance issues to escalate. DHCFP staff do not currently use standard operating procedures to guide their review of MCO reports.

- **Implement P4P programs.** The Nevada MCO contract beginning July 1, 2017 allows for (but does not require) a P4P program. Navigant recommends implementing this program as another step to increase the accountability of MCOs. We also suggest exploring increasing the amount of the P4P withhold from 1.25 percent to create a more meaningful consequence, while staying within bounds of what is actuarially permitted. Based on Navigant's review of nine states with MCO quality withhold programs, seven states had a quality withhold of 1.5 percent or greater.[42] The current P4P measures do not cover behavioral health, and we therefore suggest adding a behavioral health measure to assess performance, as stakeholder feedback suggests that behavioral health services have been an area of concern, particularly with the expansion of the

[41] Based on Navigant review of Managed Care Organization RFP, Attachment T, released July 1, 2016.
[42] Based on most recent data publicly available, Illinois, Indiana, Kansas, Minnesota, New Mexico, Oregon and Tennessee had withholds of at least 1.5 percent in at least one contract year. Michigan and Washington had withholds of 1 percent.

Medicaid program to low-income adults. DHCFP may also consider including a P4P measure related to improvements in member satisfaction ratings.

The P4P program can also be used to align incentives among DHCFP, MCOs and providers and generate forums for collaboration and shared goals, as a number of stakeholders expressed that relationships between MCOs and some providers are not very collaborative.

In addition to recommendations related to state oversight of the MCO program, we also recommend that DHCFP:

- **Increase communications and transparency regarding the Medicaid FFS and MCO programs.** Some stakeholders reported that they were unsure if they were part of the FFS or MCO programs. DHCFP may consider modifying existing communications with recipients to provide clear information about what program they are in, as well as what services are available to them under that program, and requiring MCOs to do so as well.

  There is also an opportunity to make more information available through the DHCFP website, such as information about MCOs' value-added programs and more frequent data about MCO performance. Providing more information about these accomplishments can provide an additional perspective on the MCO program of which many stakeholders are unaware. For example, the Florida Agency for Health Care Administration provides the following snapshot of value-added benefits available through its MCOs (but not the Medicaid FFS program) in its overview of its managed care program:[43]

Figure 3. Florida's MCO Value-Added Benefits

List of Expanded Benefits	Amerigroup	Better	Coventry	Humana	Molina	Prestige	SF CCN	Simply	Staywell	Sunshine	United
Adult dental services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult vision services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y			Y	Y				Y	Y	
Equine therapy									Y		
Home health care for non-pregnant adults	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Medically related lodging & food		Y		Y	Y	Y		Y	Y	Y	
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

[43] Florida Agency for Health Care Administration. (December 2015). *A Snapshot of the Florida Statewide Medicaid Managed Care Program*. Retrieved from: https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf.

List of Expanded Benefits	Amerigroup	Better	Coventry	Humana	Molina	Prestige	SF CCN	Simply	Staywell	Sunshine	United
Nutritional counseling	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Pet therapy				Y	Y				Y		
Physician home visits	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Post-discharge meals	Y	Y	Y	Y	Y			Y	Y	Y	Y
Prenatal/Perinatal visits	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Primary care visits for non-pregnant adults	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Waived co-payments	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Physical, Occupational, & Speech Therapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

- **Increase data collection and monitoring among FFS populations.** There is currently limited data readily available to understand recipient satisfaction, quality of care and outcomes for the FFS populations. In contrast to MCO programs, Medicaid FFS programs are generally not federally required to monitor performance data. However, to be equipped with data to support decision-making, we recommend increasing quality data analysis for the FFS populations, either through State employees or through a contracted vendor. Collecting data for the FFS populations will also provide DHCFP with a performance baseline, if FFS populations are moved into MCOs in the future and will allow DHCFP to proactively identify areas of strength and weakness among the FFS population. For example, DHCFP may begin by collecting a small number of HEDIS measures for the entire FFS population, combined with additional measures to evaluate care for special populations.[44]

FFS Measurement in Colorado

Colorado uses its external quality review organization to calculate HEDIS rates for its FFS population, using nearly all of the same measures as reported by MCOs. The vendor also trends FFS performance year over year.

Source: Health Services Advisory Group. (December 2014.) *Colorado Medicaid HEDIS 2014 Results Statewide Aggregate Report.*

Phase 2: Improve Medicaid Access

It is well recognized that there are network adequacy challenges across Nevada, in both the FFS and MCO programs. Nevada ranks 47 out of 50 states in terms of active physicians per

[44] Center for Health Care Strategies. (October 2010). *Performance Measurement in Fee-For-Service Medicaid: Emerging Best Practices*. Retrieved from: http://www.chcs.org/media/CA_FFS_Performance_Measures_Final_102610.pdf.

100,000 population.[45] Some Nevada providers do not participate in the Medicaid program; for example, a study found that approximately 75 percent of Nevada physicians accept Medicaid.[46] Further, some Nevada Medicaid providers do not accept new Medicaid patients or do not participate in MCO networks, either because they do not wish to or because the MCO chooses not to contract with them. Reasons cited for providers not participating in Nevada Medicaid and Medicaid MCOs include low reimbursement rates, lengthy and resource-intensive provider credentialing processes, burdensome prior authorization procedures and no-shows and lack of compliance among Medicaid recipients. Stakeholders provided these reasons through public comments and focus group meetings; Navigant did not conduct an audit of this information.

DHCFP can pursue several strategies to encourage providers to participate in the Medicaid FFS and MCO programs, thereby increasing access and choice for Medicaid recipients.

Administrative Simplification

First, DHCFP should consider implementing strategies to simplify administrative responsibilities for Medicaid providers such as:

- **Design and implement a centralized credentialing process.** DHCFP could contract with an organization to perform credentialing for both the FFS and MCO programs and provider enrollment for the FFS program. This type of central process could result in a single application to become a Medicaid provider, regardless of whether the provider wishes to participate in the FFS program, one MCO or all MCOs. Benefits of this approach include the ability to save time, increase efficiency, eliminate duplication of data and reduce the time period for providers to receive credentialing decisions. Arizona and Georgia are examples of states that have centralized credentialing vendors.[47] [48]

- **Design and implement a prior authorization simplification process.** DHCFP could design a standard prior authorization request process for providers. For example, DHCFP could implement a portal through which providers would submit all prior authorization requests, for the FFS and MCO programs. For providers requesting prior authorization for MCO members, this information would be provided to the appropriate MCO. The MCOs would retain authority for prior authorization review and approval. The prior authorization portal vendor would be accountable for assuring the prior authorization requests are routed correctly.

  Using such a portal would allow for some standardization and create efficiencies for Medicaid recipients, providers and MCOs and the potential to speed up the care delivery

[45] Association of American Medical Colleges. (November 2015). *2015 State Physician Workforce Data Book*. Retrieved from: http://members.aamc.org/eweb/upload/2015StateDataBook%20(revised).pdf.
[46] Sommers, B.D. & Kronick K. (January 5, 2016). Measuring Medicaid Physician Participation Rates and Implications for Policy. *Journal of Health Politics, Policy and Law.*
[47] Arizona Association of Health Plans. (October 2012). *Announcing New Coordinated Credentialing Process to Ease the Credentialing Burden on Arizona Providers*. Retrieved from: https://www.azahcccs.gov/shared/downloads/news/credentialingalliance.pdf.
[48] Georgia Department of Community Health. *Centralized CVO*. Retrieved from: https://dch.georgia.gov/centralized-cvo.

process.[49] This system would also allow for additional reporting to increase DHCFP's oversight of the prior authorization process (e.g., prior authorization response times, percent approvals and denials, etc.). In addition, several states have developed standard prior authorization forms that Medicaid providers are required or encouraged to use, and/or MCOs are required to accept.[50]

As a MCO contracting strategy to support access to providers and choice of providers, DHCFP may consider including an "any willing provider" clause in its MCO contracts. "Any willing provider" clauses would require MCOs to allow providers to become network providers if they meet certain conditions. These clauses are often grounded in state law, and can be limited to certain types of providers or be applied broadly. Approximately 27 states have "any willing provider" statutes.[51] It should be noted that while these clauses are sometimes perceived as a protection to providers or recipients, these laws could interfere with MCO efforts to develop provider networks that deliver greater efficiency and higher quality, and insurers argue that these laws limit their contracting flexibility and increase costs.[52]

Increasing Provider Capacity in Hawaii

Hawaii's Section 1115 demonstration waiver states that Hawaii's MCO contracts may contain financial incentives for expanded HCBS capacity beyond annual thresholds established by the State. Contracts may also contain sanctions penalizing MCOs that fail to expand community capacity at an appropriate pace. Hawaii MCOs must share a portion of any incentives with providers to ensure that provider capacity is maintained and improved.

Source: CMS Special Terms and Conditions. (October 26, 2015.) *QUEST Integration Medicaid Section 1115 Demonstration.*

Reimbursement Rates

DHCFP may consider conducting a Medicaid reimbursement rate study to evaluate the sufficiency of current rates across provider types. Based on the results of the rate study, DHCFP could recommend rate changes to the Legislature. Low provider reimbursement was a common theme across listening sessions and focus groups among multiple provider types. Increasing reimbursement rates may increase provider participation in the program, which could help with access issues.

[49] American Medical Association. *Prior Authorization and Utilization Management Reform Principles. Retrieved from: https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf.*
[50] Ohio, Texas and New Hampshire
[51] National Conference of State Legislators. *Any Willing or Authorized Providers*. Retrieved from: http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx.
[52] The Urban Institute. (May 2014). *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*. Retrieved from: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413135-Narrow-Provider-Networks-in-New-Health-Plans.PDF.

Telemedicine

In addition to examining reimbursement rates and administrative policies, telemedicine is another strategy to increase access to providers and specialists. In particular, nationally, telemedicine for mental health assessment and treatment has been found to be effective and to increase access to care.[53]

DHCFP and its contracted vendors can employ strategies to educate providers about this option and provide technical assistance and training to promote telemedicine's use. For example, the State of New Mexico has leveraged its MCO contracts to require MCOs to:

- Identify, develop and implement training for telemedicine practices
- Participate in the needs assessment of the organizational, developmental and programmatic requirements of telemedicine programs
- Participate in Project ECHO, in collaboration with the University of New Mexico; Project ECHO employs videoconferencing to conduct virtual clinics with community providers, which allows primary care doctors, nurses and other clinicians to expand their capacity to provide specialty care to patients in their own communities[54]

New Mexico Project ECHO Results

After implementation of Project ECHO at the University of New Mexico, wait times for rheumatology appointments declined from six months to one month. Project ECHO also trained PCPs on how to treat hepatitis C, and found that patients had outcomes comparable to those of patients treated by specialists.

Source: Agency for Healthcare Research and Quality. (July 2013). *Improving Access to Specialty Care for Medicaid Patients.*

Phase 3: Enhance Provider Capabilities

During the listening sessions and focus groups, a number of participants expressed that more Medicaid provider payments should be tied to value and quality, and not simply the amount of services provided. This principle is consistent with CMS' goal to tie 50 percent of traditional FFS Medicare payments to quality or value through alternative payment models by the end of 2018.

Patient-Centered Medical Homes

Stakeholders also expressed the desire for using evidence-based models, such as PCMHs to deliver more integrated care to Medicaid recipients. A PCMH is an enhanced model of primary care in which care teams, led by a PCP, respond to the needs of patients and provide whole-person, comprehensive, coordinated and patient-centered care. PCMHs typically receive per member per month payments, ranging from $2 to $10 dollars. States may also employ value-based payments in which practices that meet performance criteria can share in any savings that they generate.[55]

PCMHs are becoming more common among Medicaid programs; 29 states reported having PCMH programs in state fiscal year 2015, 11 states reported having adopted or expanded PCMHs in state fiscal year 2016 and 13 states indicated plans to do so in state fiscal year

[53] Hilty, D. M. & Ferrer, D.C. (June 2013). The Effectiveness of Telemental Health: A 2013 Review. *Telemedicine Journal and E-Health*. 9(6): 4 44-454.
[54] State of New Mexico Human Services Department. *Medicaid Managed Care Agreement.*
[55] Takach, M. (2011). Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results. *Health Affairs.* 30, no.7:1325-1334.

2017.[56] A study of four state-sponsored PCMH initiatives found that each initiative reported improvement in one or more cost metrics. In North Carolina, a state auditor report found that Community Care of North Carolina resulted in reductions in emergency department visits, inpatient admissions and readmissions.[57] PCMH clinics in California reduced emergency department visits by 70 visits per 1,000 members per year and also increased office visits relative to non-PCMH clinics.[58]

Navigant recommends that DHCFP use its vendor contracts to provide support to primary care practices to develop PCMH capabilities and provide enhanced payments to those practices that develop PCMH capabilities and achieve quality metrics. To receive PCMH per member per month payments, provider groups should be certified and enrolled in Medicaid as PCMHs based on recognition by an accrediting entity such as the National Committee for Quality Assurance (NCQA) or by achieving other DHCFP requirements. Recognizing the varied level of readiness among primary care practices in Nevada, practices should not be required to become PCMHs, but instead should be incentivized to do so through these payments. It is important to note that, while PCMHs are a good option for Nevada, significant funding is needed to support PCMH development, and the benefits of PCMH programs often take several years to materialize.

Table 10 below describes advantages and disadvantages associated with a PCMH model.

Table 10. PCMH Model Advantages and Disadvantages

Key Advantages	Key Disadvantages
• Teams of healthcare providers can address the whole scope of recipients' needs and provide an enhanced level of care coordination • PCMHs can contract with other payers and provide enhanced care coordination services to other populations, therefore impacting care delivery for populations beyond Medicaid • Potential to increase use of early intervention and preventive services, while reducing avoidable emergency department visits and inpatient admissions • Allows for value-based payment components • Can help increase the sophistication and readiness of providers for other alternative delivery systems and payments in the future	• There are currently limited PCMHs in Nevada • Many providers may not have resources or infrastructure to become PCMHs, which take significant amounts of time to develop • Typically requires states to appropriate new funding to pay for increased payments to providers and offer practice support; states have used federal State Innovation Model (SIM) funding to develop and implement PCMH programs, however there are currently no additional SIM funding opportunities[59] • Adds administrative responsibilities for DHCFP (e.g., recognizing PCMHs, developing systems for PCMH payments (PMPM and incentive-

[56] Kaiser Family Foundation and Health Management Associates. (October 2016). *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*. Retrieved from: http://files.kff.org/attachment/Report-Implementing-Coverage-and-Payment-Initiatives.

[57] Patient-Centered Primary Care Collaborative. (February 2016). *The Patient-Centered Medical Home's Impact on Cost and Quality. Annual Review of the Evidence 2014-2015*. Retrieved from: https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf.

[58] Chu, L, & Tu, M. (2016). The Impact of Patient-Centered Medical Homes on Safety Net Clinics. *American Journal of Managed Care.* Retrieved from: http://www.ajmc.com/journals/issue/2016/2016-vol22-n8/ the-impact-of-patient-centered-medical-homes-on-safety-net-clinics.

[59] State Health Access Data Assistance Center. (August 2015). *State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level: Final Report*. Retrieved from: https://www.macpac.gov/wp-content/uploads/2015/08/State-Medicaid-Reforms-Aimed-at-Changing-Care-Delivery-at-the-Provider-Level.pdf.

Key Advantages	Key Disadvantages
	based payments), monitoring quality measures, etc.) • Limited additional budget predictability as a stand-alone strategy

We recommend that DHCFP focus on development of PCMHs rather than ACOs, as PCMHs require less infrastructure development than ACOs and could serve as a building block for ACOs in the future. Although practices require resources to develop into PCMHs, DHCFP can use its vendor contracts to provide support to practices wishing to provide advanced primary care. For example, states have used the following vendor requirements regarding medical home development and support.

Table 11. Vendor Requirements for Medical Home Development and Support

State and Program	Requirement
Connecticut Administrative Services Organization Program	Contractor provides a statewide team of Regional Network Managers to: • Identify and recruit potential practices • Evaluate readiness to apply for PCMH • Work in collaboration with the practice to fulfill PCMH application requirements • Provide data and analytics support to providers and guide primary care practices towards improved patient outcomes[60]
Oregon Coordinated Care Organization Program	• Contractor shall provide support for moving providers along the spectrum of the Patient Centered Primary Care Home (PCPCH) model (from Tier 1 to Tier 3) • Contractor shall assist providers within its delivery system to establish PCPCHs • Contractor shall promote and assist other providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible[61]
Pennsylvania HealthChoices Program	MCOs are expected to participate in the following as part of the Enhanced Medical Home model: • Embed care managers in high volume practices • Work with high volume practices to achieve NCQA Medical Home recognition • Participate with regional learning network collaboratives[62]

DHCFP could employ contract language with both managed FFS vendors and MCOs regarding PCMH development and support.

Other Alternative Payment Models

Within the MCO program, DHCFP can use its contracts with MCOs to increase the proportion of Medicaid provider payments that are tied to value and quality, rather than the amount of services provided. A recent study found that, in fiscal year 2016, 12 states had contracts that encouraged or required MCOs to adopt alternative provider payment models. Examples include:

[60] Connecticut Department of Social Services. (December 2015). *The DSS Glide Path to PCMH and MCQA 2014 Standards*. Retrieved from: http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/webinars/DSS_Glide_Path_PCMH_WebinarPresentation12-9-15.pdf.
[61] Oregon Health Authority. *Oregon Health Plan, Health Plan Services Contract*.
[62] Pennsylvania Department of Public Welfare. *HealthChoices Agreement*.

- Arizona has a target of five percent for the share of each MCO's total payments to providers made under alternative payment models; Arizona intends to raise this target to 50 percent by 2018 for acute care payments
- Iowa has a target of 40 percent for the share of an MCO's membership to be covered by a value-based payment arrangement by fiscal year 2018
- Nebraska targets 30 percent of a plan's provider network to be under alternative payment models by year three of its contract, and 50 percent by year five[63]

Although Nevada MCOs report that they currently use performance incentive models with their provider network, DHCFP may consider implementing formal contract requirements to encourage a phased approach to increase the proportion of Medicaid providers receiving payments that are tied to value and quality.

Phase 4: Expand Care and Case Management and Support Services

As described above, there are currently Medicaid recipients across Nevada that have limited access to care and case management, integrated care, education regarding disease management, dedicated PCPs and assistance on where to seek care, among other topics. As states typically do not have enough staff and resources to provide these services themselves, we discuss how Nevada can use both a managed FFS approach and MCOs to expand these types of care and case management and support services to Medicaid recipients. Nevada's HCGP provides some of these services for FFS recipients; however, despite achieving savings, it has had limited success in improving healthcare outcomes. It appears that the HCGP does not have the level of oversight we would recommend of such a program, which may contribute to its limited success in improving healthcare outcomes. We recommend ending the HCGP when the Section 1115(a) demonstration waiver period ends and replacing it with a new managed FFS program.

> It is important to note that strong oversight, technical assistance and collaboration among the State, MCOs/vendors, providers and community organizations is essential to the success of both a managed FFS and an expanded MCO approach. A number of managed care features are currently included in the HCGP and the MCO program design. However, based on stakeholder input, it appears that not all of these components are working as anticipated; activities in Phase 1 through 3 above are aimed to address some of these challenges.

Managed FFS Program

The new managed FFS program could expand the availability of care and case management and support services among FFS populations, including those served through the HCGP. It is important for the FFS populations to have access to care and case management services, and that those individuals receiving care management services through the HCGP should continue to have access to care management services. The new program would serve all Medicaid recipients remaining in the FFS program, regardless of their county of residence. The program would build upon the HCGP and increase the value and reach of the program, as well as

[63] Kaiser Family Foundation and Health Management Associates. (October 2016). *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*. Retrieved from: http://files.kff.org/attachment/Report-Implementing-Coverage-and-Payment-Initiatives/.

prepare the vendor, Medicaid recipients and providers for potential expansion of the MCO program in the future.

We recommend that DHCFP contract with one or more the MCOs participating in the MCO program to serve as the vendor for the managed FFS program. With this approach, DHCFP can:

- Leverage its relationships with current vendor(s)
- Benefit from MCOs' skill set in providing care and case management and integrated care
- Allow MCOs to build experience with Nevada's FFS populations
- Allow new populations to gain familiarity with MCOs and the components of managed care models, without limiting the provider network or imposing additional prior authorization requirements

By using one or more MCOs as the managed FFS vendor, this program would serve as pathway to prepare MCOs to take on full-risk for additional populations and services. Below, we describe elements of the new managed FFS program and contrast those elements with the current functions of the HCGP. The elements of the managed FFS program are designed to build on lessons learned through the HCGP and support other state and county case management services. The new managed FFS program would also impact some of the services provided by Hewlett Packard Enterprise, such as prior authorization of certain services and conducting provider meetings. Therefore, modifications to Hewlett Packard Enterprise's contract would be required.[64]

It is important to note that the managed FFS program will not provide the same level of budget predictability for Nevada as a full-risk MCO program. However, the managed FFS program can help prepare for the successful implementation of an expanded MCO program in the near future that can provide improved budget predictability for the State. Further, an expanded MCO program that is implemented before the necessary groundwork is laid (e.g., adequate MCO monitoring and oversight infrastructure, sufficient provider access for complex populations) will experience challenges with sustainability.

[64] Changes may also be required to Nevada's Medicaid Management Information Systems modernization. This is currently under review with DHCFP.

Table 12. Comparison of Existing HCGP to Proposed Managed FFS Program

	HCGP	Proposed Managed FFS Program
Geographic Area	Statewide	Statewide
Eligible Recipients	High cost/high need individuals in Medicaid and Nevada Check Up who are not enrolled in an MCO that have specific chronic conditions, mental health conditions or high utilization; certain groups excluded (discussed below)	All Medicaid and Nevada Check Up recipients who are not enrolled in an MCO
HCBS Waiver Recipients	Excluded	Included; with assigned roles and responsibilities for vendor and waiver case manager and incentives for collaboration between vendor and waiver case manager
Recipients Receiving Targeted Case Management	Excluded	Included; with assigned roles and responsibilities for vendor and targeted case manager and incentives for collaboration between vendor and targeted case manager
Children Receiving Foster Care or Adoption Assistance	Excluded	Included; with assigned roles and responsibilities for vendor and case manager and incentives for collaboration between vendor and case manager
Full Benefit Dual Eligibles	Excluded	Included
Care and Case Management Services	• Develop a care plan using a multi-disciplinary care planning team • Include medication monitoring in approach to care plan monitoring and reassessment • Provide reminders to enrollees • Establish and implement a disease management program targeted to the chronic population • Provide health coaching to facilitate enrollee behavioral changes to address underlying health risks such as obesity or weight management • Establish programs specific to certain groups (e.g., mental health program, oncology management program) • Coordinate hospital discharge planning and provide care transition services • Establish and implement programs that redirect inappropriate use from hospital emergency departments	• Cover similar services to the HCGP, with more specific contract requirements around: – Timeframes for conducting assessments, developing care plans and contacting recipients – Face-to-face vs. telephonic interventions – Care plan development to consider long-term care services and social determinants (e.g., housing, employment, childcare) • Expand medication monitoring into a medication therapy management program

	HCGP	Proposed Managed FFS Program
	(EDs) for enrollees accessing EDs for non-emergent care that can be addressed in a primary care setting	
Other Recipient Services	• Establish a usual source of primary care for all enrollees and assist enrollees in selecting a PCP (vendor does not assign PCPs) • Provide referral and scheduling assistance for enrollees needing specialty healthcare or transportation services • Provide health education, health promotion and patient education for all enrollees (e.g., appropriate use of healthcare services, tobacco cessation, self-care) • Provide nurse call services 24 hours/ 7 days a week • Maintain directory of community resources available to assist enrollees • Have an enrollee services department to respond to enrollee inquiries	• Cover similar services to the HCGP, with more specific contract requirements around: – Assignment of PCPs – Timeframes for establishing a PCP relationship after recipient enters program • Provide general population health management services for all recipients, including reminders, EPSDT services confirmation, health education, wellness initiatives, etc. • Conduct quality improvement projects and initiatives focused on improving quality of care and access to care, in collaboration with DHCFP and providers
Provider Support Services	• Provide feedback to enrollee's PCP and/or other treating providers regarding enrollee's adherence to care plan • Routinely provide and collect pertinent clinical information to and from enrollee's PCP • Monitor and provide reminders to enrollee's PCP and/or other treating provider(s) • Educate providers on use of evidence-based practice guidelines • Identify provider performance that suggests patterns of potential inappropriate utilization	• Cover similar services to the HCGP • Provide case managers or other staff to work with providers and hospitals, to serve as a resource for providers to assist with transformation of service delivery and help recipients transfer to lower levels of care as appropriate • Work with PCP practices to offer expanded hours • Offer education about available telemedicine resources, how to bill for telemedicine, what technology is needed to use telemedicine, etc. • Conduct provider workshops, trainings and technical assistance on clinical topics, including introducing evidence-based and emergency best practices and delivering a person-centered approach to care (current Hewlett Packard Enterprise service; however managed FFS program would expand this function) • Develop and manage a P4P program for providers – Recruit providers – Provide evidence-based practices and coding guidelines – Report P4P performance

	HCGP	Proposed Managed FFS Program
		– Perform outreach to under-participating P4P providers
Administrative Services Provided	• Conduct a grievance, appeal and state fair hearing process	• Cover similar services to the HCGP • Prior authorization of certain FFS program services (current Hewlett Packard Enterprise service); authorization of HCBS waiver services would not be affected • Assist DHCFP in FFS network adequacy analysis and Medicaid provider network development (including network development for long-term services and supports services and in frontier/rural areas) • Conduct semi-annual community meetings to gather stakeholder input
Relationship with State Divisions and County Agencies	No specific requirements for coordination with other State divisions or county agencies	• HCBS waivers and targeted case management recipients retain current case managers, however DHCFP offers incentives for: – Vendor to provide State Division/county agency case managers with data on highest-risk recipients and proposed medical interventions – State Divisions/county agencies to act upon that data to improve their clients' medical outcomes • Refer clients to waiver case management and targeted case management when they may meet eligibility criteria • Opportunity to participate with vendor in shared savings/incentive programs associated with improvements in quality and lower costs
Payment Approach	• Per member per month payment • P4P bonus based on savings and quality scores	• Per member per month payment, with a withhold tied to savings and quality; the quality component of the withhold should be based, in part, on metrics tied to care and case management and integrated care
Data Approach	• Measure quality performance related to FFS populations with specific conditions, care transitions, utilization, well care visits, satisfaction, etc.	• Measure FFS program performance with respect to access, quality and cost for all FFS recipients and include stratification for special populations • Measure performance of PCMH providers, with respect to access, quality and cost

	HCGP	Proposed Managed FFS Program
Program Authority	Section 1115(a) demonstration waiver; expires June 30, 2018	1915(b) waiver or State Plan Amendment

MCO Expansion Timing

After the implementation of the managed FFS program, Navigant recommends operating the MCO program and managed FFS program concurrently for at least two years, while closely monitoring and enforcing contract and performance requirements and evaluating results and trends in both programs. This timeframe is recommended due to the time it takes to obtain performance measure results; for example, audited HEDIS results for CY 2017 are generally not available until summer 2018 because of the time necessary for claims runout and audit activities. If DHCFP sees improvement in performance, access and availability of appropriate providers and satisfaction among recipients and providers, at that time it may consider re-evaluating whether to begin planning to expand MCOs' roles, by transitioning additional populations from the managed FFS program to the full-risk MCO program.

Connecticut Administrative Services Organization

In 2012, Connecticut moved away from MCOs and used an administrative services organization that provides member support services (e.g., care coordination, intensive care management, call center), utilization management, provider support services (e.g., network development, PCMH transformation, call center) and data analytics, among other services.

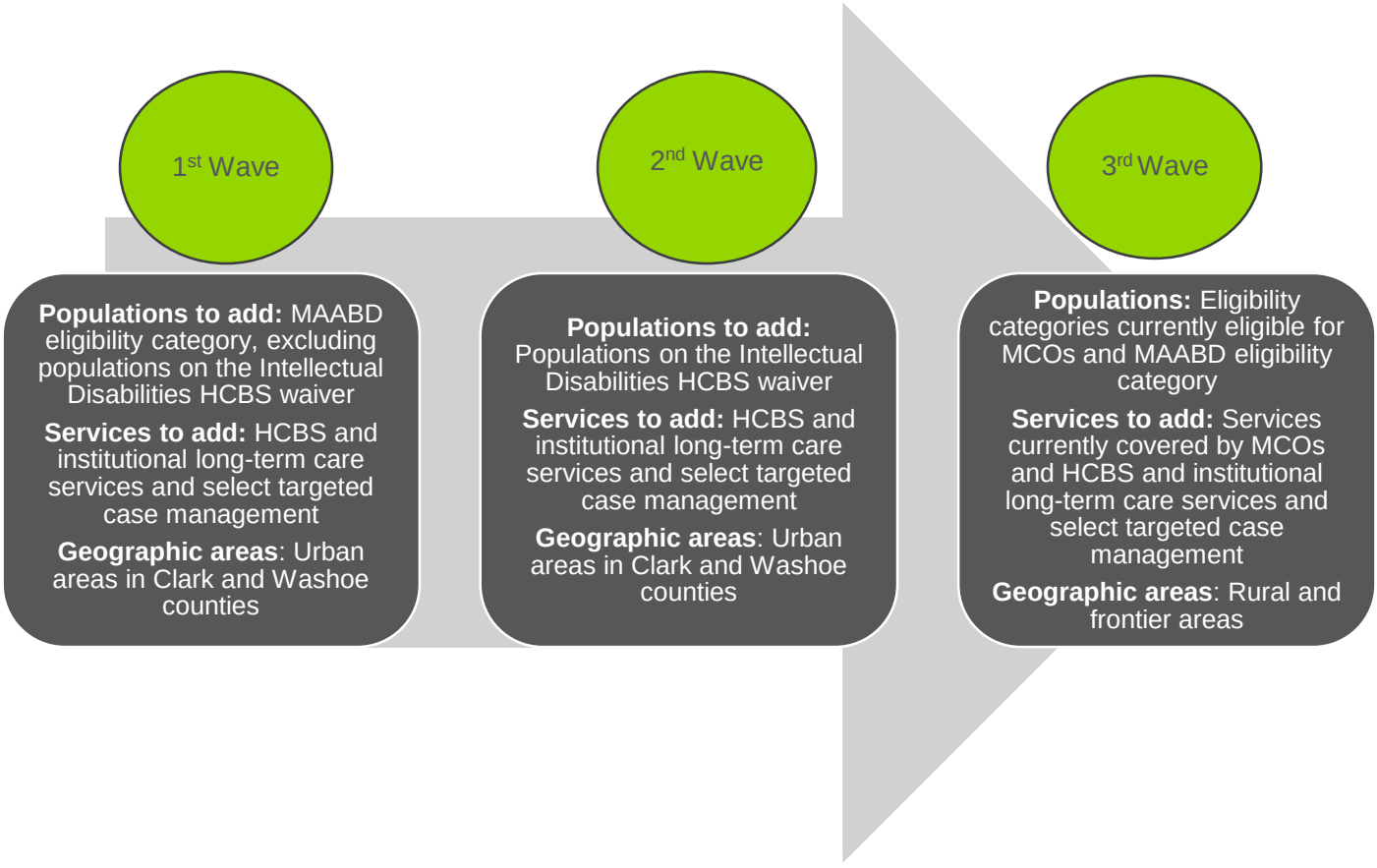
Since implementing the administrative services organization model, the number of PCPs enrolled in Medicaid has increased by 15 percent, non-emergent medical visits have decreased by 14 percent and the average cost per patient per month has decreased from $718 in 2012 to $670 in 2015.

Sources: Beck, Melinda. Wall Street Journal. (March 18, 2016). *Connecticut Moves Away from Private Insurers to Administer Medicaid Program*; Connecticut Department of Social Services. (October 2014). *A Precis of the Connecticut Medicaid Program.*

It is unknown at this time whether DHCFP would be required to undergo a new procurement if it decides to expand the scope of services that are included in the current MCO contracts, or how many MCOs would serve the new populations. If a re-procurement is necessary, DHCFP could select a mix of for-profit, non-profit, traditional MCOs or provider-sponsored MCOs to participate in the expanded full-risk MCO program. We do not recommend expanding full-risk MCOs to additional populations and geographic areas until DHCFP sees trending improvements in these areas. If data supports moving forward with MCO expansion, DHCFP could award priority scoring to MCOs that participate in the managed FFS program. This would provide MCOs incentive to perform care and case management and quality improvement activities, both under the managed FFS program and under the current full-risk MCO program.

Figure 4 below presents a sample strategy for expansion of populations and services into the MCO program, if DHCFP sees sustained improvement in the above areas. We recommend that the first wave of MCO expansion only begin once it is determined that the system is ready for MCO expansion. We would recommend at least one year between each of these MCO program expansions, to allow for sufficient lead times for design, readiness assessment and testing, stakeholder education and incorporation of modifications based on experience.

Figure 4. Example Progression of MCO Expansion



By beginning MCO expansion with seniors and people with physical disabilities in the urban areas of Clark and Washoe counties, there is more opportunity for MCOs to contract with providers in the largest population centers to meet network adequacy requirements. Additionally, MCOs generally have more experience delivering services to seniors and people with physical disabilities as compared to individuals with intellectual or developmental disabilities. Although we recommend that DHCFP add populations on the Intellectual Disabilities HCBS waiver to the MCO program in the second wave, there are some Medicaid recipients with intellectual disabilities who are not on the Intellectual Disabilities HCBS waiver, and these individuals would be included in the first wave of MCO expansion. In the MCO expansion progression scenario in Figure 4 above, payment for services received by the Frail Elderly and Physical Disabilities HCBS waiver populations would continue to be on a FFS basis until the first wave, and payment for services received by the Intellectual Disabilities waiver population would continue to be on a FFS basis until the second wave. DHCFP can work with MCOs and stakeholders to adjust the approach and build up staff capacity and collaboration processes before enrolling additional populations and expanding to new geographic areas. Education and outreach to any population newly included in the MCO program will be essential, as managed care is unfamiliar to many FFS recipients, particularly those with disabilities who have limited direct exposure to managed care.

A phased approach to MCO expansion can help to alleviate cash flow issues that states can experience when contracting with a MCO as part of a Medicaid delivery model. MCOs are typically paid *prior* to the delivery of services (i.e., "prepaid"). At the same time, a Medicaid agency is still responsible for paying FFS claims that have occurred in the past (i.e., the FFS "tail"), a situation which can create short-term cash flow issues for around the time of implementation.[65] By phasing in new populations over time, it can help to lessen the cash flow impact. Appendix I provides an analysis from Milliman that contains more information about the cash flow implications of an MCO expansion.

Mandatory and Voluntary Enrollment Recommendations

If, based on sustained improvements in performance, access and satisfaction, Nevada elects to move forward with MCO expansion to the additional populations in Figure 4 above, we recommend DHCFP use a mandatory enrollment approach. Mandatory enrollment can help ensure the MCOs will have enough enrollees to make their preparations for serving this population financially viable. Additionally, mandatory enrollment reduces the potential for MCOs to select Medicaid recipients with better health, leaving sicker recipients to be served by the FFS system, and would allow DHCFP to develop capitation rates that better support the expected cost of the program.[66]

Phase-In Approaches

States have used various approaches to phasing in managed long-term care.

- Florida introduced managed long-term care across the state over an eight month period
- Illinois added long-term services to its managed care program over the course of one year
- New York expanded managed long-term care to half of the state's 33 most populous counties over the course of two years and the remaining half over the subsequent year
- Through the CHOICES program, Tennessee brought managed long-term services into the existing MCO program, first in Middle Tennessee in March 2010 and then in East and West Tennessee in August 2010. In 2016, individuals with intellectual and developmental disabilities began enrollment into MCOs

Source: Mathematica Policy Research. (March 2016). *Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States*.

If expanding MCOs to cover the additional populations in Figure 4, we also recommend DHCFP consider moving towards mandatory enrollment for adults with serious mental illness and children with severe emotional disturbance. As noted previously, MCO enrollment is currently optional for these populations, however these groups have the potential to receive more integrated and coordinated care,

[65] In March 2015, the Nevada Assembly introduced *Assembly Bill 310*, which would have covered Medicaid recipients who are aged, blind or disabled and who reside in Clark and Washoe counties through a Medicaid managed care program. In response to this bill, DHCFP worked with its actuary to determine the cash flow implications of bringing in this new population into the MCO program on July 1, 2015. In an executive agency fiscal note, DHCFP summarized that this change to the MCO program would create a negative cash flow for DHCFP in the first year of the biennium and would require additional funds in SFY 2016 with a small savings in SFY 2017 and thereafter. Counties would also experience a cash flow issue, but on a smaller scale.

[66] Mathematica Policy Research. (March 2016). *Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States*. Retrieved from: https://www.mathematica-mpr.com/-/media/publications/pdfs/health/2016/mltss-wp44.pdf.

again, if DHCFP sees improvement among MCOs in performance, access and availability of appropriate providers and satisfaction among recipients and providers over the next several years. From a DHCFP monitoring perspective, it is essential that the managed care oversight team include individuals knowledgeable about the needs of people with mental illness and substance abuse issues to effectively monitor the quality and adequacy of the services provided by MCOs.

We also suggest that the following groups remain voluntary (i.e., have choice of either the FFS program of the MCO program), as federal regulations place limitations on enrolling these groups into MCOs on a mandatory basis. Although states can seek waivers to require mandatory enrollment for these groups, we do not recommend requiring enrollment of these populations into MCOs in the short-term because of the more stringent process to receive federal approval and because there is little interest across the State and stakeholders to make these populations mandatory.

- Native Americans
- Children under 19 years of age who are eligible for SSI under Title XVI
- Children eligible under section 1902(e)(3)of the Act
- Children in foster care or other out-of-home placement
- Children receiving foster care or adoption assistance

While more states are moving to mandatory managed care for children receiving foster care, including separate MCOs for this population (e.g., Georgia, Tennessee, Texas), these states typically have larger foster care populations compared to that in Nevada.[67] Since July 2016, children receiving foster care have had the option to enroll in a MCO if they live in the urban areas of Clark and Washoe counties, however, no one has requested to enroll in a managed care program, suggesting that there is not much support for mandatory managed care for children receiving foster care at this time. Appendix E provides stakeholder comments regarding Medicaid services and managed care for children receiving foster care, while Appendix G provides a discussion of states that have implemented separate MCO programs for children receiving foster care.

MCO Covered Services Considerations

Carving out certain services from MCOs can create fragmentation in service delivery. Therefore, we suggest that, if expanding MCOs to additional populations, the MCOs continue to cover physical health, behavioral health and pharmacy services, in addition to expanding their services to also include HCBS and institutional long-term care services and targeted case management, as illustrated in Figure 4 above. As previously mentioned, DHCFP began a stand-alone contract with a statewide NET vendor in July 2016 and will implement a stand-alone contract with a dental vendor beginning in July 2017. We recommend that DHCFP closely monitor the outcomes of these contracts and recipient and provider satisfaction with their services before determining whether NET and dental services should remain outside of the MCO contract.

[67] Boston University School of Social Work. *The 50 State Chartbook on Foster Care*. Retrieved from: http://www.bu.edu/ssw/research/usfostercare/.

Appendices J, K and L provide a discussion of advantages and disadvantages associated with carving in additional populations into the MCO program, carving in services that are currently excluded from the MCO benefit package and expanding the MCO program statewide.

Managed Care for Seniors and People with Disabilities

New Mexico: Coordinated Long Term Supports and Services and Centennial Care

In 2008, New Mexico launched the Coordinated Long Term Supports and Services (CoLTS), program, which provided acute, primary and specialty care, as well as long-term services and supports to older adults, individuals with disabilities and dual eligibles not using long-term services. In January 2014, to streamline its managed care programs, the State consolidated the CoLTs program; Salud! - the managed care program for children, pregnant women and low-income adults; and Salud! Behavioral Health - the managed behavioral health program into Centennial Care. Under Centennial Care, physical health, behavioral health, long-term care and community benefit services are provided by four MCOs.

Through Centennial Care, the State removed the requirement to have a waiver slot in order to access the community benefit; the community benefit includes adult day health, respite care and personal care services. The percentage of individuals meeting a nursing facility level of care and living in the community has increased from 80 percent in 2009 to 87 percent in 2015.

Sources: New Mexico Human Services Department. (April 1, 2016). *Centennial Care Waiver Demonstration.*

Tennessee: TennCare CHOICES

In 2010, Tennessee integrated HCBS and nursing facility services for the elderly and adults with physical disabilities into the three existing MCOs through TennCare CHOICES. This program has demonstrated:

- Increase in the share of long-term services and supports population using HCBS from 17 percent before program implementation to 30 percent after the first year
- A 37-day reduction in average nursing facility length of stay
- 129 nursing facility-to-community transitions in 2009 compared to 740 in 2012

Beginning in July 2016, certain individuals with I/DD could also enroll in two of the three TennCare MCOs through the Employment and Community First program. This program has a tiered benefit structure based on the needs of individuals enrolled in each group, which is designed to provide more cost-effective services to serve more people over time. Benefits include:

- Employment services and supports (e.g., employment discovery, benefits counseling)
- Individual services and supports (e.g., independent living skills training, community integration support services, community transportation)
- Family caregiver supports (e.g., family caregiver stipend, respite, family caregiver education and training)

The Tennessee Department of Intellectual and Developmental Disabilities continues to have a role in person-centered planning training, intake, quality assurance and critical incident management.

Sources: Department of Intellectual and Developmental Disabilities. *Renewal and Redesign of Tennessee's LTSS Delivery System for Individuals with Intellectual and Developmental Disabilities*; Tennessee Division of Health Care Finance and Administration. *Employment and Community First CHOICES*.

Modifications to Relationships with State Divisions and Counties

State divisions and counties are currently responsible for delivering case management services to Medicaid recipients. CMS will not pay for duplicate care or case management services provided through multiple systems. For example, if an MCO provides primary care and behavioral health case management services to an individual, CMS would not pay for that individual to also receive primary care and behavioral health case management services through another entity.

Therefore, when introducing vendors that provide care and case management services to additional Medicaid populations, whether provided by a full-risk MCO or other vendor, it is important to consider how beneficiaries receive their care and case management services so as not to provide duplicative services.

Under the proposed managed FFS program, we recommend a collaborative approach between the vendor and the State and county employees providing targeted case management or waiver case management services, as described in Table 12 above. The State and county employees providing these services would still retain primary responsibility for these services, but could receive additional support and data from the vendor to facilitate more timely and targeted interventions with Medicaid recipients.

If Nevada elects to expand the MCO program to include HCBS waiver populations and select targeted case management services, it will need to decide how MCOs will deliver care and case management to those individuals, so as not to duplicate case management services already provided by State and county employees. If MCOs are responsible for providing waiver case management and targeted case management services, Table 13 below summarizes three care/case management models generally employed by MCOs, all of which would be disruptive to current State and county case managers, and may result in some job losses or reassignments.[68] In practice, when states move HCBS waiver populations to MCOs, the MCOs hire many case managers previously working for the State or other local entities.[69]

Table 13. MCO Care/Case Management Models

Model	Model Description	Implications for Current System
In-house model	• MCO hires its own staff to conduct care and case management • Staff can include nurses, social workers, behavioral health specialists, pharmacy consultants and others • MCOs can still be required to collaborate and coordinate with State and local entities	• State/county case managers would no longer be responsible for providing most case management functions to MCO enrollees (there can be exceptions if MCOs do not have responsibility for certain case management functions) • State/county could provide training to case managers and reassign them to take on other responsibilities required by

[68] A legislative fiscal note found that including HCBS waiver services in MCOs would require ADSD to lay off 216 employees. These employees include administrative staff, social workers, developmental specialists, and other employees with ADSD's HCBS program, Desert Regional Center, and Sierra Regional Center.
[69] AARP Public Policy Institute. (July 2015). *Care Coordination in Managed Long-Term Services and Supports*. Retrieved from: http://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf.

Model	Model Description	Implications for Current System
		the new MCO model (as discussed below) • MCOs could hire state/county case managers
Shared functions model	• MCO executes subcontracts with entities for some care and case management functions • MCO retains other care and case management functions	• State/county case managers could continue to provide some case management services, with the MCO as the lead • Would need to develop clear roles for the MCO vs. the State/county case managers so as not to duplicate services • MCOs rather than DHCFP would pay state/county case managers
Delegated model	• MCO delegates the entire care management function to an entity(ies) • MCO retains monitoring and compliance functions	• State/county case managers could continue to provide primary case management services for certain populations • MCOs rather than DHCFP would pay state/county case managers

Because MCOs would assume responsibility for the care and case management functions in each of these care/case management models, some of Nevada's CPE programs would be heavily impacted. Section 7: Recommended Improvements to Nevada's Medicaid Delivery Model, provides more details on how expansion of the MCO program would impact revenue associated with some CPE programs.

Additional Roles for State/County Employees

Under a MCO model that includes managed long-term services and supports, states are required to provide certain functions. These functions require new job positions, which could be fulfilled by State and county employees. State and county employees previously responsible for case management services could shift their responsibilities to cover these new functions to provide:

- An access point for complaints and concerns about MCO enrollment, access to covered services and other related matters
- Education on enrollees' grievance and appeal rights within the MCO; the State fair hearing process; enrollee rights and responsibilities; and additional resources outside of the MCO
- Assistance in navigating the grievance and appeal process within the MCO, as well as appealing adverse benefit determinations by the MCO to a State fair hearing
- Review and oversight of long-term services and supports program data to provide guidance to DHCFP on identification, remediation and resolution of systemic issues[70]

[70] Beneficiary Support System, 42 C.F.R. 438.71(d) (2016).

Other roles commonly performed by State and local entities include level of care assessments, referrals and ombudsman program management and operations. These types of activities can typically receive a 50 percent Medicaid administrative match.

Supplemental Payment and Certified Public Expenditure Programs

As discussed previously, Nevada has a number of supplemental payment programs that are key in generating revenue for providers (i.e., hospitals, nursing facilities, select practitioners employed by the University of Nevada School of Medicine). These programs, however, are at risk under a Medicaid managed care expansion to new populations and new geographic areas.

In the past, when states have moved from FFS to managed care, they have often sought to continue supplemental payment programs by requiring MCOs to "pass-through" the supplemental payments from the Medicaid agency to the designated providers. However, with the recent *Medicaid and CHIP Managed Care Final Rule*, and further clarifying policies and proposed regulations, CMS has made it clear that states will not be permitted to add new or increased pass-through payments to their MCO programs.[71]

Nevada's CPE programs may also be affected by a managed care expansion. Under Nevada's CPE programs, State divisions and counties may certify that they expend public funds to support the full cost of providing Medicaid-covered services or program administrative activities. In turn, these expenditures are eligible for federal financial match.[72] Nevada's CPE programs include government units that provide:

- Targeted case management
- Adult day healthcare
- Public and mental health services
- Developmental services
- Emergency transportation services
- Paratransit services

All of the above services are currently carved out of the MCO benefit package. However, if the MCO program were expanded to include these services, *42 CFR §438.6* would not allow Nevada to maintain these CPE programs, which in turn would affect revenue to the State divisions and counties that provide these services.

Impact of MCO Expansion on Supplemental Payment and CPE Programs

The CMS regulations as described above create significant issues for Nevada as the State explores options for expanding Medicaid managed care. Navigant estimated the financial impact

[71] The *Medicaid and CHIP Managed Care Final Rule* provides a 10-year transition period to phase-out pass-through payments for hospitals. The regulations also provide a 5-year transition period to phase out pass-through payments to physicians and nursing facilities. After those transition periods, the pass-through payments will no longer be permitted. CMS clarified the *Final Rule* in a July 2016 Informational Bulletin, stating that adding new or increased pass-through payments beyond what was included as of July 5, 2016, into Medicaid managed care contracts would exacerbate a problematic practice. CMS later issued a final rule in January 2017 that prevents the addition of new or increased pass-through payments beyond those in place on July 5, 2016.

[72] Medicaid and CHIP Payment and Access Commission (MACPAC). *Non-federal financing*. Retrieved from: https://www.macpac.gov/subtopic/non-federal-financing/.

associated with reductions in the scope of the supplemental payment and CPE programs as a result of managed care expansion, assuming three different expansion alternatives as follows:

- **Scenario 1.** MCO geographic area expanded statewide, but no additional eligibility categories or services are added
- **Scenario 2.** MCO populations expanded to enroll all individuals in the MAABD eligibility category and cover all long-term services (institutional and HCBS, including waivers) and select targeted case management, only in Clark and Washoe counties
- **Scenario 3.** MCO geographic area expanded statewide and MCO populations expanded to enroll all individuals in the MAABD eligibility category and cover all long-term services (institutional and HCBS, including waivers) and select targeted case management

We found that under each of these scenarios, there would be a negative multi-million dollar impact to state divisions (ranging from $6.5 million in Scenario 1 to $9.8 million in Scenario 3). There would be a total negative impact to affected providers (e.g., hospitals, nursing facilities, select practitioners employed by the University of Nevada School of Medicine) ranging from $75 million in Scenario 1 to $143 million in Scenario 3. Counties would see a positive impact (ranging from $12 million in Scenario 1 to $17 million in Scenario 3) because the amount of funds they currently supply to DHCFP as intergovernmental transfers (IGTs) for non-federal share would be reduced. These amounts are based on the impact of the supplemental payment loss under *42 CFR §438.6* and do not account for any change in base payments. Appendix M provides more detailed information by supplemental payment program for each of the three scenarios, as well as a description of the methodology to arrive at these estimates.

DHCFP is not the only State division that would experience a loss. Because CMS regulations do not allow Nevada to maintain CPE programs for services that would be covered by the MCOs, the following State and county agencies would experience a negative financial impact because Medicaid services they currently provide would become the responsibility of MCOs:

Table 14. Agencies Impacted by MCO Expansion Scenarios

State/County Agency	Affected Services	Rationale for Negative Financial Impact
Aging and Disability Services Division	Targeted case management for individuals with intellectual disabilities or related conditions	MCOs would provide this service directly under Scenarios 2 and 3
Division of Child and Family Services	Targeted case management for children and adolescents who are Non-Severely Emotionally Disturbed with a mental illness (in urban counties)	MCOs would provide this service directly under Scenarios 2 and 3
Division of Public and Behavioral Health	Targeted case management for: • Children and adolescents who are Non-Severely Emotionally Disturbed with a	MCOs would provide this service directly under Scenarios 2 and 3

State/County Agency	Affected Services	Rationale for Negative Financial Impact
	mental illness (in rural counties) • Adults who are Non-Seriously Mentally Ill with a mental illness	
Washoe County Senior Services	Adult day healthcare services	MCOs would contract for and pay providers for this service directly under Scenarios 2 and 3

The targeted case management programs administered by Clark County Family Services, Clark County Juvenile Justice, Washoe County Juvenile Services and Washoe County Social Services would not be affected by the MCO expansion scenarios, as we do not recommend that the foster care and juvenile justice populations be required to enroll in MCOs.

Options for Replacing or Modifying Supplemental Payment and CPE Programs

There are potential options for replacing the revenues lost through supplemental payment and CPE programs, however. We have identified two primary options:

Option 1: Delivery System Reform Incentive Payment Program

DHCFP could develop a Delivery System Reform Incentive Payment (DSRIP)-like program. These programs pay additional funds to providers to support them in changing how they deliver care to Medicaid recipients. Payments are generally tied to outcome or quality achievements. To date, these programs have been implemented under a Section 1115 demonstration waiver. It is possible that CMS may allow similar outcome- or quality-based programs to be implemented under State Plan Amendment authority in the future, as the *Medicaid and CHIP Managed Care Final Rule* indicates that states may require MCOs to implement value-based purchasing models for provider reimbursement that recognize value or outcomes, and requiring Section 1115 demonstration waivers for all of these models could become onerous. The *Final Rule* also mandates that providers cannot be required to enter into or adhere to an IGT agreement as a condition of participating in such a program.[73]

This option allows states to support value-based purchasing and delivery reform, and provides the flexibility to target the programs to address states' most pressing healthcare needs. This option can also help providers develop the necessary infrastructure to deliver more efficient and higher quality care in the future, which can generate lasting value for states as well.

There are also potential disadvantages associated with this option. To date, CMS-approved DSRIP programs often have significant administrative and reporting requirements both for states and providers, and often require that providers have data systems and reporting capabilities to fulfill federal and state requirements. These programs also require a funding source to pay for the incentive payments. Additionally, since these programs only make payments based on outcome and quality achievements, there are no guarantees that providers

[73] Centers for Medicare and Medicaid Services. (May 6, 2016). *Medicaid and CHIP Managed Care Final Rule*.

will receive the same level of payments as they did under FFS supplemental payment programs. For example, in New York's Delivery System Reform Incentive Payment program, hospitals could apply for funding to integrate primary care and behavioral health services, but the amount of funding they receive is based on how fully they achieve certain milestones and metrics associated with the project, such as reducing potentially preventable emergency room visits for individuals with behavioral health diagnoses.[74]

Option 2: Development of Enhanced Rates

DHCFP could increase FFS payment rates (base rates) for inpatient and outpatient hospital services, nursing facilities, services provided by select practitioners associated with the University of Nevada's School of Medicine and county or state government providers that participate in a CPE program. Combining the supplemental payment program amounts and base rates into an "enhanced rate" would allow providers to receive both types of payments in a single rate, and DHCFP could require that MCOs pay at least these minimum payment rates to providers. This approach could increase reimbursement to the providers because providers would receive the enhanced rate for services provided to all Medicaid recipients. The increased payment rates to county and state government providers could allow counties to provide additional funding through IGTs for other Medicaid services.

A potential disadvantage of this option is that Medicaid could not target the enhanced rates. Provider rates would be based on the payment methodology established in the State Plan and the provider's utilization. In other words, DHCFP could not arbitrarily pay one provider more or less than others, to create a payment equal to what is paid currently. Rather, DHCFP must create a reasonable methodology and follow that for all providers in a class. Given that the incentives in managed care are different from the incentives in FFS Medicaid (e.g., reduced inpatient utilization), there would likely be some shift in overall distribution of dollars across providers in comparison to current payments.

Navigant developed a simple model that estimated the effect of an enhanced rate on inpatient services provided by county-owned hospitals using payment per discharge.[75] We found that, overall, this group of hospitals would be able to maintain or increase the revenues from Medicaid recipients regardless of the MCO expansion scenario. We developed the model using county-owned hospitals because counties could provide IGTs to DHCFP. Because the higher rates would increase the MCO capitated rates paid by DHCFP, IGTs from the counties could provide the non-federal share of the change in MCO capitated rates.

An enhanced rate methodology could be applied to private hospitals if a source of non-federal share of matching funds could be identified. A healthcare related tax for private hospitals is one option to fund the non-federal share of the enhanced rates. With any healthcare related tax there are some potential disadvantages, however. For example, the federal government could

[74] New York State Department of Health. (February 25, 2016). *Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual.* Retrieved from: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-02-25_measure_specific_rpting_manual.pdf.

[75] DHCFP currently reimburses hospitals using a per diem rate with five classifications. Implementation of an enhanced rate would calculate per diem rates based on these classifications at a hospital specific rate.

reduce the limit for hold harmless calculations to less than the six percent of net patient revenue that is currently allowed.[76] Such a reduction could require Nevada to find additional revenue sources to fund the enhanced rates to private hospitals that are incorporated into MCO capitated rates.

The enhanced rate methodology could also be enacted for other provider types (i.e., outpatient hospitals, nursing facilities, physicians, targeted case managers). To do so, DHCFP would need to estimate the amount of non-federal share necessary to implement the rates and determine if a source is available for the non-federal share increase.

As discussed above, DHCFP could require MCOs to adopt a minimum fee schedule for network providers to ensure that MCOs also use the enhanced rate with providers, unless otherwise agreed to with the provider. The enhanced rates would increase the MCO capitated rates that DHCFP would pay the MCOs. The non-federal share of these increases would be covered by the current mix of IGT agreements, provider taxes and other current sources of revenue or a new mix of these sources of revenues. It is important to note that requiring MCOs to adopt a minimum fee schedule limits the flexibility of MCOs to negotiate contracted rates with providers.

Appendix N provides more information about these two options for replacing the revenues lost through supplemental payment and CPE programs.

Approach to Provider Payment Issues

Critical Access Hospitals

If DHCFP were to expand managed care statewide, MCOs would need to contract with CAHs to have a sufficient network of hospitals in rural areas, and CAHs would receive a much greater proportion of payments from MCOs as opposed to payments directly from DHCFP. As discussed previously, most CAHs are located in the rural and frontier areas of the State, areas that are not currently covered by MCO contracts. If DHCFP expands MCO service areas statewide, to ensure that CAHs continue to receive the same rates for hospital services as they do under FFS, DHCFP may contractually require MCOs to pay CAHs using the FFS methodology, unless otherwise agreed to by the CAH and the MCO. This payment would be accomplished by creating a prospective cost based rate for CAHs and requiring MCOs to pay that rate. The MCO would then be responsible for the full payment to CAHs, without any additional wraparound payments from DHCFP to the CAHs. Table 15 includes example MCO contract language from other states regarding CAH payment.

Table 15. Example MCO Contract Language on CAH Payment

State	Contract Language
Hawaii	The health plan shall reimburse CAHs for hospital services and nursing home services at rates calculated prospectively by the DHS using Medicare reasonable cost principles[77]

[76] Hold harmless means that the taxes are not paid directly or indirectly to the entity being taxed. *42 CFR §433.68(f)(3)(i)(A)* allows for the tax to be exempt from the hold harmless qualification if the tax equals less than six percent of the net patient revenue for the entities being taxed.
[77] Hawaii Department of Human Services. *QUEST Integration Managed Care to Cover Medicaid and Other Eligible Individuals. RFP–MQD–2014-005.*

State	Contract Language
Kentucky	The Contractor shall reimburse CAHs at rates that are at least equal to those established by CMS for Medicare reimbursement to a critical access hospital[78]
Oregon	If Contractor has a contractual relationship with a designated Type A, Type B, or Rural CAH, the Contractor and each said hospital shall provide representations and warranties to OHA: (1) That said contract establishes the total reimbursement for the services provided to persons whose medical assistance benefits are administered by the Contractor; and (2) That hospital reimbursed under the terms of said contract is not entitled to any additional reimbursement from OHA for services provided to persons whose medical assistance benefits are administered by Contractor.[79]

Rural Health Clinics

Under a statewide managed care expansion, MCOs would need to contract with RHCs to have sufficient provider networks, and RHCs would receive a much greater proportion of payments from MCOs as opposed to payments directly from DHCFP. The Medicaid State Plan does allow for quarterly or monthly supplemental payments from DHCFP to RHCs to make up the difference between the MCO payments and the payments the RHC would have received under the FFS methodology. However, RHCs currently experience challenges with cash flow and according to the Nevada Rural Hospital Partners, RHCs would not be able to accommodate quarterly reimbursement from DHCFP to make up any difference between the MCO payments and the payments the RHC would have received under the FFS payment methodology.[80] Monthly reconciliation payments, on the other hand, create an administrative burden for DHCFP.

DHCFP has two better alternatives for RHC payment to alleviate RHCs' cash flow concerns. The first is to increase FFS payments to RHCs to the Medicare PPS rate, and require MCOs to pay RHCs at least this amount, unless otherwise agreed to between the MCO and the RHC based on 42 CFR §438.6(c)(iii)(A). Under this approach, RHCs would receive their full payment from the MCOs and would not need to wait until the end of the quarter to receive a supplemental payment from DHCFP.

The second option is to create an alternative payment methodology (APM). CMS acknowledged that RHCs have found supplemental payment programs to "have created many complex issues under Medicaid managed care programs, including reconciliation disputes and complaints regarding the timeliness of supplemental payments."[81] CMS describes the APM as follows:

> "To accomplish this goal, a state could amend its state plan to implement an APM, which is an optional alternative to the PPS requirements, including the supplemental payment requirements described above, as authorized under section 1902(bb)(6) of the Act. In order to use an APM to accomplish this goal, two conditions must be met: (1) the state and FQHC or RHC agree to use the APM; and (2) the APM results in FQHCs or RHCs

[78] Kentucky Department of Medicaid Services. *Medicaid Managed Care Contract.*
[79] Oregon Health Authority. *Oregon Health Plan, Health Plan Services Contract.*
[80] Focus Group with Joan Hall, Nevada Rural Hospital Partners. (October 11, 2016).
[81] Vikki Wachino. (April 26, 2016). *RE: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care*. *SHO #16-006.*

receiving at least their full PPS reimbursement rate from the managed care organization."

The APM would employ the Medicare PPS rate issued annually by Medicare.

Under both options, DHCFP would need to include a requirement in their MCO contracts that MCOs pay contracted RHCs at least the full Medicare PPS rate for covered services and DHCFP would include the full PPS payment rate in calculating the actuarially sound MCO capitation rates.[82] Table 16 includes RHC payment approaches that states have used with their MCOs.

Table 16. Example State Approaches for RHC Payment

State	Approach
Texas	The MCO must pay full encounter rates to FQHCs and RHCs for Medically Necessary Covered Services provided to Medicaid and CHIP Members using the prospective payment methodology described in Sections 1902(bb) and 2107(e)(1) of the Social Security Act. Because the MCO is responsible for the full payment amount in effect on the date of service, HHSC cost settlements (or "wrap payments") will not apply.[83]
Minnesota	The State of Minnesota eliminated the issue related to supplemental payments by carving out payments to RHCs and FQHCs from Medicaid MCO capitated rates. The Medicaid MCOs adjudicate claims and then send them to the Minnesota Department of Human Services for payment.[84]

Section 8: Conclusion and Next Steps

This report is intended to provide the Legislature with recommendations on modifications to Nevada's Medicaid delivery system. Based on the direction the Nevada leadership, DHCFP will need to conduct a planning process to further determine all key design features associated with the recommendations that DHCFP intends to implement. The options the State selects may require up front implementation funding, which is an important element to explore in the planning process. DHCFP should:

- Develop a high-level implementation timeframe
- Convene a team to develop recommendations for detailed program design features
- Convene advisory groups and/or task forces, as needed
- Assess the recommended program design features with stakeholders and modify the design features to incorporate stakeholder feedback
- Identify and develop strategies to mitigate risks
- Develop a detailed implementation plan and timeline, including steps to receive federal approval for the strategy and determine budgetary needs

[82] Vikki Wachino. (April 26, 2016). *RE: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care*. *SHO #16-006.*
[83] Texas Health and Human Services Commission. (2016). *Uniform Managed Care Terms and Conditions. Version 2.17.*
[84] Minnesota Department of Human Services. *Federally Qualified Health Center and Rural Health Clinics.* Retrieved from: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_155131#managed.

Continued use of a deliberate decision making strategy, combined with thorough planning and robust communication with stakeholders, will help DHCFP prepare for and implement modifications to the Nevada Medicaid delivery system to achieve its objectives.

Appendix A: Comparison of Nevada's MCO, FFS and HCGP Program Components

Program Component	MCO Program	FFS Program	HCGP Program[85] [86]
Primary Care Provider	• Each member assigned to PCP • Members with disabilities, chronic conditions or complex conditions can select specialist as PCP	• Except for individuals receiving services from HCGP, recipients generally do not receive assistance in locating or being assigned to a PCP	• Participants receive assistance with selection of a PCP
Member Assessment	• MCOs must arrange for or conduct an assessment of new members identified as potential candidates for case management • Assessment must evaluate physical health, behavioral health, co-morbid conditions and psycho-social, environmental and community support needs	A limited proportion of FFS recipients receive assessments related to: • Pre-Admission Screening and Resident Review and Level of Care assessments • HCBS waiver services • Targeted case management services	• Vendor uses predictive modeling to assess potentially eligible recipients and identify their risk level and presence of qualifying conditions
Care and Case Management Services	• MCOs must offer and provide care and case management services which coordinate and monitor the care for those with specific diagnoses and/or who require high-cost or extensive services • MCOs must develop and implement a care treatment plan, incorporating person centered planning and system of care principles • Person centered care treatment plan should reflect the recipient's primary health condition, any co-morbidity, and psychological and community support needs	• Individuals receiving HCBS waiver services, children receiving foster care and other select groups receive case management services • Generally, FFS recipients do not receive care or case management services, unless they also qualify for targeted case management or HCBS waiver services or are eligible for the HCGP	• Participants receive individualized care and case management services, based on their identified risk level • Vendor offers help obtaining equipment, medications and coordinating transportation

[85] Division of Health Care Financing and Policy. (September 204). *Nevada Health Care Guidance Program.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/IHS/CMO-FAQsSheetFinal-Final.pdf?n=6462.
[86] Division of Health Care Financing and Policy. *Health Care Guidance Program Provider Manual.* Retrieved from: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/IHS/HCGP-ProviderManual.pdf?n=7647.

Program Component	MCO Program	FFS Program	HCGP Program[85] [86]
Provider Network	• MCOs must develop a network that includes an adequate number of PCPs, specialists and hospitals that are appropriately located in geographically and physically accessible locations • Must meet provider ratio and appointment availability standards for select provider types[87] • MCOs may limit the providers their enrolled members may see • Medicaid providers may elect not to contract with Medicaid MCOs	• Any willing and qualified provider is permitted to participate in Medicaid • Recipients can seek care from any Nevada Medicaid provider	• Any willing and qualified provider is permitted to participate in Medicaid • Recipients can seek care from any Nevada Medicaid provider
Evidence-based Clinical Guidelines	• MCOs must implement mechanisms to educate and equip physicians with evidence-based clinical guidelines or best practice approaches	• Generally, no programs to educate physicians about evidence-based clinical guidelines or best practice approaches	• HCGP Provider Portal supplies evidence-based clinical guideline information for providers
Performance Measures	• MCOs are required to annually report on a set of HEDIS measures • Limited data to assess performance for Medicaid sub-populations	• DHCFP does not calculate or monitor quality measures, if the recipient is not participating in another program	• Vendor is required to report on a number of HEDIS measures
Member Satisfaction	• MCOs must annually collect and submit to DHCFP child and adult satisfaction surveys	• No formal programs to assess satisfaction among FFS recipients	• Vendor measures participant (and provider) satisfaction through a third party satisfaction survey
Pay for Performance Program	• Beginning in July 2017, DHCFP's MCO contract will allow a P4P program to provide MCOs financial incentives[88] • The program would withhold 1.25 percent of the MCO's net premium and delivery payments	• No P4P programs with FFS providers	• Vendor may develop and implement P4P programs for PCPs, pending DHCFP approval

[87] New federal regulations effective July 2018 also require states to have additional network adequacy standards for their MCO programs.
[88] State of Nevada Purchasing Division. (July 1, 2016). *Request for Proposal 3260 for Managed Care Organizations.*

Program Component	MCO Program	FFS Program	HCGP Program[85] [86]
	• MCOs can earn back up to 100 percent of their withheld amount based on its performance on six HEDIS performance measures[89] • DHCFP does not employ P4P under the existing MCO contract • MCOs employ P4P programs with some network providers		

[89] The six HEDIS measures are: Children and Adolescents Access to PCPs (12-24 Months); Children and Adolescents Access to PCPs (25 months-6 years); Children and Adolescents Access to PCPs (12-19 years); Childhood Immunization Status – Combo; Comprehensive Diabetes Care – HbA1cTesting; Frequency of Ongoing Prenatal Care (81-100% of visits).

Appendix B: Summary of State, County and Provider Revenue from Supplemental Payment Programs

Supplemental Payment Program	Without MCO Expansion		
	State Agency Revenue	County Revenue	Provider Revenue
Direct Graduate Medical Education	$3,203,652	($12,372,660)	$26,003,995
Inpatient Supplemental Payment for Non-State Governmentally Owned or Operated Hospitals	$7,277,726	($28,106,937)	$59,073,202
Inpatient Supplemental Payment for Private Hospitals[90]	($8,446,425)	$0	$23,954,693
Indigent Accident Fund (IAF) Supplemental Payment	$1,033,333	($25,463,180)	$72,215,486
Outpatient Hospital Supplemental Payments	$2,903,705	($8,785,016)	$16,679,840
Supplemental Payment to Free-Standing Nursing Facilities	$327,040	$0	$59,119,466
Enhanced Rates for Practitioner Services Delivered by the University of Nevada School of Medicine	($957,497)	$0	$2,717,105

The amounts reported above are based on the most recent UPL models available from DHCFP. See Appendix M for more information on the timeframe for each UPL model used.

[90] Private hospitals enter into collaboration agreements with either State government agencies or political sub-divisions of the State of Nevada where the government entity supplies the non-federal share of the collaboration UPL payments. The amount of non-federal share is reported under State Agency Revenue, as a breakdown between State, County and/or City government was not available.

Appendix C: Summary of State, County and Provider Revenue from CPE Programs

Supplemental Payment Program	Without MCO Expansion		
	State Agency Revenue	County Revenue	Provider Revenue
Division of Child and Family Services: Targeted Case Management Services	($31,498,710)	$0	$88,475,140
Division of Public and Behavioral Health- Public & Mental Health Services	($6,459,751	$0	$16,797,590
Aging and Disability Services Division: Developmental Services	($5,336,317)	$0	$16,736,776
Clark County Family Services: Targeted Case Management Services	($4,938,825)	$1,996,114	$14,006,878
Clark County Juvenile Justice: Targeted Case Management Services	($407,124)	$404,103	$1,154,633
Washoe County Juvenile Services: Targeted Case Management Services	($154,089)	$119,915	$437,007
Washoe County Senior Services: Daybreak Adult Services	($100,134)	($90,233)	$283,987
Washoe County Social Services: Targeted Case Management Services	($693,650)	($220,322)	$1,967,242

The amounts reported above are based on the audited cost reports for SFY 2015. The State agency revenue for each row equals the State share amount for SFY 2017 for interim payments. The three State agencies have the State agency revenue adjusted by the federal share of the CPE amount. The county revenue represents the federal funds portion of the CPE amount for the county providers. The CPE amount is the difference between the adjusted cost of services and the interim payment of services provided by the entity. The provider revenue is the total of interim payments made by DHCFP.

Note: There is also a CPE program for fire districts providing emergency transportation services that began in 2016, however because this is a newer CPE program, data was not available to include this CPE program in the analysis. Paratransit services provided by the Regional Transportation Commission were not included in this analysis.

Appendix D: List of Stakeholder Meetings

Meeting	Date
Listening Session – Washoe County	January 5, 2016
Focus Group – Washoe County	January 20, 2016
Listening Session – Clark County	January 20, 2016
Focus Group	January 21, 2016
Listening Session – Clark County	February 1, 2016
Listening Session – Clark County 1	February 2, 2016
Listening Session – Clark County 2	February 2, 2016
Focus Group – Washoe County	February 5, 2016
Focus Group – Washoe County	February 9, 2016
Listening Session – White Pine County	February 17, 2016
Listening Session – Elko 1	February 18, 2016
Internal Listening Session – Elko	February 18, 2016
Internal Listening Session – Elko	February 19, 2016
Listening Session – Humboldt County	February 19, 2016
Focus Group – Carson City	February 25, 2016
Listening Session – Washoe County	March 7, 2016
Listening Session – Lyon County	March 10, 2016
Listening Session – Clark County	March 15, 2016
Focus Group – Clark County	March 16, 2016
Internal Listening Session – Clark County	March 24, 2016
Internal Listening Session – Clark County 1	March 25, 2016
Internal Listening Session – Clark County 2	March 25, 2016
Focus Group - Washoe County	April 6, 2016
Focus Group – Washoe County	May 5, 2016
Focus Group	May 13, 2016
DHCFP Representatives	July 13-15, 2016
DPBH Representative	July 13, 2016
Governor's Office Representative	July 13, 2016
DCFS Representative	July 14, 2016
Nevadans for a Common Good and Easter Seals	September 12, 2016
Nevada State Medical Association	September 12, 2016

Meeting	Date
Listening Session – Las Vegas 1	September 12, 2016
Listening Session – Las Vegas 2	September 13, 2016
Listening Session – Las Vegas 3	September 13, 2016
Listening Session – Reno 1	September 14, 2016
Listening Session – Reno 2	September 14, 2016
Nevada Association of Counties	September 14, 2016
National Alliance on Mental Illness Nevada	September 14, 2016
Nevada Governor's Council on Developmental Disabilities	September 15, 2016
Nevada Medicaid MCOs	September 15, 2016
Nevada Hospital Association	September 15, 2016
Nevadans for the Common Good	October 11, 2016
Nevada Hospital Association/Nevada Rural Hospital Association	October 11, 2016
Children's Mental Health and Foster Care Focus Group	October 14, 2016
Frail Elderly Focus Group	October 24, 2016
Physical Disability Focus Group	October 24, 2016
Nevada Association of Counties	October 26, 2016
The A-Team	November 16, 2016
Town Hall Meeting – Las Vegas 1	January 9, 2017
Town Hall Meeting – Las Vegas 2	January 9, 2017
Town Hall Meeting – Las Vegas 3	January 10, 2017
Town Hall Meeting – Las Vegas 4	January 10, 2017
Town Hall Meeting – Reno 1	January 11, 2017
Town Hall Meeting – Sparks	January 11, 2017
Health Care Guidance Program	January 11, 2017
Town Hall Meeting – Reno 2	January 12, 2017
Town Hall Meeting – Carson City	January 12, 2017

Appendix E: Summary of Stakeholder Comments Regarding Special Populations

Children Receiving Foster Care	• **Access to services.** Children receiving foster care have difficulty accessing services currently, and some providers are unwilling to see this more challenging population. It is important for these children to receive timely access to screening, assessment, medications and therapy. • **Team meetings.** Children receiving foster care require child and family team meetings with various providers, but Nevada Medicaid only allows one provider to bill for this meeting. • **Challenges with transitions.** There are challenges transitioning health information and insurance coverage when children transition out of the foster care system or change placements. • **Coordination with court system.** Children receiving foster care often require coordination with the court system to receive authorization for medical services; there is concern that adding MCOs in the mix would further slowdown the service authorization process. • **Vulnerable population.** This population has history of trauma, behavioral health issues and other severe medical problems. • **Psychotropic medications.** This population is more likely to take multiple psychotropic medications compared to other children on Medicaid. • **Current initiatives.** There are multiple programs in Nevada designed to improve care for children receiving foster care including System of Care grants; these programs are having successes and there is concern that MCOs could interfere with this progress. • **MCO care management.** MCO care management should not replace the comprehensive case management currently provided by trained and licensed social workers and probation officers. • **Targeted case management.** Counties depend on revenue from targeted case management, provided by county employees, to support county programs.
Individuals Receiving Long-term Services and Supports[91]	• **Complex needs.** Individuals receiving long-term services and supports often require care from a wide array of specialists and need specialized equipment. Stakeholders fear that their services will be delayed or denied under a MCO program. There is also concern that MCOs are not familiar with the non-medical services provided through HCBS waivers since managed care is typically a medical model. • **Relationships with providers.** Many vulnerable populations receiving long-term services and supports have long-standing and trusted relationships with their providers. There is concern that they would need to change providers under an MCO program, which could cause disruption and negative impacts to their health and progress. • **Person-centered planning.** Person-centered planning is an essential component of high quality healthcare and has shown the best outcomes for people with disabilities. • **Case management.** Some recipients receiving HCBS waiver services or targeted case management feel that they have unmet needs and that their case managers do not have a full understanding of the available resources. • **Involvement of caregivers.** Family caregivers should be included as part of the care team and should be provided training and support as needed. Caregivers need more assistance navigating the system and accessing resources. • **Accessibility.** Programs need to consider special outreach and accommodations to address communication and physical accessibility barriers, including providing materials in alternate formats.

[91] Includes comments from focus groups specific to the frail elderly, individuals with physical disabilities and individuals with intellectual and developmental disabilities.

	• **Recipient protections.** Individuals receiving long-term services and supports may have limited ability to advocate for themselves, which needs to be carefully considered in any Medicaid delivery model. • **Coordination among State divisions.** Coordination among State divisions can be challenging as multiple State divisions are involved in HCBS waivers, and coordination with the Nevada Division of Welfare and Supportive Services can be confusing to recipients. • **Community integration.** Individuals currently receiving care in their home or community want to continue to do so. The State should help individuals receiving care in institutional settings to move to the community, as appropriate. • **Dual eligibles.** Recipients who are also enrolled in Medicare have difficulty understanding what is covered by Medicaid versus Medicare, and how to access those services. • **Independence.** Recipients want to be more independent, but need more assistance with medical needs. • **Self-directed care.** HCBS waiver recipients want to maintain their option to self-direct their care and use family caregivers as paid providers. • **HCBS waitlists.** There are currently waitlists for each of the State's three HCBS waivers. Stakeholders feel that all HCBS waiver waitlists should be eliminated before any MCO expansion occurs.
Individuals with Behavioral Health Needs	• **Timely access to services.** Waitlists for children with severe emotional disturbance are lengthy and the intensity of services provided is not sufficient. • **Non-licensed providers.** Basic skills training providers, psychosocial rehab providers and Substance Abuse Prevention and Treatment Agency providers have had trouble being included in MCO networks because they are not licensed providers and do not always meet MCO credentialing standards. • **Integration.** Integration of physical and behavioral health is essential and should be a part of all Medicaid programs, including the MCO program. • **Level of services.** Stakeholders feel MCOs may not have sufficient experience with the seriously and chronically mentally ill and homeless populations to provide intensive care management and help them receive care in the right setting. • **Mental health parity.** The State needs to assure that its MCO and FFS programs are compliant with the Mental Health Parity law before expanding the MCO program to additional populations.
Frontier / Rural Area Residents	• **Provider access.** Provider access issues are heightened in the rural and frontier areas of the State. Rural health clinics have difficulty keeping staff. • **Service integration.** It can be more difficult to integrate care in rural areas as there are limited providers of different types and it is harder to connect behavioral health, physical health and dental providers. • **Enhanced service delivery.** Rural areas of the state also need enhanced levels of care coordination and support for providers and recipients, such as those provided through PCMH models. • **Connection with services.** There are challenges connecting recipients with available community resources. • **Transportation.** Transportation challenges are more prominent in rural and frontier areas, with long travel times and a cumbersome process to access transportation

Appendix F: Summary of Stakeholder Comments on Draft Report

DHCFP and Navigant held town hall meetings the week of January 9, 2017 in Las Vegas, Reno and Carson City. During these meetings, Navigant presented a summary of the delivery model recommendations, and meeting attendees had the opportunity to ask questions and provide comments on the draft recommendations. The following table provides a summary of the comments, organized by phase of the recommendation. This summary is focused on new comments that had not been captured elsewhere in this report.

Some individuals and entities felt the phased approach for modifications to Nevada's Medicaid delivery system limits the ability of the State to achieve more budget predictability and for FFS recipients to access enhanced care coordination. Others felt the phased approach may not allow sufficient time for stakeholders to prepare. Individuals also asked how much each of the phases would cost. Navigant did not calculate cost estimates as part of this report, however DHCFP is considering cost estimates through a separate analysis.

Topic	Comment Themes
Phase 1: Build State Capacity	
State oversight	• The *Medicaid and CHIP Managed Care Final Rule* addresses administrative oversight, quality reporting, network adequacy and the State can purse recommendations in these areas without delaying the expansion of the MCO program to additional populations and geographic areas
Communications and transparency	• Communications should conform with recent Medicaid managed care regulations that requires mechanisms for support and education for recipients requiring long-term services and supports
MCO reporting	• More MCO reporting and monitoring is needed for special populations, such as adults with serious mental illness and individuals with autism • Providers should have access to data from MCO reports on topics like performance measures, access and satisfaction
Phase 2: Improve Medicaid Access	
Prior authorization portal	• A portal does not address provider concerns that MCOs have differing prior authorization policies • The portal should have turn-around standards so as not to delay prior authorization decision timeframes • A portal could slow down the prior authorization process and create additional complexities • Only a few entities currently conduct prior authorization for long-term services and having more entities involved could complicate the process
Centralized credentialing vendor	• A centralized credentialing vendor could make the process more efficient • Legal considerations and other challenges in the design and implementation of a centralized credentialing vendor should be considered before moving forward
Medicaid reimbursement rate study	• Providers and stakeholders do not want to wait additional years for a reimbursement rate study to be completed, and want quicker, stronger action to address the current rates and provide for automatic rate increases based on certain criteria
Telemedicine	• Telemedicine alone will not address the shortage of providers in the State • Telemedicine is a challenge in rural areas due to issues such as low payments for the originating site, poor bandwidth and resistance from specialists in using telemedicine

Topic	Comment Themes
Other	• "Any willing provider" clauses create barriers for MCOs to develop efficient and effective networks of providers that deliver high quality care • It is important to differentiate between access to PCPs and specialists, as it is often more difficult to find specialists, particularly within certain geographic areas
Phase 3: Enhance Provider Capabilities	
PCMHs	• Nevada laws could present a barrier for PCMHs and other integrated care strategies • PCMHs are a great idea but it can be hard for providers to achieve certification, particularly due to requirements for having different types of providers participate in the care team; this is particularly difficult in frontier areas • PCMH models should be careful not to prevent individuals from receiving family planning services if those individuals do not want to see a PCP before receiving family planning services • FQHCs in Nevada are nationally recognized PCMHs (NCQA accredited), and the PCMH model of integrated, outcome-based health care delivery is also consistent with the goal of transforming Medicaid delivery from a sick-care, volume-based system to one that is value-based • In addition to PCMHs, ACOs are also important to improving outcomes and controlling costs
Alternative payment models	• There was large support for value-based care and stakeholders want to be involved in discussions of what comprises value and how value will be measured • Adequate provider networks, particularly access to preventive care, are necessary for alternative payment models to work appropriately • Alternative payment models should consider family planning services and ensure family planning providers receive the appropriate payments • It is essential that providers receive additional support tailored to their specific needs to assist them in adopting value-based purchasing arrangements
Other	• The State should pursue pilot delivery system changes with providers that have demonstrated readiness; results from the pilots can inform Medicaid and the provider community so that when there is broader readiness, there will be proven delivery system reforms that can be implemented • FQHCs should be part of any delivery system transformation because they already contract with MCOs, currently serve Medicaid populations and provide integrated care (primary, behavioral and dental care)
Phase 4: Expand Care and Case Management Support Services	
Managed FFS program	• Care management for the FFS population is essential and has benefited chronically ill FFS recipients • It is essential to address social determinants of health to achieve improved quality and health outcomes • A managed FFS program makes sense as an interim step before expanding the MCO program • A new managed FFS program could cause confusion among Medicaid recipients if they are later moved to a full-risk MCO program, and is an unnecessary step • National MCOs have experience serving a broad range of populations in urban, rural and frontier areas as well as serving aged, blind and disabled individuals and providing institutional and home and community-based

Topic	Comment Themes
	services, and are already prepared to provide these same services in Nevada, without an interim managed FFS program
Expanded MCO program	• MCOs should not be limited to national, for-profit entities • The State may experience issues retaining state case managers in the short term if those individuals think they will lose their current jobs in several years with an expanded MCO program • State and county employees are concerned about their jobs and asked about more detailed reports of changes to pay grades and the number of eliminated positions that could result from an expanded MCO program • HCBS waiver waiting lists needs to be addressed before the MCO program is expanded; this is particularly an issue in Clark County • HCBS waiver programs do a good job of providing health coaching, education and support to waiver populations • If the MCOs have improvements serving the current MCO populations, that does not necessarily mean they will perform well with populations with intellectual disabilities • DHCFP should look at HEDIS measures for special populations when deciding how to move forward with MCO expansion • DHCFP should use measures that build on widely accepted, evidence-based measures specific to the populations enrolled in the program; these measures should reflect environmental factors, quality of life, use of self-direction and availability of social supports, among other factors • Actuarially-sound rate setting is necessary to ensure the financial viability of the program • Waivers to receive federal approval of an expanded MCO program should be as inclusive of state Medicaid spending and policy considerations as possible to avoid rework and unintended consequences • Commenters provided alternative MCO expansion scenarios and timeframes, such as: – Managed care should first be expanded for non-aged, blind and disabled recipients throughout the State, then expanded to include managed long-term services and supports in Clark and Washoe counties and then expanded to include managed long-term services and supports in the remaining counties; this could be done in a period of two to four years – Managed care should be expanded to aged, blind and disabled recipients who do not require waiver services in July 2017, followed by the waiver populations in Clark and Washoe counties and later expanding to rural areas; this could be done in a 12 to 18 month timeframe – DHCFP should also use a single MCO for statewide coordination across multiple agencies and stakeholders serving children and youth in foster care, adoption assistance and juvenile justice systems
Other Comments	
Nursing facilities	• The nursing facility provider tax is complicated and DHCFP should reduce the complexity of this tax • DHCFP should implement presumptive eligibility for nursing facilities
Measure performance	• Nevada's systemic barriers such as provider shortages, insufficient and inaccurate beneficiary demographic information, lack of practical data for decision making and the social determinants of health significantly affect efforts to achieve higher HEDIS and other performance measure rates

Topic	Comment Themes
Stakeholder feedback	• Stakeholder feedback addressing: provider issues, reimbursement rates, system navigation, evidence-based models, how health care is accessed, and data performance/monitoring, including stronger, binding contractual provisions, should be thoroughly assessed before undertaking any other action

Appendix G: Description of Other Delivery System Options Considered

Accountable Care Organizations

An accountable care organization (ACO) is a payment and delivery model comprised of a network of doctors and hospitals with shared patient responsibility. ACOs aim to tie provider reimbursements to quality metrics and total cost of care reductions for an assigned population of patients. The structure of an ACO may vary (a hospital with employed physicians, a health system consisting of several hospitals and employed physicians, physician joint ventures or multi-provider networks). However, ACOs have some common elements, such as a focus on primary care and service integration, payment reform and accountability for quality and costs of care for a defined population.[92]

There are seven Medicare Shared Savings Program ACOs that include parts of Nevada in their service area.[93] Some of these ACOs also contract with other payers. Through its MCO contracts, DHCFP encourages its Medicaid MCOs to use ACOs when available and appropriate.

Ten states have launched Medicaid ACO programs. While Medicaid ACOs are relatively new and many states have not yet published results, some states have achieved promising findings. For example:

- All nine of **Minnesota's Integrated Health Partnerships** achieved shared savings, exceeded quality targets and reduced inpatient and emergency department utilization in the program's second year
- **Colorado** estimates its **Accountable Care Collaborative** has avoided a net total of $139 million since the program began in 2011 and members who spent more time in the program used fewer high-cost services than members in the program for less than six months

Sources: Center for Health Care Strategies. (September 2016). *Medicaid Accountable Care Organizations: State Update*; Colorado Department of Health Care Policy and Financing. *Accountable Care Collaborative FY 2015-2016.*

In addition to encouraging its MCOs to contract with ACOs, DHCFP may also develop a Medicaid ACO program, in which DHCFP certifies new or existing ACOs to serve the Medicaid population, using a shared savings arrangement. Under this agreement, ACOs that save money while also meeting quality targets would keep a portion of the savings. Medicaid providers would continue to be paid either by DHCFP or by MCOs (depending on the Medicaid recipient and the service provided). Key advantages and disadvantages associated with this model are shown below.

Key Advantages	Key Disadvantages
• Providers may retain more control • Providers may be most familiar with recipient needs	• May lack provider capacity to develop ACOs • Significant provider start-up costs • May have limited ability to serve populations requiring long-term services and supports • Increased DHCFP administrative responsibilities • Limited evidence regarding outcomes for Medicaid ACOs • Limited additional budget predictability as a stand-alone strategy

[92] The Commonwealth Fund and the National Academy for State Health Policy. (February 2011). *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations.* Retrieved from: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2011/feb/on-the-road-to-better-value/1479_purington_on_the_road_to_better_value_acos_final.pdf.

[93] CMS. (Accessed October 6, 2016). *2015 Medicare Shared Savings Program Organizations*.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a long-standing program for frail elders who need nursing home level of care that allows states to provide comprehensive Medicare and Medicaid medical and social services using an interdisciplinary team approach. States provide services through a PACE organization, which is a not-for-profit private or public entity that operates as an adult day health center. Payment is capitated and includes all preventive and primary care, acute medical care, pharmacy services, medical and assistive devices, mental and behavioral health services and long-term services and supports. Individuals can join PACE programs if they meet certain conditions:

- Age 55 or older
- Live in the service area of a PACE organization
- Eligible for nursing home care
- Be able to live safely in the community[94]

PACE generally targets small populations and so has not been used as a broad-based solution. As of September 2015, there were about 33 states with PACE programs and total enrollment was approximately 33,000.[95] Nevada does not currently have any PACE programs.

In November 2015, President Obama signed the PACE Innovation Act into law, which allows CMS to develop PACE pilot projects that could serve more seniors as well as younger individuals with disabilities that are in need of integrated care and services.[96] In December 2016, CMS released a request for information to inform possible development of a test model under the PACE Innovation Act, however CMS has not yet released information on these pilot projects. Key advantages and disadvantages associated with the PACE model are shown below.

Key Advantages	Key Disadvantages
• Aligns Medicare and Medicaid services • Federal regulations require PACE entities to be not-for-profit, which is attractive to some stakeholders • Some evidence that PACE improves certain aspects of quality, such as pain management and enrollees have a lower mortality rate[97]	• Pending additional guidance from CMS regarding expanded eligibility for PACE programs, there is limited ability to reach a large number of individuals through this model • Some evidence that PACE is associated with higher Medicaid costs; there is mixed evidence regarding the impact of PACE on Medicare costs, with some studies showing lower Medicare costs compared to FFS enrollees and

[94] Centers for Medicare and Medicaid Services. *Program of All-Inclusive Care for the Elderly.* Retrieved from: https://www.medicaid.gov/medicaid/ltss/pace/index.html.
[95] Integrated Care Resources Center. (September 2015). *Program of All Inclusive Care for the Elderly Enrollment by State and by Organization. Retrieved from:* http://www.chcs.org/media/ICRC-PACE-program-enrollment-September-2015.pdf.
[96] National PACE Association. (November 6, 2015). *President Signs PACE Innovation Act into Law.* Retrieved from: http://www.npaonline.org/about-npa/press-releases/president-signs-pace-innovation-act-law.
[97] Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (January 2014). *Evaluating PACE: A Review of the Literature*. Retrieved from: https://aspe.hhs.gov/sites/default/files/pdf/76976/PACELitRev.pdf.

	others showing no significant difference compared to HCBS enrollees[98]

Dual Eligible Special Needs Plans

Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan that serve recipients enrolled in both Medicare and Medicaid. D-SNPs must have a contract with a state in order to operate in the state. D-SNPs are federally required to perform actions to improve coordination of Medicare and Medicaid services for dual eligibles. In addition, states can require D-SNPs to perform additional coordination activities. In 2015, there were 210 D-SNPs across 38 states and the District of Columbia.[99] There are no D-SNPs in Nevada. States can require MCOs that provide long-term services and supports to have a companion D-SNP or to offer D-SNPs directly.

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are a special type of D-SNP, which allow a greater degree of integration of Medicare and Medicaid services. FIDE SNPs must contract with the state to cover Medicaid long-term care services, using a capitated approach. They must also coordinate the delivery of Medicare and Medicaid health and long-term care services. D-SNPs must request CMS review and approval in order to obtain FIDE SNP status. As of January 2015, there were 37 FIDE SNPs operating in seven states.[100]

D-SNP Results

According to a 2013 study from the Medicare Payment Advisory Commission, overall D–SNPs tend to have average to below-average performance on quality measures compared with other Medicare Advantage Special Needs Plans and regular Medicare Advantage plans. However, D–SNPs with close integration with Medicaid performed well on the Medicare Star ratings.

Minnesota's Senior Health Options (MSHO) is one such D-SNP with close integration with Medicaid. MSHO began in 1995 and is a voluntary program, only available to dual eligibles. Findings from the program include:

- Approximately 98 percent of MSHO enrollees have annual primary care visits
- Hospital admissions for community seniors by risk adjusted categories are lower for in MSHO enrolls than for FFS Medicare or other Medicare Advantage members
- MSHO D-SNPs have had average Star ratings of 4.0 Stars
- MSHO is highest rated Medicaid program
- Despite voluntary enrollment, MSHO disenrollment is less than 2 percent

Sources: MedPAC. (March 2013). *Report to Congress: Medicare Payment Policy (Chapter 14)*; Minnesota Department of Human Services. (June 2013). *Minnesota's Alternative Demonstration for Persons with Medicare and Medicaid.*

[98] Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (January 2014). *Evaluating PACE: A Review of the Literature*. Retrieved from: https://aspe.hhs.gov/sites/default/files/pdf/76976/PACELitRev.pdf.
[99] Kaiser Family Foundation. (2015). *Medicare Advantage: Special Needs Plans, by SNP Type*. Retrieved from: http://kff.org/medicare/state-indicator/special-needs-plan-offerings/?currentTimeframe=0.
[100] Integrated Resource Center. (November 2015). *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options*. Retrieved from: http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf.

Key advantages and disadvantages associated with the D-SNPs are shown below.

Key Advantages	Key Disadvantages
• Provides an opportunity for DHCFP to enter into arrangements to better integrate Medicaid and Medicare services without participating in the CMS Financial Alignment Initiative (which is not currently accepting new applications) • D-SNPs are complementary to MCO programs that include long-term services and supports since many of the recipients are also eligible for Medicare • Reduces complexity for recipients as they will no longer require two different ID cards, enrollee handbooks, etc. • Helps to coordinate provider activities and care plans	• Enrollment in D-SNPs is voluntary, although DHCFP can mandate that individuals eligible for Medicare and Medicaid enroll in the Medicaid MCO[101] • D-SNPs must tailor their Medicare Advantage applications, benefit packages and geographic service areas to be consistent with state requirements • Requiring Medicaid MCOs to be D-SNPs could limit the pool of eligible MCOs • Requires additional coordination and approval with other offices at CMS • As Nevada does not currently have any D-SNPs, resources are necessary to develop this product and design approach to coordinate with Medicaid

Stand-Alone Managed Long-term Services and Supports MCO

A number of states have implemented managed care programs, specifically for recipients requiring long-term services and supports. Typically to qualify for enrollment in this type of program, Medicaid recipients must need a nursing facility level of care. In this program, the MCOs would be responsible for providing institutional and HCBS, and could also provide additional services such as medical, behavioral health and pharmacy services.

Florida Managed Long-Term Care Program

Florida introduced its statewide managed long-term care program using a phased-in approach, between August 2013 and March 2014. Florida's program is mandatory for most people needing long-term services and supports and includes HCBS and institutional long-term care services. There are currently six MCOs operating in various regions across the State.

Since the program was implemented, overall, quality levels have remained the same or improved and 75 percent of satisfaction survey respondents indicated that their quality of life has improved and 60 percent reported that their overall health has improved.

Sources: Florida Agency for Health Care Administration. (October 2016). *A Snapshot of the Florida Statewide Medicaid Managed Care Program*; Florida Agency for Health Care Administration. (March 2016). *A Snapshot of the Florida Statewide Medicaid Managed Care Program*.

There has yet to be a comprehensive study of managed long-term services and supports outcomes due to program diversity across states and unreliable encounter data. While short term results like easier budgeting have been achieved for states, most savings and health

[101] Integrated Resource Center. (November 2015). *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options*. Retrieved from: http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf.

outcomes may only be achieved in the long-term, if at all.[102] Additionally, there is not a national measure set for managed long-term services and supports, so it is more difficult to identify national outcomes. CMS has commissioned a national evaluation of Section 1115 waivers that focus on long-term services and supports. The evaluation will attempt to examine:

- System-wide costs for long-term services and supports and whether institutional care costs decline relative to HCBS costs
- Beneficiary access, health services utilization and quality of long-term services and supports
- Program design characteristics[103]

The interim and final evaluations are expected to be complete in 2017 and 2019, respectively.

Key advantages and disadvantages associated with a stand-alone managed long-term services and supports model are shown below.

Key Advantages	Key Disadvantages
• Many of the same advantages of MCO models described previously in this report, such as improved care management and support services and integrated care • Opportunity to select MCOs with specific long-term services and supports expertise	• Many of the same disadvantages of MCO models described previously in this report, such as limited providers and lack of support from provider and advocacy communities • Number of recipients requiring long-term services and supports may not support a separate program

Managed Care Programs for Children Receiving Foster Care and Youth Involved in the Juvenile Justice System

Children receiving foster care have significant physical, dental and behavioral health needs. Nationally, these children are more likely to use behavioral health services and psychotropic medications compared to children in Medicaid overall.[104] In Nevada, children receiving foster care have the option of enrolling in MCOs if they live in an MCO service area, however, no one has requested to enroll in a managed care program.

Youth involved in the juvenile justice system often have significant physical and behavioral health needs, with the majority having at least one mental health condition.[105] In Nevada, if youth involved in the juvenile justice system are in the custody of their parents and live in an MCO service area, they are enrolled in MCOs; however if they are in the custody of the State, they are served through the Medicaid FFS system. Additionally, if Nevada youth are committed to Youth Centers, they are terminated from Medicaid, as federal regulations do not allow for

[102] American Health Care Association. *Future Spending Fears Spur Managed Care for Older Adults: A Risky Business with Challenges and Uncertainties for all Parties*. Retrieved from: https://www.ahcancal.org/facility_operations/medicaid/Documents/MLTSS%20Analysis.pdf.
[103] Mathematica Policy Research. (May 15, 2015). *Medicaid 1115 Demonstration Evaluation Design Plan*. Retrieved from: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf.
[104] Center for Health Care Strategies. (March 2013). *Medicaid and Children in Foster Care*. Retrieved from: http://childwelfaresparc.org/wp-content/uploads/2013/03/medicaid-and-children-in-foster-care.pdf.
[105] National Academy for State Health Policy. (December 2013). *Facilitating Access to Health Care Coverage for Juvenile-Justice Involved Youth*. Retrieved from: http://www.nashp.org/sites/default/files/Facilitating_Access_to_Health_Care_Coverage.pdf.

federal Medicaid matching funds for inmates of public institutions (although law permits states to suspend rather than terminate Medicaid eligibility during this time).[106]

Only a few states have developed separate MCO programs for children receiving foster care and youth involved in the juvenile justice system. Examples include TennCare Select in Tennessee, in which there is a single MCO for children who are in the custody of the State, children receiving SSI benefits, children in an institutional eligibility category, enrollees with intellectual disabilities and enrollees temporarily living out of State.[107] TennCare Select has special requirements such as:

- Provide customer service specific to the needs of Department of Child Services (DCS) family service workers and foster parents through a call center staffed by employees knowledgeable of DCS processes
- Work with Medicaid and DCS around issues of psychotropic medication use, informed consent and physical and behavioral health needs of children
- Meets with DCS to develop and implement strategies to improve care for children in state custody[108]

When children exit state custody, they remain enrolled in TennCare Select for a specified period of time and then are disenrolled. After disenrollment, they are either enrolled in a family member's MCO or are given the opportunity to select another MCO.[109]

In addition, the Georgia Families 360 program is served by a single MCO, which enrolls select youth involved in the juvenile justice system who are in non-secure settings, in addition to children receiving foster care and adoption assistance. Components of the Georgia Families 360 program include:

- Members have a medical and dental home to promote consistency and continuity of care
- Each member has an assigned care coordination team to work closely with Division of Family and Children Services and the

Georgia Families 360 Results

The Georgia Department of Community Health reported the following results from the first year of the program:

- 18 percent reduction in psychotropic medications
- 22 percent reduction in inpatient hospital admissions
- 14 percent reduction in emergency room visits
- 22 percent reduction in psychiatric residential treatment facility admissions
- HEDIS performance measure rates identified some successes and some areas needing improvement

Sources: Georgia Department of Community Health. Monitoring and Oversight Committee presentations. October 7, 2015 and January 20, 2015.

[106] Kaiser Family Foundation. (May 2014). *Health Coverage and care for Youth in the Juvenile Justice System: The Role of Medicaid and CHIP*. Retrieved from: https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8591-health-coverage-and-care-for-youth-in-the-juvenile-justice-system.pdf.
[107] BlueCare Tennessee. *TennCare Select.* Retrieved from: http://bluecare.bcbst.com/Health-Plans/TennCareSelect.html.
[108] Center for Health Care Strategies. (March 2013). *Medicaid and Children in Foster Care*. Retrieved from: http://childwelfaresparc.org/wp-content/uploads/2013/03/medicaid-and-children-in-foster-care.pdf.
[109] Tennessee Department of Finance and Administration. (July 1, 2016). *Statewide Contract with Amendment 4.* Retrieved from: https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf.

Department of Juvenile Justice personnel and affiliated providers
- Care coordination teams and agency staff collaborate to develop care plans and monitor each member's health outcomes
- Providers, foster parents, adoptive parents and other caregivers are involved in ongoing care plans
- 24/7 Intake Line for calls from foster and adoptive parents, caregivers, providers and members
- Medication management program that focuses on appropriate monitoring of psychotropic and ADD/ADHD medication use[110]

As a third example, the Milwaukee County Behavioral Health Division administers a county-based managed care program, Wraparound Milwaukee, for children in the child welfare or juvenile justice systems who have serious behavioral health needs placing them at risk of being placed in a residential treatment program. This program uses both capitation and case rate financing from multiple payers including Medicaid, mental health, child welfare and juvenile justice and has demonstrated reduced lengths of stay in intensive levels of treatment, improved clinical and functional outcomes and lower average per-client monthly costs compared to more costly settings that serve this high-risk, high-need population.[111]

Key advantages and disadvantages associated with a stand-alone managed care program for children receiving foster care and/or youth involved in the juvenile justice system are shown below.

Key Advantages	Key Disadvantages
• Many of the same advantages of MCO models described throughout this report, such as improved care management and support services and integrated care • Opportunity to select MCOs with specific expertise serving these population and familiarity with their unique needs	• Many of the same disadvantages of MCO models described throughout this report, such as limited providers • Number of youth involved in the juvenile justice system and/or children receiving foster care may not support a separate MCO program • Would require additional funding sources to cover services required for this population, but not covered by Medicaid • Little data is available regarding managed care programs for children receiving foster care and youth involved in the juvenile justice system

[110] Georgia Department of Community Health. *Foster Care, Adoption Assistance and Juvenile Justice – Georgia Families 360. Retrieved from:* https://dch.georgia.gov/foster-care-adoption-assistance-juvenile-justice-%E2%80%93-georgia-families-360.
[111] Wraparound Milwaukee. *2014 Year End Report*. Retrieved from: http://wraparoundmke.com/wp-content/uploads/2013/09/2014-Annual-Report.pdf.

Appendix H: Summary Evaluation of Medicaid Program Approaches and Provider-Level Models Ability to Execute Strategies

Objective	Strategy	State-Level Program Approach			Provider-Level Model	
		Unmanaged FFS Program (no vendors)	Managed FFS Program	MCO Program	PCMH Model	ACO Model
Ensure appropriate use of healthcare services	Connect Medicaid recipients with a dedicated PCP	No	Yes	Yes	Yes	Yes
	Provide targeted outreach to frequent emergency department users and other high utilizers	No	Yes	Yes	Yes	Yes
	Provide transition support to beneficiaries when changing care settings	No	Yes	Yes	Yes	Yes
	Provide coaching, education and support for patient self-management	No	Yes	Yes	Yes	Yes
	Help individuals access and use home and community-based services rather than institutional services, if desired	No	Limited	Yes	Limited	Limited
Enhance access to quality care for Medicaid recipients	Create incentives to increase the number of providers participating in Medicaid	No	Limited	Yes	No	No
	Hold providers to higher quality standards	No	No	Yes	Yes	Yes
	Maintain or increase choice of Medicaid providers compared to current state	Yes	Yes	Limited	NA	NA
	Reduce the length of time between scheduling an appointment and seeing a provider	No	Limited	Limited	Limited	Limited
	Evaluate increase in provider reimbursement rates (budget authority issue)	TBD	TBD	TBD	TBD	TBD
	Increase use of telemedicine to support PCPs and connect recipients with services	Limited	Yes	Yes	Limited	Limited
Maintain access to, and viability of, safety net providers	Assist safety net providers in developing financially sustainable models	Limited	Limited	Yes	Limited	Limited
	Support full choice of safety net providers, including community-based providers	Yes	Yes	Limited	NA	NA
	Maintain supplemental payment programs to safety net providers	Yes	Yes	No	Yes	Yes
Streamline provider administrative responsibilities	Streamline provider credentialing process across entities	Yes	Yes	Yes	NA	NA
	Streamline prior authorization process across entities	Yes	Yes	Yes	NA	NA
Help Medicaid recipients to better	Provide more resources to help recipients find providers and services	No	Yes	Yes	Yes	Yes
	Provide more resources to help recipients manage their health conditions	No	Yes	Yes	Yes	Yes

Objective	Strategy	State-Level Program Approach			Provider-Level Model	
		Unmanaged FFS Program (no vendors)	Managed FFS Program	MCO Program	PCMH Model	ACO Model
navigate the healthcare system	Provide enhanced support to recipients when they experience problems with quality, access or level of services provided	No	Yes	Yes	Yes	Yes
Increase use of evidence-based practices	Increase education and technical assistance to providers regarding evidence-based practices	No	Yes	Yes	Yes	Yes
	Require providers to use evidence-based practices as a condition of model participation	No	No	Yes	Yes	Yes
Allow for integrated delivery of services and person-centered planning, particularly for complex populations	Require development of a person-centered plan and regular updates	Limited	Yes	Yes	Yes	Yes
	Use interdisciplinary care teams, including family members	Limited	Yes	Yes	Yes	Yes
	Provide a dedicated case manager for high risk individuals	Limited	Yes	Yes	Yes	Yes
	Integrate physical, behavioral and long-term services	No	Limited	Yes	Limited	Limited
	Provide support for recipients' social needs (e.g., housing, employment)	Limited	Limited	Limited	Limited	Limited
Improve ability to monitor quality for all Medicaid recipients	Allow for resources for statewide data collection, measure calculation and auditing	No	Yes	Yes	No	No
Achieve a sustainable business model for the State	Maintain funding streams to finance the Medicaid program	Yes	Yes	No	NA	NA
	Provide budget predictability to the State	No	No	Yes	No	No
Support operational feasibility from a State administrative and oversight perspective	Ensure State staff monitor the program and enforce accountability of vendors/providers	Limited	Yes	Yes	Limited	Limited
	Allow for phased implementation	NA	Yes	Yes	Yes	Yes
	Allow for modifications to model based on implementation experience	Yes	Yes	Yes	Yes	Yes
	Realign jobs for State employees to improve efficiency[1]	Yes	Yes	Yes	Yes	Yes
Align provider and/or vendor payments with the value generated for the State and Medicaid recipients	Increase the percentage of Medicaid providers that have payments based on quality improvements (incentives)	No	No	Yes	Yes	Yes
	Increase percentage of Medicaid providers whose payments include down-side risk	No	No	Yes	Yes	Yes
	If using vendors, condition a portion of vendor payment on agreed-upon outcomes	NA	Yes	Yes	NA	NA
Overall Score		**1.7**	**2.5**	**2.8**	**2.6**	**2.6**

[1] Jobs may change and additional training may be required; impact on jobs is dependent upon decisions on case management models.

Appendix I: Milliman Managed Care Expansion Budget Analysis

[see following pages]

Managed Care Expansion Budget Analysis

State of Nevada

Division of Health Care Financing and Policy

Prepared for:
Betsy Aiello
Deputy Administrator

Prepared by:
Jennifer L. Gerstorff, FSA, MAAA
Consulting Actuary

Catherine Lewis, FSA, MAAA
Actuary

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101 USA

Tel +1 206 613 8124
Fax +1 206 682 1295

milliman.com

Table of Contents

I. EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) was retained by the State of Nevada Department of Health Care Finance and Policy (DHCFP) to assist in the understanding of Medicaid budget implications related to the expansion of managed care to cohorts of the Medicaid population which are currently covered under the fee-for-service (FFS) delivery system.

We have developed cash flow projections on a monthly basis to assist DHCFP in understanding the estimated total cost of funding managed care premium payments and FFS claims run-out simultaneously during the initial phase of a transition to managed care. We have also summarized the estimated cost-effectiveness related to the migration of several Medicaid FFS populations to a managed care setting.

It is our understanding that this analysis was intended to provide a high level overview of the impact of Medicaid managed care expansion. This analysis may not be appropriate for other purposes. This report is intended to replace the report entitled *Managed Care Expansion Budget Analysis* delivered on December 9, 2016.

The results presented in this report include three managed care expansion scenarios as requested by the state and outlined below. The primary assumptions that vary in expansion scenarios include:

- Region: Currently, managed care is mandatory for Clark and Washoe counties. DHCFP may consider expanding geographic coverage to all counties in the state.
- Populations: Currently, managed care is mandatory for the TANF, Check-Up, and Expansion populations. DHCFP may consider expanding coverage to the aged, blind, or disabled (ABD) population, including those members who receive long-term support services (LTSS) in either an institutional or community setting.
- Benefits: Currently, managed care only covers acute care services. DHCFP may consider expanding managed care-covered services to include LTSS where applicable.

Cash Flow Testing Scenarios – Coverage Options			
Scenario	**Region**	**Populations**	**Benefits**
Baseline (Current)	Clark/Washoe Counties	TANF, Check-Up, Expansion	Acute Care Services
Scenario 1	Statewide	TANF, Check-Up, Expansion	Acute Care Services
Scenario 2	Clark/Washoe Counties	TANF, Check-Up, Expansion, ABD, LTSS	Acute Care, LTSS, Targeted Case Management
Scenario 3	Statewide	TANF, Check-Up, Expansion, ABD, LTSS	Acute Care, LTSS, Targeted Case Management

Results for each scenario were calculated twice: (1) with and (2) without optionally eligible enrollees. The optionally eligible enrollee groups were:

- Child welfare recipients, including foster children and those receiving adoption assistance
- American Indian/Alaskan native (AI/AN)
- Children with special health care needs (CSHCN)
- Children determined severely emotionally disturbed and adults determined seriously mentally ill (SED/SMI)

An implementation timeline has not been prepared by DHCFP at this time, but it may include a roll-out of the expanded managed care coverage over several months. We have assumed an effective transition date of January 1, 2018 for all affected members.

Table 1 illustrates our estimates of the total program savings and the savings to the state general fund (SGF).

Table 1a State of Nevada Department of Health Care Finance and Policy Managed Care Expansion Estimated Program Savings (State & Federal), January 2018 through June 2020							
	Member	FFS	MCO	FFS	Estimated Savings		
Scenario	Months	PMPM	PMPM	Runout	Percent	PMPM	Total ($Ms)
Scenario 1 w Opt	1,465,092	$ 386.98	$ 366.09	$ 10.88	2.6%	$ 10.02	$ 14.7
Scenario 1 wo Opt	1,437,972	379.58	366.70	10.53	0.6%	2.35	3.4
Scenario 2 w Opt	987,052	2,063.23	1,990.06	64.82	0.4%	8.35	8.2
Scenario 2 wo Opt	976,927	2,057.53	1,991.69	64.36	0.1%	1.48	1.4
Scenario 3 w Opt	2,559,403	1,090.11	1,048.61	33.65	0.7%	7.85	20.1
Scenario 3 wo Opt	2,519,608	1,087.72	1,052.65	33.39	0.2%	1.67	4.2

Table 1b State of Nevada Department of Health Care Finance and Policy Managed Care Expansion Estimated Program Savings (State General Fund), January 2018 through June 2020							
	Member	FFS	MCO	FFS	Estimated Savings - SGF		
Scenario	Months	PMPM	PMPM	Runout	Percent	PMPM	Total ($Ms)
Scenario 1 w Opt	1,465,092	$ 65.11	$ 61.45	$ 1.94	2.6%	$ 1.71	$ 2.5
Scenario 1 wo Opt	1,437,972	63.03	61.35	1.85	(0.3%)	(0.18)	(0.3)
Scenario 2 w Opt	987,052	706.66	681.60	22.20	0.4%	2.86	2.8
Scenario 2 wo Opt	976,927	704.70	682.15	22.04	0.1%	0.51	0.5
Scenario 3 w Opt	2,559,403	334.76	322.55	10.51	0.5%	1.71	4.4
Scenario 3 wo Opt	2,519,608	334.32	323.87	10.44	0.0%	0.01	0.0

The FMAP percentages used are 65.75% for TANF and ABD, and 99.03% for Check-Up for all years. For Expansion, the FMAP is assumed to be 94% in CY 2018, 93% in CY 2019 and 90% thereafter.

Note that the MCO premiums for all scenarios include cost and enrollment data for members who choose to enroll on an optional basis based on historical penetration of these populations in managed care. For the budget estimates that indicate they have been projected without optional enrollment, the assumption was that all optional populations would remain fee-for-service, while premiums were estimated to include some proportion of them. Thus, the savings estimate reflects a conservative estimate of managed care migration which could be increased with a retroactive selection factor adjustment to capitation rates reflecting the actual enrolled population morbidity relative to what was expected at the time of rate setting.

Appendices

Detailed budget projections are included for each scenario in the enclosed exhibits. Exhibits 1a through 3b show the monthly cash flows beginning January 1, 2018, when FFS populations are projected to transition to FFS. Only the populations projected to move into managed care are shown in each scenario's exhibit. The following exhibits are included in this report:

- Exhibit 1a: Scenario 1 with optionally eligible enrollees
- Exhibit 1b: Scenario 1 without optionally eligible enrollees
- Exhibit 2a: Scenario 2 with optionally eligible enrollees

- Exhibit 2b: Scenario 2 without optionally eligible enrollees
- Exhibit 3a: Scenario 3 with optionally eligible enrollees
- Exhibit 3b: Scenario 3 without optionally eligible enrollees
- Exhibit 4: Premium development

The following columns are in each of Exhibits 1a through 3b:

- "Managed care premiums:" These are the estimated premiums to be paid under managed care for the members transitioning from FFS to managed care. The methodology for projecting these premiums is discussed later in this report
- "FFS tail run out:" This column represents runout for claims still being paid under FFS, incurred prior to January 1, 2018, for the population which transitioned to managed care.
- "Est FFS cost:" This is the estimated amount paid under FFS had the transition to managed care not occurred on January 1, 2018.
- The cumulative columns show these amounts accumulated starting at January 1, 2018.

II. DATA, METHODOLOGY, AND ASSUMPTIONS

DATA

We received an extract of detailed historical claims and enrollment from DHCFP to conduct our analysis.

Claims completion patterns were analyzed using data incurred between June 1, 2013 and November 30, 2015. We used data paid through May 2016 to calculate completion factors. We filtered the data to be paid through November 30, 2015 to calculate estimated future payments by lag month used in the calculation of FFS runout.

To project managed care organization (MCO) premiums and FFS costs for non-Expansion populations, we used FFS claims data incurred between December 1, 2013 and November 30, 2015, with claims paid through May 31, 2016. For the Expansion population, we used incurred months between December 1, 2014 and November 30, 2015, with claims paid through May 31, 2016.

For membership projections, we used membership data from January 2012 through May 31, 2016.

Claims trends and the Hepatitis C adjustment factor relied on data from the MCOs used in the development of the 2017 managed care rates. The data used for the 2017 rate analysis included claims incurred between April 2014 and March 2016 and paid by the plans through May 2016 (Health Plan of Nevada) or June 2016 (Amerigroup). This data is further described in the September 30, 2016 correspondence titled "Calendar *Year 2017 Managed Medicaid Capitation Rates"* (September 2016 Report).

We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

ASSUMPTIONS

Completion Factors

We developed completion factors to complete claims paid through May 2016. These factors were calculated with data paid through May 31, 2016.

The impacts of completing the claims used in our projections are shown in Table 2. Table 2 does not represent the factors as they were calculated or applied, but rather a summary of the factors.

Completion factors were applied and calculated by month, population (TANF/Check-up, Expansion, ABD), service category (inpatient, outpatient, professional, pharmacy) and age band (1-18, and 19+ for TANF/Check-Up, 1-20, 21-64 and 65+ for ABD, adult-only for Expansion). Newborn claims were completed using the child completion factors. Furthermore, ABD claims were analyzed separately for HCBS and nursing home (NH) claims and members. HCBS includes adults with developmental disabilities and NH includes intermediate care facilities for persons with mental retardation.

Table 2 State of Nevada Department of Health Care Finance and Policy Managed Care Expansion Estimated Completion Impact for Cost Projection	
Aid Category	**Impact**
TANF	0.1%
Check-Up	0.1%
Expansion	0.3%
ABD	0.1%

Claims Tail Factors

We calculated claims tail factors in order to estimate the runout of FFS claims incurred prior to the managed care transition. To calculate these claims lag factors, we limited our data to be paid through November 30, 2015, and used the claims projection method to project the most recent months.

A summary of the factors used to project the claims tail is shown in Table 3. The factors in Table 3 represent the percentage of claims paid at each lag for a given incurred month. Table 3 does not represent the factors as they were calculated or applied, but rather a summary of the factors.

Table 3 State of Nevada Department of Health Care Finance and Policy Managed Care Expansion Distribution of FFS Claim Payments by Paid Lag Month					
Lag Month	**TANF/ Check-Up**	**Expansion**	**Other ABD**	**Nursing Home**	**HCBS**
1	28.1%	36.6%	38.1%	15.3%	0.0%
2	48.8%	49.0%	46.0%	74.5%	0.1%
3	11.4%	8.5%	8.6%	6.0%	58.9%
4	5.8%	2.3%	2.8%	1.8%	39.5%
5	2.9%	1.7%	2.3%	0.9%	1.0%
6	1.5%	0.8%	1.2%	0.3%	0.2%
7	0.7%	0.7%	0.6%	0.5%	0.3%
8	0.2%	0.2%	0.2%	0.3%	0.0%
9	0.1%	0.0%	0.1%	0.1%	0.0%
10	0.1%	0.1%	0.1%	0.1%	0.0%
11	0.0%	0.0%	0.0%	0.0%	0.0%
12	0.0%	0.0%	0.0%	0.0%	0.0%

Like completion factors, claims tail factors were applied and calculated by month, population (TANF/Check-up, Expansion, ABD), service category (inpatient, outpatient, professional, pharmacy) and age band (1-18, and 19+ for TANF/Check-Up, 1-20, 21-64 and 65+ for ABD, adult-only for Expansion). Newborn claims runout was calculated using child claims tail factors. Furthermore, ABD claims were analyzed separately for HCBS and NH claims and members.

Fee schedule and policy changes

Several fee schedule and policy changes have occurred between the experience period and the projection period. These include the following:

- Effective July 1, 2015
  - Increase to acute inpatient hospital per diems
  - Increase of NICU InterQual Level II claims to Level III payment rates
  - Changes made to many CPT and HCPCS codes for specific provider types
- Effective January 1, 2016
  - Increase to transplant reimbursement
  - Changes made to many CPT and HCPCS codes for specific provider types
- Effective March 1, 2016
  - Expansion of fibrosis-level criteria for Hepatitis C drugs
- Effective July 1, 2016
  - Increase to home health reimbursement
  - Changes made to many CPT and HCPCS codes for specific provider types

Each of these changes is described in more detail below. Note that each of the fee schedule adjustments described above was applied only to claims data with dates of service prior to the effective date of the change.

Effective July 1, 2015

DHCFP made changes to their fee schedules for several provider types:

- Acute Inpatient Hospitals, Excluding NICU and Behavioral Health Days
- Physicians
- Advanced Registered Nurse Practitioners (APN)
- Nurse Midwives, and
- Physician Assistants (PA).

For acute inpatient hospitals, per diem rates increased 5%. Therefore, we applied a 5% increase to all paid claims at an acute inpatient facility, for services prior to July 1, 2015. The only exceptions to this increase were for payments for NICU bed days and inpatient behavioral health claims which did not receive a 5% increase.

To evaluate the impact of the rate adjustments for non-hospital providers listed above, we used specialty code to identify qualifying providers and claims. Changes to the fee schedule varied widely by specific CPT/HCPCS code. Therefore, rate changes were applied as a percentage change to the paid amounts in the FFS data, with distinct percentages calculated for each unique combination of HCPCS, modifier, and provider type. For claims missing specialty code, we populated specialty code by assuming these claims would follow the same distribution by provider type as those claims with specialty code populated for the same category of service.

In 2015, DHCFP changed its policy to pay NICU InterQual Level II claims at the Level III payment rate.

Our determination of an appropriate adjustment for this change was developed using experience before and after this rate change. The cost per day for NICU claims increased significantly starting November 2014. Our analysis found that the average cost per NICU day was $1,121 after November 2014, compared to $781 before November 2014. Therefore, a factor of 1.43 was applied to claims prior to November 2014.

Effective January 1, 2016

DHCFP made additional increases to Physician, APN, Nurse Midwife, and PA providers. These were applied in the same way as the July 1, 2015 changes: with distinct percentages calculated for each unique combination of HCPCS, modifier and provider type.

Also effective January 1, 2016, the DHCFP increased rates for liver, kidney, bone marrow, and corneal transplants. Where these procedures are present in the base data prior to the effective date, we have increased the claims dollars on a percentage basis to be consistent with the fee schedule increase.

Effective March 1, 2016

Beginning March 1, 2016, Nevada Medicaid was no longer able to restrict access to Hepatitis C drugs based on fibrosis level. Prior to March 1, 2016, members with fibrosis levels 0, 1 and 2 were only prescribed a Hepatitis C drug if it was deemed medically necessary. Drug prescriptions are still based on medical necessity, but increased access and decreased restrictions are expected to increase utilization of Hepatitis C drugs.

For all Hepatitis C drug claims used in this analysis, we applied a one-time utilization increase of 171% for this policy change. This factor is based on data from the managed care organizations (MCOs), since we have managed care data before and after this transition. This factor is also documented in the January 2017 managed care rate report dated September 30, 2016.

Effective July 1, 2016

The DHCFP has made an additional change to the fee schedule effective July 1, 2016. The proposed rate changes would increase Home Health reimbursement 25%. We have applied this increase to the experience period data.

DHCFP made additional increases to Physician, APN, Nurse Midwife, and PA providers. These were applied in the same way as the July 1, 2015 changes: with distinct percentages calculated for each unique combination of HCPCS, modifier and provider type.

High-Level Exclusions

The following exclusions were made to all claims:

- Members eligible for both Medicare and Medicaid were excluded (“duals”).
- Beginning March 2017, months of retrospective enrollment will not be the responsibility of MCOs. Therefore, we have excluded all months of retrospective enrollment. The exception to this for newborns, for whom we have included up to three months of retrospective enrollment.
- Foster children were excluded from the development of the PMPM cost, since they were assumed to not enroll in managed care.

Delivery System Cost Adjustments

Assumptions for managed care utilization reductions were developed using a variety of sources. Our goal was to project not only achievable discounts, but discounts likely to be accepted by MCOs. Management factors varied based on population. The utilization management factors used in this analysis are net of additional administrative costs required by the MCOs. These factors can be seen in Exhibit 4 as a “net savings %.”

Trends

The trends assumed in this analysis are consistent with those used in the development of the January 2017 managed care rates for TANF, Check-Up and Expansion, discussed in the September 2016 Report. These trends are based on managed care experience from April 2012 through March 2016. Trend rates for the ABD population were selected based

on recent experience in similar programs operating in other state Medicaid programs. Table 4 illustrates the annual medical cost trend assumptions applied in the development of projected PMPM cost by aid group.

Table 4
State of Nevada
Department of Health Care Finance and Policy
Managed Care Expansion
Claims Trend Assumptions

	TANF/Check-up		Expansion		ABD	
Inpatient						
Nursing Home	2.0%	0.5%	1.0%	0.5%	0.5%	1.0%
Other	2.0%	0.5%	1.0%	0.5%	(1.5%)	2.0%
Outpatient						
ER	2.0%	2.0%	1.0%	2.0%	(1.5%)	2.0%
Drug	0.0%	0.0%	0.0%	0.0%	(1.5%)	2.0%
Other	0.0%	2.0%	0.0%	2.0%	(1.5%)	2.0%
Professional						
Waiver Services	0.5%	1.0%	0.0%	1.0%	3.0%	0.8%
Other	0.5%	1.0%	0.0%	1.0%	3.0%	0.8%
Pharmacy (Excl Hep C)	2.0%	10.2%	1.5%	11.5%	1.6%	9.4%
Hepatitis C	2.0%	(3.0%)	1.5%	(3.0%)	1.6%	9.4%

For populations in managed care, the annual trend rate above is assumed to decrease by 1% each year to reflect an increase in management over time.

Membership

Table 5 illustrates the trends applied to enrollment groups to develop membership projections for the forecast period.

Table 5
State of Nevada
Department of Health Care Finance and Policy
Managed Care Expansion
Membership Trend Assumptions

Population	Mandatorily Enrolled	Optional Enrollees
TANF/Check-Up children	2.0%	8.0%
TANF/Check-Up adults	2.0%	2.0%
Expansion	5.0%	2.0%
ABD		
HCBS children	(5.0%)	(5.0%)
HCBS adults	5.0%	5.0%
NH children	1.0%	1.0%
NH adults	4.0%	4.0%
ABD other children	5.0%	5.0%
ABD other adults	6.0%	0.0%

Managed Care Penetration

We assumed that the managed care penetration rate (the percentage of the target population to enroll in managed care) would be consistent with the current experience in Clark and Washoe counties. We did not assume increased managed care enrollment for TANF, Check-up, or Expansion in Clark and Washoe counties because managed care is currently mandatory and appears stable. For non-mandatory rural counties, and ABD populations in Clark and Washoe, we have assumed maximum penetration of the managed care market on occurs on January 1, 2018, per instructions from DHCFP. We reviewed current managed care penetration rates in the mandatory program and selected estimated rates for expansion consistent with the current environment. Table 6 illustrates our assumptions.

The assumed penetration rate for TANF and Check-Up children was based on assumed penetration rates by optional eligibility subcategory, as shown in Table 7. Foster children were assumed to have no enrollment in managed care based on negligible enrollment in managed care in Clark and Washoe counties.

Table 6
State of Nevada
Department of Health Care Finance and Policy
Managed Care Expansion
Penetration Rate Assumption

Population	Mandatorily Enrolled	Optional Enrollees
TANF/Check-Up Children	92.0%	26.0%
TANF/Check-Up Adults	91.0%	40.0%
Expansion	96.0%	40.0%
ABD (Including NH and HCBS)	90.0%	40.0%

Table 7
State of Nevada
Department of Health Care Finance and Policy
Managed Care Expansion
Penetration Rate by Optional Eligibility Subcategory for TANF and Check-Up Children

Eligibility Group	Penetration
AI/AN	50%
SED	10%
CSHCN	50%
SMI	20%
Foster children	0%

State Share Percentage

Savings in Table 1 are shown both in total and for state government funds. The state government funds are calculated as the total funds multiplied by one less the Nevada FMAP. The FMAP percentages used are 65.75% for TANF and ABD, and 99.03% for Check-Up for all years. For Expansion, the FMAP is assumed to be 94% in CY 2018, 93% in CY 2019 and 90% thereafter.

FMAP assumptions are from the federal registrar notice, released November 15, 2016, for TANF, Check-Up, and ABD. The Expansion assumptions are from CMS FAQs released February 2013. Note that Expansion FMAP varies by year until 2020.

Items Not Included

The following considerations were not included in our analyses:

- Beginning January 1, 2016, Applied Behavioral Analysis (ABA) services became covered under FFS. These services are available to individuals under age 21 based on medical necessity. To be considered for this program, a diagnosis of Autism Spectrum Disorder (ASD) must be present.

  We assumed that costs for ABA would be the same under managed care and FFS in the projection period. Therefore we have not adjusted either the MCO premiums or the FFS claims projections for ABA since it would not impact the savings calculation.

- We have assumed no adjustment for Expansion duration or anti-selection. However, we have used a more recent experience period for Expansion to mitigate some of these effects, as noted in the "Data" section of this report.

- We have not included any provision for safety net payments to providers.

- We have not included any load for premium tax or the health insurer provider fee in the MCO premium projections.

- Maternity kick payments and stop-loss payments are assumed to be revenue neutral in the transition from FFS to managed care. In reality, there will be timing differences associated with the transition of these payments from a FFS environment to managed care which would alter the expected budget on a cash basis.

- We have not included an acuity adjustment due to changes in mix. However, we have excluded foster care children in order to reflect our projection that few would enroll in managed care. Other populations, such as developmental disability waivers, and intermediate care facility members, were studied, but we determined that no explicit adjustment was necessary.

METHODOLOGY

In order to estimate savings, we projected the following under each scenario:

- The value of MCO premiums beginning in 2018 for the populations transitioning to managed care. This is referred to as "Managed care premiums."

  - This is not meant to represent proposed rates under these scenarios. A full rate analysis would be necessary to determine the proposed rates.

- The projected FFS cost, beginning in 2018, of the populations transitioning to managed care if they had remained in FFS. This is referred to as "Estimated FFS cost."

- The amounts paid after January 1, 2018, by month, for FFS claims incurred prior to January 1, 2018 for populations transitioning to managed care on January 1, 2018. This is referred to as "FFS runout."

Final savings estimates are calculated with the following equation:

Managed care premiums + FFS runout – Estimated FFS cost = Savings

The components of this equation were calculated by scenario, for the populations transitioning to managed care in that scenario. The remainder of this section describes the assumptions underlying each component of the savings calculation.

Managed Care Premiums

We developed estimated MCO premiums on a PMPM basis using our best estimate of the population distribution for each of scenarios 1, 2, and 3, including the optional populations eligible to enroll under each scenario. To project estimated MCO premiums for non-Expansion populations, we used FFS data incurred between December 1, 2013 and November 30, 2015, with claims paid through May 31, 2016. For the Expansion population, we used incurred months between December 1, 2014 and November 30, 2015, with claims paid through May 31, 2016. The shorter experience period for Expansion was to mitigate the impacts of durational effects which we do not expect to continue into the forecast period.

The trends and adjustments applied to the claims to project 2018 premiums are described above. Adjustments include completion, claims trend, fee schedule changes, and net savings factors. Premiums for 2019 and 2020 contain an additional 12 months of trend relative to the 2018 projections. The trend rate used for 2019 and 2020 premiums is the same annual claims trend assumed in the 2018 projections, less 1% per year to simulate further management over time.

FFS Runout

In addition to paying managed care premiums for members who are newly enrolled in managed care, DHCFP will simultaneously be paying for claims which were incurred under the FFS delivery system prior to managed care implementation. This includes amounts paid after January 1, 2018 for FFS claims incurred prior to January 1, 2018. We projected costs by incurred month, then allocated estimated payments using historical average payment patterns for FFS claims. Claim payment pattern assumptions were developed by population (TANF/Check-up, Expansion, ABD), service category (inpatient, outpatient, professional, pharmacy) and age band (1-18, and 19+ for TANF/Check-Up, 1-20, 21-64 and 65+ for ABD, adult-only for Expansion). Furthermore, we also stratified ABD claims into HCBS and nursing home claims for members using LTSS.

The claims trend and membership assumptions associated with these projections are the same as those listed above in the development of MCO premium projections. However, the claims trend underlying the FFS projections does not decrease by 1% per year, since no management is assumed for these claims.

For scenarios where we have indicated a savings estimate without optional populations, all optional population enrollment and claims cost has been excluded from fee-for-service projections.

Estimated FFS Cost

In order to estimate savings related to the transition to managed care, we projected FFS costs during the forecast period as if service delivery remains FFS. The claims trend and membership assumptions associated with these projections are the same as those listed above in the development of MCO premium projections. However, the claims trend underlying the FFS projections does not decrease by 1% per year, since no management is assumed for these claims. This is an extension of the projections that we did through 2017 for the FFS population, with additional trend. These projections are illustrated on an incurred basis, while all other amounts have been presented on a paid basis. We assumed that aggregate monthly incurred claims amounts are consistent with aggregate monthly paid claims amounts for a stable population.

For scenarios where we have indicated a savings estimate without optional populations, all optional population enrollment and claims cost has been excluded from fee-for-service projections.

III. DATA RELIANCE AND LIMITATIONS

This analysis has relied extensively on data provided by the participating health plans and DHCFP. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

The terms of Milliman's contract with DHCFP amended as of April 12, 2016 apply to this report and its use.

This analysis is intended for the use of the DHCFP. To the extent that the information contained in this report is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for DHCFP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any MCO to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

Actual costs for the program will vary from our projections for many reasons. Differences between the projections and actual experience will depend on the extent to which future experience conforms to the assumptions made in this analysis. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis, with modifications to rates or to the program as necessary.

This analysis has relied extensively on data provided by the participating health plans and DHCFP. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

It should also be noted that we have not made adjustments to assumptions or methodology related to changes in the incoming administrations at the state or federal level. The projections assume the continuation of the existing Nevada Medicaid program. We did not attempt to reflect (or speculate on) changes, either explicit or implicit, that could result from changing administrations.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis in this letter.

Exhibit 1a
Nevada Division of Health Care Financing and Policy
Projected Managed Care Savings for Program Beginning January 1, 2018
Excluding Dual Eligibles and Retrospective Membership
Scenario 1: Statewide Managed Care, No Additional Eligibility Categories or Services
Including Optionally Eligible Enrollees

		Monthly Cash Flow					*Cumulative Cash Flow Analysis*			
Coverage Month	*Program Month*	*Managed Care Premiums*	*FFS Tail Run Out*	*Premium + Run Out*	*Est FFS Cost*	*Net Cash Flow*	*FFS Reserve*	*Prem + RunOut*	*Est FFS Cost*	*Net Cash Flow*
Jan-18	0	$16,796,270	$10,715,931	$27,512,201	$17,144,339	($10,367,862)	$10,715,931	$27,512,201	$17,144,339	($10,367,862)
Feb-18	1	16,847,893	2,633,570	19,481,464	17,255,483	(2,225,980)	13,349,501	46,993,665	34,399,822	(12,593,843)
Mar-18	2	16,899,893	1,178,893	18,078,786	17,367,754	(711,033)	14,528,394	65,072,451	51,767,576	(13,304,875)
Apr-18	3	16,951,893	656,806	17,608,699	17,480,776	(127,923)	15,185,200	82,681,150	69,248,352	(13,432,798)
May-18	4	17,005,485	328,611	17,334,096	17,596,201	262,105	15,513,811	100,015,245	86,844,553	(13,170,692)
Jun-18	5	17,059,077	169,251	17,228,328	17,712,404	484,075	15,683,062	117,243,574	104,556,957	(12,686,617)
Jul-18	6	17,112,670	70,019	17,182,689	17,829,390	646,701	15,753,082	134,426,263	122,386,347	(12,039,916)
Aug-18	7	17,166,262	45,940	17,212,202	17,947,168	734,966	15,799,022	151,638,465	140,333,515	(11,304,950)
Sep-18	8	17,219,854	34,416	17,254,271	18,065,744	811,473	15,833,438	168,892,736	158,399,258	(10,493,477)
Oct-18	9	17,273,446	23,824	17,297,270	18,185,124	887,854	15,857,262	186,190,006	176,584,383	(9,605,623)
Nov-18	10	17,327,039	18,113	17,345,152	18,305,317	960,166	15,875,375	203,535,157	194,889,700	(8,645,457)
Dec-18	11	17,380,631	13,546	17,394,177	18,426,330	1,032,153	15,888,921	220,929,334	213,316,030	(7,613,304)
Jan-19	12	17,840,789	9,396	17,850,185	18,548,168	697,983	15,898,317	238,779,519	231,864,198	(6,915,321)
Feb-19	13	17,896,352	8,995	17,905,348	18,671,530	766,182	15,907,312	256,684,867	250,535,728	(6,149,139)
Mar-19	14	17,952,575	8,462	17,961,036	18,796,440	835,404	15,915,774	274,645,903	269,332,169	(5,313,734)
Apr-19	15	18,008,797	7,980	18,016,777	18,922,210	905,433	15,923,754	292,662,681	288,254,379	(4,408,301)
May-19	16	18,065,019	4,987	18,070,006	19,048,847	978,841	15,928,741	310,732,687	307,303,226	(3,429,461)
Jun-19	17	18,121,531	2,753	18,124,284	19,176,666	1,052,382	15,931,494	328,856,971	326,479,893	(2,377,079)
Jul-19	18	18,178,353	1,720	18,180,073	19,305,683	1,125,610	15,933,214	347,037,044	345,785,575	(1,251,469)
Aug-19	19	18,235,175	1,109	18,236,284	19,435,594	1,199,309	15,934,323	365,273,329	365,221,169	(52,160)
Sep-19	20	18,291,997	754	18,292,751	19,566,407	1,273,656	15,935,077	383,566,080	384,787,576	1,221,497
Oct-19	21	18,348,819	513	18,349,332	19,698,131	1,348,798	15,935,590	401,915,412	404,485,707	2,570,295
Nov-19	22	18,406,305	268	18,406,573	19,831,485	1,424,912	15,935,858	420,321,985	424,317,192	3,995,206
Dec-19	23	18,463,792	0	18,463,792	19,965,770	1,501,979	15,935,858	438,785,777	444,282,962	5,497,185
Jan-20	24	18,769,562	0	18,769,562	20,101,729	1,332,167	15,935,858	457,555,339	464,384,691	6,829,352
Feb-20	25	18,828,548	0	18,828,548	20,238,643	1,410,094	15,935,858	476,383,888	484,623,334	8,239,446
Mar-20	26	18,887,534	0	18,887,534	20,376,519	1,488,985	15,935,858	495,271,422	504,999,853	9,728,431
Apr-20	27	18,946,520	0	18,946,520	20,515,367	1,568,847	15,935,858	514,217,943	525,515,221	11,297,278
May-20	28	19,005,617	0	19,005,617	20,655,312	1,649,695	15,935,858	533,223,560	546,170,532	12,946,973
Jun-20	29	19,064,714	0	19,064,714	20,796,246	1,731,532	15,935,858	552,288,274	566,966,778	14,678,504

Exhibit 1b
Nevada Division of Health Care Financing and Policy
Projected Managed Care Savings for Program Beginning January 1, 2018
Excluding Dual Eligibles and Retrospective Membership
Scenario 1: Statewide Managed Care, No Additional Eligibility Categories or Services
Excluding Optionally Eligible Enrollees

		Monthly Cash Flow					*Cumulative Cash Flow Analysis*			
Coverage Month	*Program Month*	*Managed Care Premiums*	*FFS Tail Run Out*	*Premium + Run Out*	*Est FFS Cost*	*Net Cash Flow*	*FFS Reserve*	*Prem + RunOut*	*Est FFS Cost*	*Net Cash Flow*
Jan-18	0	$16,505,114	$10,223,697	$26,728,810	$16,465,760	($10,263,051)	$10,223,697	$26,728,810	$16,465,760	($10,263,051)
Feb-18	1	16,556,365	2,478,066	19,034,432	16,575,082	(2,459,350)	12,701,763	45,763,242	33,040,841	(12,722,401)
Mar-18	2	16,607,993	1,110,119	17,718,112	16,685,520	(1,032,592)	13,811,882	63,481,354	49,726,361	(13,754,993)
Apr-18	3	16,659,621	617,137	17,276,758	16,796,714	(480,044)	14,429,018	80,758,112	66,523,075	(14,235,037)
May-18	4	16,712,842	309,459	17,022,301	16,910,293	(112,009)	14,738,478	97,780,413	83,433,368	(14,347,046)
Jun-18	5	16,766,062	159,577	16,925,640	17,024,653	99,013	14,898,055	114,706,053	100,458,021	(14,248,032)
Jul-18	6	16,819,283	65,910	16,885,193	17,139,803	254,610	14,963,965	131,591,246	117,597,823	(13,993,422)
Aug-18	7	16,872,504	43,025	16,915,528	17,255,747	340,219	15,006,989	148,506,774	134,853,571	(13,653,203)
Sep-18	8	16,925,724	32,232	16,957,957	17,372,495	414,538	15,039,222	165,464,731	152,226,066	(13,238,665)
Oct-18	9	16,978,945	22,264	17,001,208	17,490,052	488,844	15,061,485	182,465,939	169,716,118	(12,749,821)
Nov-18	10	17,032,165	16,916	17,049,081	17,608,426	559,345	15,078,401	199,515,020	187,324,544	(12,190,476)
Dec-18	11	17,085,386	12,652	17,098,038	17,727,624	629,586	15,091,054	216,613,058	205,052,168	(11,560,890)
Jan-19	12	17,538,490	8,762	17,547,252	17,847,654	300,402	15,099,815	234,160,310	222,899,822	(11,260,488)
Feb-19	13	17,593,675	8,392	17,602,066	17,969,197	367,131	15,108,207	251,762,376	240,869,019	(10,893,357)
Mar-19	14	17,649,518	7,896	17,657,414	18,092,295	434,881	15,116,103	269,419,790	258,961,314	(10,458,476)
Apr-19	15	17,705,362	7,449	17,712,811	18,216,258	503,447	15,123,552	287,132,601	277,177,572	(9,955,029)
May-19	16	17,761,205	4,681	17,765,886	18,341,093	575,207	15,128,233	304,898,488	295,518,665	(9,379,822)
Jun-19	17	17,817,338	2,547	17,819,885	18,467,116	647,231	15,130,780	322,718,373	313,985,781	(8,732,591)
Jul-19	18	17,873,781	1,593	17,875,374	18,594,336	718,962	15,132,373	340,593,747	332,580,118	(8,013,629)
Aug-19	19	17,930,224	1,031	17,931,256	18,722,457	791,201	15,133,404	358,525,002	351,302,574	(7,222,428)
Sep-19	20	17,986,667	698	17,987,365	18,851,485	864,120	15,134,102	376,512,368	370,154,059	(6,358,308)
Oct-19	21	18,043,110	476	18,043,586	18,981,430	937,844	15,134,578	394,555,953	389,135,490	(5,420,464)
Nov-19	22	18,100,218	248	18,100,465	19,112,998	1,012,532	15,134,825	412,656,419	408,248,487	(4,407,932)
Dec-19	23	18,157,325	0	18,157,325	19,245,503	1,088,178	15,134,825	430,813,744	427,493,990	(3,319,753)
Jan-20	24	18,458,862	0	18,458,862	19,379,690	920,828	15,134,825	449,272,605	446,873,680	(2,398,925)
Feb-20	25	18,517,465	0	18,517,465	19,514,838	997,372	15,134,825	467,790,070	466,388,517	(1,401,553)
Mar-20	26	18,576,069	0	18,576,069	19,650,955	1,074,887	15,134,825	486,366,139	486,039,473	(326,666)
Apr-20	27	18,634,672	0	18,634,672	19,788,052	1,153,380	15,134,825	505,000,811	505,827,525	826,713
May-20	28	18,693,387	0	18,693,387	19,926,249	1,232,862	15,134,825	523,694,198	525,753,774	2,059,576
Jun-20	29	18,752,101	0	18,752,101	20,065,443	1,313,342	15,134,825	542,446,299	545,819,217	3,372,918

Exhibit 2a
Nevada Division of Health Care Financing and Policy
Projected Managed Care Savings for Program Beginning January 1, 2018
Excluding Dual Eligibles and Retrospective Membership
Scenario 2: Current Managed Care Counties, With Additional Eligibility Categories and Services
Including Optionally Eligible Enrollees

		Monthly Cash Flow					*Cumulative Cash Flow Analysis*			
Coverage Month	*Program Month*	*Managed Care Premiums*	*FFS Tail Run Out*	*Premium + Run Out*	*Est FFS Cost*	*Net Cash Flow*	*FFS Reserve*	*Prem + RunOut*	*Est FFS Cost*	*Net Cash Flow*
Jan-18	0	$59,722,231	$39,312,929	$99,035,161	$59,755,103	($39,280,058)	$39,312,929	$99,035,161	$59,755,103	($39,280,058)
Feb-18	1	59,975,614	14,108,575	74,084,188	60,265,326	(13,818,862)	53,421,504	173,119,349	120,020,429	(53,098,920)
Mar-18	2	60,228,996	6,115,154	66,344,150	60,779,503	(5,564,647)	59,536,658	239,463,499	180,799,931	(58,663,567)
Apr-18	3	60,484,386	2,137,039	62,621,425	61,299,663	(1,321,762)	61,673,698	302,084,924	242,099,594	(59,985,330)
May-18	4	60,739,776	1,094,591	61,834,367	61,823,868	(10,499)	62,768,289	363,919,291	303,923,462	(59,995,829)
Jun-18	5	60,995,166	534,880	61,530,046	62,352,156	822,110	63,303,169	425,449,337	366,275,618	(59,173,719)
Jul-18	6	61,255,418	219,711	61,475,129	62,889,925	1,414,796	63,522,880	486,924,466	429,165,543	(57,758,923)
Aug-18	7	61,515,671	133,186	61,648,857	63,431,903	1,783,046	63,656,066	548,573,324	492,597,446	(55,975,877)
Sep-18	8	61,775,924	98,749	61,874,673	63,978,130	2,103,457	63,754,815	610,447,997	556,575,576	(53,872,421)
Oct-18	9	62,038,184	65,319	62,103,503	64,530,699	2,427,195	63,820,135	672,551,500	621,106,275	(51,445,226)
Nov-18	10	62,300,444	43,397	62,343,842	65,087,615	2,743,773	63,863,532	734,895,342	686,193,889	(48,701,453)
Dec-18	11	62,562,705	31,089	62,593,794	65,648,918	3,055,124	63,894,621	797,489,136	751,842,807	(45,646,329)
Jan-19	12	65,284,795	20,536	65,305,332	66,217,928	912,597	63,915,157	862,794,467	818,060,735	(44,733,732)
Feb-19	13	65,562,535	16,054	65,578,589	66,792,791	1,214,203	63,931,211	928,373,056	884,853,526	(43,519,530)
Mar-19	14	65,840,274	14,013	65,854,287	67,372,207	1,517,921	63,945,224	994,227,343	952,225,734	(42,001,609)
Apr-19	15	66,120,108	13,003	66,133,111	67,958,336	1,825,226	63,958,227	1,060,360,454	1,020,184,070	(40,176,383)
May-19	16	66,399,942	10,151	66,410,094	68,549,125	2,139,031	63,968,378	1,126,770,547	1,088,733,195	(38,037,352)
Jun-19	17	66,681,872	3,787	66,685,659	69,146,755	2,461,096	63,972,166	1,193,456,206	1,157,879,950	(35,576,256)
Jul-19	18	66,963,801	2,258	66,966,059	69,749,153	2,783,094	63,974,424	1,260,422,265	1,227,629,103	(32,793,162)
Aug-19	19	67,245,730	1,535	67,247,265	70,356,364	3,109,099	63,975,958	1,327,669,529	1,297,985,467	(29,684,063)
Sep-19	20	67,531,113	1,005	67,532,118	70,972,000	3,439,882	63,976,963	1,395,201,648	1,368,957,467	(26,244,181)
Oct-19	21	67,818,117	778	67,818,895	71,594,758	3,775,863	63,977,741	1,463,020,543	1,440,552,225	(22,468,318)
Nov-19	22	68,105,121	589	68,105,710	72,222,521	4,116,812	63,978,329	1,531,126,252	1,512,774,746	(18,351,506)
Dec-19	23	68,394,220	0	68,394,220	72,857,544	4,463,324	63,978,329	1,599,520,472	1,585,632,290	(13,888,182)
Jan-20	24	70,695,020	0	70,695,020	73,497,688	2,802,669	63,978,329	1,670,215,491	1,659,129,978	(11,085,513)
Feb-20	25	70,993,128	0	70,993,128	74,143,004	3,149,876	63,978,329	1,741,208,620	1,733,272,982	(7,935,638)
Mar-20	26	71,300,261	0	71,300,261	74,802,940	3,502,680	63,978,329	1,812,508,880	1,808,075,922	(4,432,958)
Apr-20	27	71,607,393	0	71,607,393	75,468,220	3,860,827	63,978,329	1,884,116,273	1,883,544,142	(572,131)
May-20	28	71,921,446	0	71,921,446	76,145,974	4,224,528	63,978,329	1,956,037,719	1,959,690,117	3,652,397
Jun-20	29	72,235,498	0	72,235,498	76,829,221	4,593,722	63,978,329	2,028,273,218	2,036,519,337	8,246,120

Exhibit 2b
Nevada Division of Health Care Financing and Policy
Projected Managed Care Savings for Program Beginning January 1, 2018
Excluding Dual Eligibles and Retrospective Membership
Scenario 2: Current Managed Care Counties, With Additional Eligibility Categories and Services
Excluding Optionally Eligible Enrollees

		Monthly Cash Flow					*Cumulative Cash Flow Analysis*			
Coverage Month	*Program Month*	*Managed Care Premiums*	*FFS Tail Run Out*	*Premium + Run Out*	*Est FFS Cost*	*Net Cash Flow*	*FFS Reserve*	*Prem + RunOut*	*Est FFS Cost*	*Net Cash Flow*
Jan-18	0	$59,140,350	$38,705,743	$97,846,093	$58,943,119	($38,902,973)	$38,705,743	$97,846,093	$58,943,119	($38,902,973)
Feb-18	1	59,392,429	13,833,125	73,225,554	59,448,735	(13,776,819)	52,538,868	171,071,647	118,391,855	(52,679,792)
Mar-18	2	59,644,509	5,988,694	65,633,203	59,958,282	(5,674,921)	58,527,562	236,704,850	178,350,137	(58,354,713)
Apr-18	3	59,898,596	2,087,616	61,986,212	60,473,789	(1,512,423)	60,615,179	298,691,062	238,823,926	(59,867,136)
May-18	4	60,152,683	1,072,714	61,225,397	60,993,319	(232,078)	61,687,893	359,916,459	299,817,245	(60,099,214)
Jun-18	5	60,406,770	525,181	60,931,951	61,516,908	584,957	62,213,074	420,848,410	361,334,153	(59,514,257)
Jul-18	6	60,665,720	216,011	60,881,731	62,049,941	1,168,210	62,429,085	481,730,142	423,384,094	(58,346,047)
Aug-18	7	60,924,670	130,861	61,055,531	62,587,160	1,531,629	62,559,947	542,785,673	485,971,254	(56,814,419)
Sep-18	8	61,183,620	97,165	61,280,785	63,128,604	1,847,819	62,657,112	604,066,458	549,099,859	(54,966,600)
Oct-18	9	61,444,577	64,304	61,508,881	63,676,367	2,167,486	62,721,416	665,575,339	612,776,225	(52,799,114)
Nov-18	10	61,705,535	42,676	61,748,211	64,228,453	2,480,242	62,764,092	727,323,550	677,004,679	(50,318,872)
Dec-18	11	61,966,492	30,607	61,997,099	64,784,904	2,787,805	62,794,699	789,320,649	741,789,582	(47,531,067)
Jan-19	12	64,663,994	20,238	64,684,232	65,349,036	664,804	62,814,937	854,004,881	807,138,619	(46,866,263)
Feb-19	13	64,940,374	15,840	64,956,214	65,918,985	962,770	62,830,777	918,961,096	873,057,603	(45,903,492)
Mar-19	14	65,216,754	13,821	65,230,574	66,493,462	1,262,887	62,844,598	984,191,670	939,551,065	(44,640,605)
Apr-19	15	65,495,228	12,834	65,508,063	67,074,628	1,566,565	62,857,432	1,049,699,732	1,006,625,693	(43,074,040)
May-19	16	65,773,703	10,013	65,783,716	67,660,429	1,876,713	62,867,445	1,115,483,448	1,074,286,122	(41,197,327)
Jun-19	17	66,054,273	3,725	66,057,998	68,253,047	2,195,050	62,871,170	1,181,541,446	1,142,539,169	(39,002,277)
Jul-19	18	66,334,842	2,216	66,337,059	68,850,410	2,513,351	62,873,386	1,247,878,504	1,211,389,579	(36,488,926)
Aug-19	19	66,615,412	1,506	66,616,918	69,452,560	2,835,642	62,874,892	1,314,495,423	1,280,842,139	(33,653,284)
Sep-19	20	66,899,436	984	66,900,420	70,063,098	3,162,678	62,875,876	1,381,395,843	1,350,905,236	(30,490,606)
Oct-19	21	67,185,080	759	67,185,839	70,680,732	3,494,892	62,876,636	1,448,581,682	1,421,585,968	(26,995,714)
Nov-19	22	67,470,725	574	67,471,298	71,303,347	3,832,048	62,877,209	1,516,052,980	1,492,889,315	(23,163,666)
Dec-19	23	67,758,464	0	67,758,464	71,933,195	4,174,732	62,877,209	1,583,811,444	1,564,822,510	(18,988,934)
Jan-20	24	70,039,311	0	70,039,311	72,568,142	2,528,830	62,877,209	1,653,850,755	1,637,390,652	(16,460,104)
Feb-20	25	70,336,015	0	70,336,015	73,208,234	2,872,219	62,877,209	1,724,186,770	1,710,598,886	(13,587,884)
Mar-20	26	70,641,742	0	70,641,742	73,862,857	3,221,115	62,877,209	1,794,828,512	1,784,461,743	(10,366,769)
Apr-20	27	70,947,469	0	70,947,469	74,522,798	3,575,328	62,877,209	1,865,775,981	1,858,984,540	(6,791,441)
May-20	28	71,260,117	0	71,260,117	75,195,141	3,935,024	62,877,209	1,937,036,098	1,934,179,681	(2,856,417)
Jun-20	29	71,572,764	0	71,572,764	75,872,951	4,300,187	62,877,209	2,008,608,863	2,010,052,632	1,443,770

Exhibit 3a
Nevada Division of Health Care Financing and Policy
Projected Managed Care Savings for Program Beginning January 1, 2018
Excluding Dual Eligibles and Retrospective Membership
Scenario 3: Statewide Managed Care, With Additional Eligibility Categories and Services
Including Optionally Eligible Enrollees

		Monthly Cash Flow					*Cumulative Cash Flow Analysis*			
Coverage Month	*Program Month*	*Managed Care Premiums*	*FFS Tail Run Out*	*Premium + Run Out*	*Est FFS Cost*	*Net Cash Flow*	*FFS Reserve*	*Prem + RunOut*	*Est FFS Cost*	*Net Cash Flow*
Jan-18	0	$82,182,898	$53,848,202	$136,031,100	$82,477,909	($53,553,191)	$53,848,202	$136,031,100	$82,477,909	($53,553,191)
Feb-18	1	82,505,770	18,146,031	100,651,801	83,139,376	(17,512,425)	71,994,233	236,682,901	165,617,285	(71,065,616)
Mar-18	2	82,829,018	7,899,670	90,728,688	83,806,240	(6,922,448)	79,893,903	327,411,589	249,423,524	(77,988,064)
Apr-18	3	83,154,273	2,981,724	86,135,997	84,480,099	(1,655,898)	82,875,626	413,547,586	333,903,624	(79,643,962)
May-18	4	83,481,122	1,517,063	84,998,185	85,160,730	162,545	84,392,690	498,545,771	419,064,354	(79,481,416)
Jun-18	5	83,807,970	753,828	84,561,798	85,846,548	1,284,750	85,146,518	583,107,568	504,910,902	(78,196,666)
Jul-18	6	84,139,681	309,989	84,449,670	86,542,830	2,093,160	85,456,507	667,557,238	591,453,732	(76,103,506)
Aug-18	7	84,471,392	190,948	84,662,340	87,244,444	2,582,104	85,647,455	752,219,578	678,698,176	(73,521,402)
Sep-18	8	84,803,103	141,785	84,944,887	87,951,440	3,006,553	85,789,240	837,164,465	766,649,616	(70,514,849)
Oct-18	9	85,138,244	94,897	85,233,141	88,667,850	3,434,708	85,884,137	922,397,606	855,317,466	(67,080,141)
Nov-18	10	85,473,385	65,497	85,538,882	89,389,780	3,850,898	85,949,634	1,007,936,488	944,707,246	(63,229,242)
Dec-18	11	85,808,526	47,602	85,856,128	90,117,282	4,261,154	85,997,236	1,093,792,616	1,034,824,528	(58,968,088)
Jan-19	12	89,228,782	31,884	89,260,667	90,853,599	1,592,932	86,029,120	1,183,053,283	1,125,678,127	(57,375,156)
Feb-19	13	89,582,213	26,663	89,608,876	91,597,655	1,988,778	86,055,784	1,272,662,159	1,217,275,781	(55,386,378)
Mar-19	14	89,936,303	23,942	89,960,246	92,348,187	2,387,941	86,079,726	1,362,622,405	1,309,623,968	(52,998,437)
Apr-19	15	90,292,489	22,373	90,314,862	93,106,605	2,791,743	86,102,099	1,452,937,267	1,402,730,573	(50,206,694)
May-19	16	90,648,674	16,272	90,664,946	93,870,931	3,205,985	86,118,372	1,543,602,213	1,496,601,504	(47,000,709)
Jun-19	17	91,007,243	6,824	91,014,067	94,643,601	3,629,533	86,125,196	1,634,616,280	1,591,245,105	(43,371,175)
Jul-19	18	91,366,123	4,147	91,370,270	95,422,624	4,052,354	86,129,343	1,725,986,551	1,686,667,729	(39,318,821)
Aug-19	19	91,725,003	2,762	91,727,765	96,207,747	4,479,982	86,132,105	1,817,714,316	1,782,875,476	(34,838,839)
Sep-19	20	92,087,337	1,830	92,089,167	97,002,520	4,913,353	86,133,935	1,909,803,482	1,879,877,996	(29,925,486)
Oct-19	21	92,451,291	1,344	92,452,635	97,805,656	5,353,021	86,135,279	2,002,256,117	1,977,683,652	(24,572,466)
Nov-19	22	92,815,909	893	92,816,802	98,615,830	5,799,028	86,136,172	2,095,072,919	2,076,299,482	(18,773,437)
Dec-19	23	93,182,623	0	93,182,623	99,434,534	6,251,912	86,136,172	2,188,255,542	2,175,734,016	(12,521,525)
Jan-20	24	95,984,040	0	95,984,040	100,260,444	4,276,404	86,136,172	2,284,239,582	2,275,994,460	(8,245,121)
Feb-20	25	96,361,938	0	96,361,938	101,092,893	4,730,955	86,136,172	2,380,601,519	2,377,087,353	(3,514,166)
Mar-20	26	96,748,860	0	96,748,860	101,941,220	5,192,359	86,136,172	2,477,350,380	2,479,028,573	1,678,193
Apr-20	27	97,135,782	0	97,135,782	102,796,282	5,660,500	86,136,172	2,574,486,162	2,581,824,855	7,338,693
May-20	28	97,531,270	0	97,531,270	103,667,411	6,136,141	86,136,172	2,672,017,432	2,685,492,266	13,474,834
Jun-20	29	97,926,757	0	97,926,757	104,545,473	6,618,716	86,136,172	2,769,944,189	2,790,037,739	20,093,550

Exhibit 3b
Nevada Division of Health Care Financing and Policy
Projected Managed Care Savings for Program Beginning January 1, 2018
Excluding Dual Eligibles and Retrospective Membership
Scenario 3: Statewide Managed Care, With Additional Eligibility Categories and Services
Excluding Optionally Eligible Enrollees

		Monthly Cash Flow					*Cumulative Cash Flow Analysis*			
Coverage Month	*Program Month*	*Managed Care Premiums*	*FFS Tail Run Out*	*Premium + Run Out*	*Est FFS Cost*	*Net Cash Flow*	*FFS Reserve*	*Prem + RunOut*	*Est FFS Cost*	*Net Cash Flow*
Jan-18	0	$81,182,387	$52,687,774	$133,870,160	$80,919,045	($52,951,115)	$52,687,774	$133,870,160	$80,919,045	($52,951,115)
Feb-18	1	81,503,584	17,695,089	99,198,673	81,574,540	(17,624,133)	70,382,863	233,068,833	162,493,585	(70,575,248)
Mar-18	2	81,825,157	7,696,483	89,521,640	82,235,409	(7,286,232)	78,079,346	322,590,474	244,728,994	(77,861,480)
Apr-18	3	82,148,738	2,889,128	85,037,866	82,903,266	(2,134,601)	80,968,474	407,628,340	327,632,260	(79,996,080)
May-18	4	82,473,912	1,474,023	83,947,935	83,577,863	(370,072)	82,442,497	491,576,275	411,210,123	(80,366,152)
Jun-18	5	82,799,085	733,352	83,532,438	84,257,637	725,199	83,175,849	575,108,712	495,467,759	(79,640,953)
Jul-18	6	83,129,122	301,744	83,430,866	84,947,860	1,516,994	83,477,593	658,539,578	580,415,620	(78,123,959)
Aug-18	7	83,459,158	185,454	83,644,612	85,643,407	1,998,795	83,663,047	742,184,191	666,059,027	(76,125,164)
Sep-18	8	83,789,195	137,833	83,927,027	86,344,327	2,417,299	83,800,880	826,111,218	752,403,354	(73,707,864)
Oct-18	9	84,122,661	92,193	84,214,854	87,054,656	2,839,802	83,893,072	910,326,072	839,458,010	(70,868,062)
Nov-18	10	84,456,128	63,475	84,519,603	87,770,498	3,250,896	83,956,547	994,845,675	927,228,508	(67,617,166)
Dec-18	11	84,789,595	46,152	84,835,747	88,491,903	3,656,157	84,002,699	1,079,681,421	1,015,720,412	(63,961,010)
Jan-19	12	88,173,260	30,905	88,204,164	89,222,121	1,017,957	84,033,604	1,167,885,586	1,104,942,533	(62,943,053)
Feb-19	13	88,524,952	25,799	88,550,751	89,960,046	1,409,294	84,059,403	1,256,436,337	1,194,902,579	(61,533,758)
Mar-19	14	88,877,304	23,139	88,900,443	90,704,439	1,803,996	84,082,542	1,345,336,780	1,285,607,018	(59,729,762)
Apr-19	15	89,231,751	21,630	89,253,381	91,456,713	2,203,332	84,104,172	1,434,590,161	1,377,063,731	(57,526,430)
May-19	16	89,586,197	15,795	89,601,993	92,214,888	2,612,895	84,119,967	1,524,192,154	1,469,278,619	(54,913,535)
Jun-19	17	89,943,029	6,544	89,949,573	92,981,402	3,031,829	84,126,511	1,614,141,726	1,562,260,021	(51,881,706)
Jul-19	18	90,300,170	3,973	90,304,142	93,754,256	3,450,114	84,130,484	1,704,445,869	1,656,014,277	(48,431,592)
Aug-19	19	90,657,311	2,652	90,659,963	94,533,202	3,873,239	84,133,136	1,795,105,832	1,750,547,479	(44,558,353)
Sep-19	20	91,017,906	1,751	91,019,658	95,321,784	4,302,126	84,134,888	1,886,125,490	1,845,869,263	(40,256,227)
Oct-19	21	91,380,122	1,286	91,381,408	96,118,726	4,737,318	84,136,174	1,977,506,898	1,941,987,989	(35,518,910)
Nov-19	22	91,743,002	857	91,743,859	96,922,686	5,178,827	84,137,031	2,069,250,757	2,038,910,675	(30,340,082)
Dec-19	23	92,107,977	0	92,107,977	97,735,173	5,627,196	84,137,031	2,161,358,734	2,136,645,847	(24,712,887)
Jan-20	24	94,881,374	0	94,881,374	98,554,860	3,673,486	84,137,031	2,256,240,108	2,235,200,708	(21,039,401)
Feb-20	25	95,257,485	0	95,257,485	99,381,081	4,123,596	84,137,031	2,351,497,593	2,334,581,788	(16,915,805)
Mar-20	26	95,642,619	0	95,642,619	100,223,120	4,580,500	84,137,031	2,447,140,213	2,434,804,908	(12,335,305)
Apr-20	27	96,027,754	0	96,027,754	101,071,888	5,044,134	84,137,031	2,543,167,967	2,535,876,796	(7,291,170)
May-20	28	96,421,454	0	96,421,454	101,936,679	5,515,225	84,137,031	2,639,589,421	2,637,813,476	(1,775,945)
Jun-20	29	96,815,154	0	96,815,154	102,808,398	5,993,244	84,137,031	2,736,404,574	2,740,621,873	4,217,299

Exhibit 4
Nevada Division of Health Care Financing and Policy
Development of Managed Care Premium Projections for Managed Care Expansion Budget Analysis
Excluding Dual Eligibles and Retrospective Membership
Data Incurred 12/1/2014 - 11/30/2015 (Expansion), 12/1/2013 - 11/30/2015 (Other), Paid through May 31, 2016

	Experience Data		Projection Factors								
	Total Mem Months	Raw Paid PMPM	Completion Impact	Fee Schedule Changes Impact	Total Trend Impact	Net Savings %	CY 18 Final Premium	2019/2018 Prem Change	CY 19 Final Premium	2020/2019 Prem Change	CY 20 Final Premium
TANF/CHAP											
Non-Clark, Non-Washoe Counties											
Males & Females; < 1yr old	40,008	$376.45	1.00	1.13	1.11	-2.0%	$464.17	1.019	$473.15	1.009	$477.57
Males & Females; 1 - 2 yrs old	61,344	$92.79	1.00	1.07	1.11	-2.0%	$107.63	1.019	$109.71	1.009	$110.74
Males & Females; 3 - 14 yrs old	285,294	$168.18	1.00	1.02	1.11	-2.0%	$185.86	1.019	$189.45	1.009	$191.22
Females; 15 - 18 yrs old	35,284	$341.40	1.00	1.01	1.11	-2.0%	$376.48	1.019	$383.76	1.009	$387.34
Males; 15 - 18 yrs old	34,096	$335.41	1.00	1.01	1.11	-2.0%	$367.57	1.019	$374.67	1.009	$378.17
Females; 19 - 34 yrs old	61,518	$216.35	1.00	1.02	1.11	-2.0%	$240.80	1.019	$245.46	1.009	$247.75
Males; 19 - 34 yrs old	15,686	$191.06	1.00	1.07	1.11	-2.0%	$222.14	1.019	$226.44	1.009	$228.55
Females; 35+ yrs old	30,003	$502.13	1.00	1.02	1.11	-2.0%	$555.93	1.019	$566.68	1.009	$571.98
Males; 35+ yrs old	13,850	$424.32	1.00	1.07	1.11	-2.0%	$494.70	1.019	$504.27	1.009	$508.97
Check-Up											
Non-Clark, Non-Washoe Counties											
Males & Females; < 1yr old	405	$60.87	1.00	1.14	1.12	-2.0%	$76.75	1.023	$78.52	1.013	$79.54
Males & Females; 1 - 2 yrs old	2,985	$77.50	1.00	1.07	1.12	-2.0%	$91.18	1.023	$93.28	1.013	$94.50
Males & Females; 3 - 14 yrs old	41,166	$129.18	1.00	1.02	1.12	-2.0%	$145.71	1.023	$149.06	1.013	$151.01
Females; 15 - 18 yrs old	6,172	$183.36	1.00	1.02	1.12	-2.0%	$205.69	1.023	$210.43	1.013	$213.17
Males; 15 - 18 yrs old	6,466	$179.07	1.00	1.02	1.12	-2.0%	$200.37	1.023	$204.98	1.013	$207.66
Expansion											
Non-Clark, Non-Washoe Counties											
Females; 19 - 34 yrs old	40,888	$269.46	1.00	1.02	1.11	-2.0%	$302.15	1.026	$309.90	1.016	$314.75
Males; 19 - 34 yrs old	34,295	$254.82	1.00	1.01	1.11	-2.0%	$282.37	1.026	$289.62	1.016	$294.15
Females; 35+ yrs old	65,390	$563.21	1.00	1.05	1.11	-2.0%	$647.71	1.026	$664.33	1.016	$674.72
Males; 35+ yrs old	57,760	$548.82	1.00	1.07	1.11	-2.0%	$642.67	1.026	$659.15	1.016	$669.46
HCBS											
Clark County											
Males & Females; <1yr old	-	$0.00	-	-	-	1.0%	$0.00	1.000	$0.00	1.000	$0.00
Males & Females; 1 - 20 yrs old	1,735	$7,561.33	1.00	1.02	1.16	1.0%	$9,043.14	1.032	$9,330.00	1.022	$9,532.67
Males & Females; 21 - 64 yrs old	16,899	$4,351.92	1.00	1.02	1.16	1.0%	$5,173.73	1.032	$5,337.85	1.022	$5,453.80
Males & Females; 65+ yrs old	9,648	$1,298.49	1.00	1.11	1.16	1.0%	$1,679.70	1.032	$1,732.98	1.022	$1,770.63
Washoe County											
Males & Females; <1yr old	-	$0.00	-	-	-	1.0%	$0.00	1.000	$0.00	1.000	$0.00
Males & Females; 1 - 20 yrs old	696	$6,476.74	1.00	1.01	1.16	1.0%	$7,650.40	1.032	$7,893.08	1.022	$8,064.53
Males & Females; 21 - 64 yrs old	4,744	$5,262.59	1.00	1.01	1.16	1.0%	$6,225.27	1.032	$6,422.75	1.022	$6,562.26
Males & Females; 65+ yrs old	3,544	$1,188.32	1.00	1.12	1.16	1.0%	$1,563.25	1.032	$1,612.84	1.022	$1,647.87
Non-Clark, Non-Washoe Counties											
Males & Females; <1yr old	-	$0.00	-	-	-	1.0%	$0.00	1.000	$0.00	1.000	$0.00
Males & Females; 1 - 20 yrs old	177	$8,002.63	1.00	1.03	1.16	1.0%	$9,636.73	1.032	$9,942.42	1.022	$10,158.39
Males & Females; 21 - 64 yrs old	3,095	$4,257.72	1.00	1.01	1.16	1.0%	$5,053.40	1.032	$5,213.71	1.022	$5,326.96
Males & Females; 65+ yrs old	2,926	$1,096.89	1.00	1.09	1.16	1.0%	$1,399.68	1.032	$1,444.08	1.022	$1,475.45

Exhibit 4
Nevada Division of Health Care Financing and Policy
Development of Managed Care Premium Projections for Managed Care Expansion Budget Analysis
Excluding Dual Eligibles and Retrospective Membership
Data Incurred 12/1/2014 - 11/30/2015 (Expansion), 12/1/2013 - 11/30/2015 (Other), Paid through May 31, 2016

	Experience Data		Projection Factors								
	Total Mem Months	Raw Paid PMPM	Completion Impact	Fee Schedule Changes Impact	Total Trend Impact	Net Savings %	CY 18 Final Premium	2019/2018 Prem Change	CY 19 Final Premium	2020/2019 Prem Change	CY 20 Final Premium
Nursing Home											
Clark County											
Males & Females; <1yr old	438	$4,655.65	1.00	1.08	1.07	1.0%	$5,476.58	1.010	$5,533.09	1.000	$5,534.85
Males & Females; 1 - 20 yrs old	920	$12,485.27	1.00	1.01	1.07	1.0%	$13,687.64	1.010	$13,828.88	1.000	$13,833.29
Males & Females; 21 - 64 yrs old	10,155	$6,588.91	1.00	1.02	1.07	1.0%	$7,289.12	1.010	$7,364.34	1.000	$7,366.68
Males & Females; 65+ yrs old	10,021	$3,188.17	1.00	1.00	1.07	1.0%	$3,478.33	1.010	$3,514.22	1.000	$3,515.34
Washoe County											
Males & Females; <1yr old	9	$14,940.54	1.00	1.07	1.07	1.0%	$17,361.75	1.010	$17,540.90	1.000	$17,546.49
Males & Females; 1 - 20 yrs old	84	$6,284.74	1.00	1.00	1.07	1.0%	$6,848.37	1.010	$6,919.03	1.000	$6,921.24
Males & Females; 21 - 64 yrs old	1,333	$3,763.39	1.00	1.03	1.07	1.0%	$4,215.72	1.010	$4,259.22	1.000	$4,260.58
Males & Females; 65+ yrs old	2,285	$2,142.82	1.00	1.00	1.07	1.0%	$2,332.76	1.010	$2,356.84	1.000	$2,357.59
Non-Clark, Non-Washoe Counties											
Males & Females; <1yr old	8	$71.10	1.00	1.00	1.07	1.0%	$77.10	1.010	$77.90	1.000	$77.92
Males & Females; 1 - 20 yrs old	77	$11,538.62	1.00	1.00	1.07	1.0%	$12,538.93	1.010	$12,668.32	1.000	$12,672.36
Males & Females; 21 - 64 yrs old	1,552	$6,599.21	1.00	1.01	1.07	1.0%	$7,241.76	1.010	$7,316.49	1.000	$7,318.82
Males & Females; 65+ yrs old	3,626	$2,861.67	1.00	1.00	1.07	1.0%	$3,114.43	1.010	$3,146.57	1.000	$3,147.57
Other ABD											
Clark County											
Males & Females; <1yr old	1,509	$4,015.77	1.00	1.06	1.21	-3.0%	$5,004.32	1.044	$5,222.21	1.034	$5,397.37
Males & Females; 1 - 20 yrs old	190,106	$1,076.34	1.00	1.03	1.21	-3.0%	$1,302.80	1.044	$1,359.53	1.034	$1,405.13
Males & Females; 21 - 64 yrs old	292,698	$1,637.85	1.00	1.05	1.21	-3.0%	$2,007.51	1.044	$2,094.91	1.034	$2,165.18
Males & Females; 65+ yrs old	22,545	$1,019.86	1.00	1.02	1.21	-3.0%	$1,225.35	1.044	$1,278.71	1.034	$1,321.59
Washoe County											
Males & Females; <1yr old	154	$1,330.57	1.00	1.07	1.21	-3.0%	$1,670.61	1.044	$1,743.35	1.034	$1,801.82
Males & Females; 1 - 20 yrs old	29,385	$953.08	1.00	1.03	1.21	-3.0%	$1,149.24	1.044	$1,199.27	1.034	$1,239.50
Males & Females; 21 - 64 yrs old	56,621	$1,251.97	1.00	1.06	1.21	-3.0%	$1,552.54	1.044	$1,620.13	1.034	$1,674.47
Males & Females; 65+ yrs old	3,858	$642.26	1.00	1.07	1.21	-3.0%	$805.80	1.044	$840.88	1.034	$869.08
Non-Clark, Non-Washoe Counties											
Males & Females; <1yr old	96	$2,470.36	1.00	1.07	1.21	-3.0%	$3,089.33	1.044	$3,223.84	1.034	$3,331.97
Males & Females; 1 - 20 yrs old	17,410	$1,019.55	1.00	1.02	1.21	-3.0%	$1,212.92	1.044	$1,265.73	1.034	$1,308.19
Males & Females; 21 - 64 yrs old	47,067	$1,161.22	1.00	1.05	1.21	-3.0%	$1,422.72	1.044	$1,484.66	1.034	$1,534.46
Males & Females; 65+ yrs old	2,040	$704.65	1.00	1.02	1.21	-3.0%	$846.40	1.044	$883.26	1.034	$912.88

Appendix J: Advantages and Disadvantages to Carving in Additional Populations into MCO Program

The following table provides key advantages and disadvantages associated with carving in additional populations into the MCO program on a mandatory basis. Several of these populations are currently eligible to enroll in MCOs on a voluntary basis (e.g., adults with serious mental illness, children with severe emotional disturbance, Native American tribes). Additionally, youth involved in the juvenile justice system are required to enroll in MCOs if they are in the custody of their parents, but are served through FFS if they are in the custody of the State.

Although not separately listed for each population, concerns about sufficient MCO provider networks and stakeholder concern regarding transitioning to a new system are common across all of the populations.

Population	Key Advantages	Key Disadvantages
MAABD Population	• Population would have access to intensive clinical case and care management with the potential to improve outcomes and decrease costs of physical healthcare • Care for whole person managed by one MCO that contracts with providers to deliver comprehensive Medicaid services • Can improve the ability to share information among providers to improve coordination and avoid duplication of services for recipients, through MCO contract provisions that facilitate or require data sharing across entities	• Population typically needs other types of providers and specialized services and time is needed for MCOs to contract with these additional provider types and build infrastructure • MCOs may need time to strengthen experience with this population to assess their medical and non-medical needs and provide special outreach and accommodations to ensure meaningful access and adequate care • DHCFP would have the increased burden of oversight and monitoring over a broader scope of vendor responsibilities, and oversight for this population is critical to success
HCBS waiver population (advantages and disadvantages in addition to those for general MAABD population)	• HCBS services managed by the same entity managing other physical, behavioral health and long-term services to provide more integrated care for the whole person • Potential to reduce HCBS waitlists through savings generated or by receiving federal approval for MCOs to provide HCBS as a cost-effective alternative[112]	• Population currently receives case management services through the HCBS waivers and transition of these populations to MCOs may require them to change their case manager • If MCOs take over case management functions, must determine new roles and responsibilities for State employees previously providing waiver case management services as their functions will transition to the MCOs

[112] Tennessee's 1115 demonstration waiver permits MCOs to offer HCBS as a cost-effective alternative to TennCare enrollees who meet the criteria for CHOICES 2 but who cannot enroll because the enrollment target has been met. CHOICES 2 is the group of individuals who meet the nursing facility level of care, but choose to receive HCBS instead.

Population	Key Advantages	Key Disadvantages
		• As HCBS waiver populations often have more complex needs than the general MAABD population, the need for special outreach and accommodations is heightened
Dual eligibles (advantages and disadvantages in addition to those for general MAABD population)	• Programs that coordinate Medicare and Medicaid benefits for individuals enrolled in both programs have the potential to improve access to services and quality of care • Opportunities to achieve greater financial and service integration between the Medicare and Medicaid programs • Greater integration by requiring the MCOs to be D-SNPs, a type of Medicare Advantage plan that serves recipients dually enrolled in Medicare and Medicaid (Appendix F provides more information about D-SNPs)	• As individuals eligible for Medicare and Medicaid often have more complex needs than the general MAABD population, the need for special outreach and accommodations is heightened • Early savings typically accrue to Medicare, as Medicare is responsible for primary and acute care services[113]
Children receiving foster care	• Maintain continuity of clinical care and case management regardless of child's custody arrangement • Streamlined care coordination • MCOs are accountable for making sure members receive required services • Allows availability of clinical information when authorizing services and for considering coordination of physical and behavioral healthcare needs • Allows leverage with providers to enforce coordination of care requirements and to hold them accountable for outcomes using P4P and VBP • MCOs could be required to partner with existing initiatives to expand their reach, such as programs geared at reducing unnecessary psychotropic medications and System of Care initiatives • Changing to a different delivery system when transitioning out of foster care is not necessary	• MCOs may face challenges recruiting providers experienced with managing care for and delivering services to children receiving foster care • MCOs may be unfamiliar with the court systems and requirements for court systems to authorize certain services • If targeted case management is carved into the MCO benefit package, children receiving foster care may need to change their case manager, although State/county employees could continue to provide other services if they are not duplicated by the MCO (Appendix K provides additional discussion about targeted case management services) • Because this population often requires services that are not covered by Medicaid, additional funding sources are often needed to provide wraparound services • Because there is a relatively small number of children receiving foster care, MCOs might not be incentivized to build the infrastructure necessary to address the unique needs of this population

[113] The Lewin Group. (November 2008). *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities.* Retrieved from: http://www.communityplans.net/portals/0/Policy/Medicare/Lewin%20dual%20eligibles%20cost%20savings%20report_463514.pdf.

Population	Key Advantages	Key Disadvantages
Adults with serious mental illness and children with severe emotional disturbance (currently eligible to enroll in MCOs on a voluntary basis)	• Could provide a consistent model for all adults with serious mental illness and children with severe emotional disturbance, i.e., all will be served through MCOs • Population would have access to intensive clinical case and care management with the potential to improve outcomes and decrease costs of physical healthcare • Care for whole person managed by one MCO that contracts with providers to deliver comprehensive Medicaid services • MCOs accountable to ensure individuals receive services in a timely manner, which has been an issue for Nevada • MCOs can promote the use of evidence-based services among providers • MCOs have more flexibility to include other types of professionals, such as peer support specialist and community health workers in care model	• Individuals may not be able to see their current providers if they are not contracted with MCOs (such as non-licensed providers) • If targeted case management is carved into the MCO benefit package, individuals may need to change their case manager, although State/county employees could continue to provide other services if they are not duplicated by the MCO (Appendix K provides additional discussion about targeted case management services) • Little data is available regarding the impact of managed care programs on adults with serious mental illness or children with severe emotional disturbance • Stakeholders have expressed issues with services received by these populations in Nevada's current MCO program
Native American Tribes (currently eligible to enroll in MCOs on a voluntary basis)	• Could provide a consistent model for all Native Americans, i.e., all will be served through MCOs • Could provide more opportunity to address health disparities among Native American tribes, as MCOs have more flexibility in how they pay providers and what they pay for, as compared to FFS • Could provide opportunities to strengthen relationships between Indian Health Service (IHS) and tribal providers, other providers and MCOs • Entire population would have access to intensive clinical case and care management with the potential to improve outcomes and decrease costs of healthcare • MCOs accountable to ensure individuals receive services in a timely manner • Under a Section 1115 demonstration waiver, states can have managed care programs that provide different benefit packages for Native American populations, such as those that include alternative nontraditional services	• MCOs may be unfamiliar with the unique differences among Native American tribes in Nevada; understanding the culture of particular tribes is essential to effective engagement • MCOs may be unfamiliar with the way the IHS system works • There may be difficulties providing access to culturally appropriate providers and achieving network sufficiency of IHS and tribal providers (although MCOs cannot refuse to enroll IHS or tribal providers and cannot pay rates lower than FFS rates) • IHS and tribal providers may experience challenges receiving timely and appropriate payment from MCOs (currently these providers are paid by DHCFP even for recipients enrolled in MCOs) • On a national level, many Native Americans populations are opposed to mandatory MCO enrollment • To require recipients to enroll in an MCO, DHCFP must obtain approval from CMS either through a Medicaid state plan amendment, a 1915(b) waiver or through a section

Population	Key Advantages	Key Disadvantages
		1115 demonstration waiver; CMS typically does not grant approval unless mandatory enrollment is agreed to through State/tribal consultation
Youth involved in the juvenile justice system	• Maintain continuity of clinical care and case management regardless of child's custody arrangement • MCOs can be required to perform additional functions for this population (e.g., assessment when youth first encounters juvenile justice system) • Streamlined care coordination • MCOs can promote the use of evidence-based services among providers • MCOs are accountable for making sure members receive required services • Allows ability for improved coordination of physical and behavioral healthcare needs • Allows leverage with providers to enforce coordination of care requirements and to hold them accountable for outcomes using P4P and VBP	• MCOs may face challenges recruiting providers experienced with managing care for and delivering services to youth involved in the juvenile justice system • MCOs may be unfamiliar with the court systems and requirements for court systems to authorize certain services • If targeted case management is carved into the MCO benefit package, youth involved in the juvenile justice system may need to change their case manager, although State/county employees could continue to provide other services if they are not duplicated by the MCO (Appendix K provides additional discussion about targeted case management services) • Because there are is a relatively small number of youth involved in the juvenile justice system on Medicaid, MCOs might not be incentivized to build the infrastructure necessary to address the unique needs of this population • Because this population often requires services that are not covered by Medicaid, additional funding sources are often needed to provide wraparound services • Little data is available regarding managed care programs for youth involved in the juvenile justice system

Appendix K: Advantages and Disadvantages to Carving in Services Currently Excluded from MCO Benefit Package

The following table provides key advantages and disadvantages associated with carving in additional services into the MCO program. We have not included in this table services that are currently carved into the MCO benefit package. Although not separately listed for each service, concerns about sufficient MCO provider networks and stakeholder concern regarding transitioning services to a new system are common across all of the services.

	Key Advantages	Key Disadvantages
Long-term Services and Supports (we have combined the excluded long-term services and supports for discussion purposes)	• Intensive clinical care case management offer potential to improve outcomes and decrease cost of physical healthcare, especially for members receiving long-term services and supports who also have chronic diseases • Potential for quality management through use of quality measures and P4P measures in provider contracts • Care for whole person managed by one vendor that contracts with all levels of providers to deliver the full scope of Medicaid services • When MCOs are at risk for both community-based and institutional long-term care services, MCOs have a financial incentive to help individuals remain in or transfer to less costly community placements • Research indicates that managed long-term services and supports programs reduce the use of institutional services and increase access to HCBS[114] • Offers budget predictability, as it uses a capitated payment structure	• Time needed for MCOs to contract with nursing facilities and HCBS providers and to build infrastructure • MCO learning curve may be steep • Model is largely untested, and so findings to date regarding the impact of such a model are somewhat inconclusive, particularly as they relate to cost • Some long-term services and supports providers, particularly Nevada HCBS providers, may not be equipped to bill for services as required by MCOs • DHCFP would have the increased burden of oversight and monitoring over a broader scope of vendor responsibilities, and oversight for these services is critical to success
Dental and Orthodontia Note: Since dental services will be carved out of the MCO contract and delivered through a dental PAHP	• Allows enhanced coordination of care by having health and dental services provided through one entity, particularly related to EPSDT services • Aligns incentives to treat the "whole person" from a clinical and cost perspective • Allows access to dental and medical claims data for care management purposes and for identifying quality initiatives	• May create some administrative burden for dentists participating in multiple MCOs • Since dental services are not the sole focus of the MCO, may not have the level of focused experience as a dental vendor

[114] Kaiser Family Foundation. (February 2012). *People with Disabilities and Medicaid Managed Care: Key Issues to Consider*. Retrieved from: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8278.pdf.

	Key Advantages	Key Disadvantages
beginning in July 2017, this row presents advantages and disadvantages of carving dental services in a MCO as opposed to a dental PAHP	• Benefits administered by one entity may be less confusing to members • Streamlines the number of contracts for which DHCFP must provide administration and oversight • May avoid increased costs to the State due to one dental vendor having more negotiating leverage	
Non-emergency transportation Note: Since non-emergency transportation services are delivered through a separate vendor, this row presents advantages and disadvantages of carving non-emergency transportation services in a MCO as opposed to a separate vendor	• MCOs would have more "stake" in increasing transportation availability to impact service utilization and care management • Allows coordination of care, so that MCOs may more fully meet member care needs • Allows MCOs to directly monitor transportation providers, which enhances opportunities to identify inappropriate utilization and improve coordination • MCOs have sole responsibility for helping members access services • Streamlines the number of contracts for which DHCFP must provide administration and oversight • Current MCOs report that they provide transportation services because the current transportation vendor is sometimes not reliable	• May create additional administrative costs because transportation providers must contract with multiple MCOs • MCOs may not have as much experience managing recipient transport
Targeted case management	• Less complex and confusing for recipients to have single case manager, if those recipients are enrolled in an MCO • Streamlines administration of case management services, as CMS will not pay for duplicate case management services delivered by different entities • MCOs have a financial incentive to provide case management services to improve care delivery across services	• Recipients may be required to change their targeted case manager • Will need to determine new roles and responsibilities for State and county employees providing targeted case management services • Transition of targeted case management to MCOs would impact county revenue (Section 7 provides more information)

Appendix L: Advantages and Disadvantages of Expanding Program Statewide

	Key Advantages	Key Disadvantages
Expand statewide	• Ability for DHCFP to hold MCOs accountable for quality and financial outcomes • Reduced churn when recipients move out of current MCO service areas • MCOs could be incentivized to increase the number of current providers participating in Medicaid • Recipients living outside of the urban areas of Clark and Washoe counties would have access to more care and case management services • MCOs have more tools/incentives to encourage preventive and early intervention services to avoid emergency department visits and inpatient admissions • Option for MCOs to provide value-added services to recipients not available through the FFS system • MCOs could provide more support to providers in frontier communities to help them adopt evidence-based practices, improve data and reporting, and fulfill other business functions, etc. • Increased budget predictability for the State	• Lack of support from provider and advocacy communities • Limited FFS providers in frontier areas to support adequate MCO networks • MCO network adequacy has been an area of increased focus for CMS, who may question access in frontier areas • Increased DHCFP oversight and monitoring of MCOs needed, and currently limited resources

Appendix M: Estimated Impact of MCO Expansion Scenario on Supplemental Payment Programs

Description of MCO Expansion Scenarios

As described in Section 7, Navigant assessed three MCO expansion scenarios to determine the potential impact on supplemental payments to providers. These scenarios were:

- **Scenario 1.** MCO geographic area expanded statewide, but no additional eligibility categories or services are added.

  For this scenario, we applied the eligibility categories in the current MCO program to all geographical locations within Nevada.

- **Scenario 2.** MCO populations expanded to enroll all individuals in the MAABD eligibility category and cover all long-term services (institutional and HCBS, including waivers) and select targeted case management, only in Clark and Washoe counties.

  For this scenario, we used the geographical locations within Clark and Washoe counties identified above, however we expanded the eligibility categories that would be eligible for the MCO program to include MAABD aid codes.

- **Scenario 3.** MCO geographic area expanded statewide and MCO populations expanded to enroll all individuals in the MAABD eligibility category and cover all long-term services (institutional and HCBS, including waivers) and select targeted case management.

  For this scenario, we applied the eligibility categories in the current MCO program plus the MAABD aid codes included in Scenario 2 to all geographical locations within Nevada.

The dollar amounts identified in this report are based the most recent UPL models available from DHCFP (described below). No inflation was added to the numbers reported in the UPL models.

Scenario 1

Supplemental Payment Program	Under MCO Expansion Scenario		
	Impact on Revenue to State Agencies	Impact on Revenue to Counties	Impact on Revenue to Providers
Direct Graduate Medical Education	($1,630,336)	$3,035,766	($13,233,415)
Inpatient Supplemental Payment for Non-State Governmentally Owned or Operated Hospitals	($3,602,478)	$7,002,250	($30,075,802)
Inpatient Supplemental Payment for Private Hospitals	$0	$0	$0
Indigent Accident Fund Payment	$0	$0	($28,748,308)
Outpatient Hospital Supplemental Payments	($1,688,374)	$1,731,345	($1,688,374)

Supplemental Payment Program	Under MCO Expansion Scenario		
	Impact on Revenue to State Agencies	Impact on Revenue to Counties	Impact on Revenue to Providers
Supplemental Payment to Free-Standing Nursing Facilities	$0	$0	$0
Enhanced Rates for Practitioner Services Delivered by the University of Nevada School of Medicine	$371,660	$0	($1,054,751)

Scenario 2

Supplemental Payment Program	Under MCO Expansion Scenario		
	Impact on Revenue to State Agencies	Impact on Revenue to Counties	Impact on Revenue to Providers
Direct Graduate Medical Education	($2,274,287)	$4,197,981	($18,299,705)
Inpatient Supplemental Payment for Non-State Governmentally Owned or Operated Hospitals	($4,997,295)	$9,674,527	($41,553,664)
Inpatient Supplemental Payment for Private Hospitals	$0	$0	$0
Indigent Accident Fund Supplemental Payment	$0	$0	($41,430,344)
Outpatient Hospital Supplemental Payments	($1,511,708)	$1,550,182	($1,511,708)
Supplemental Payment to Free-Standing Nursing Facilities	($250,857)	$0	($20,262,006)
Enhanced Rates for Practitioner Services Delivered by the University of Nevada School of Medicine	$687,600	$0	($1,951,152)

Scenario 3

Supplemental Payment Program	Under MCO Expansion Scenario		
	Impact on Revenue to State Agencies	Impact on Revenue to Counties	Impact on Revenue to Providers
Direct Graduate Medical Education	($2,333,166)	$4,344,470	($18,938,275)
Inpatient Supplemental Payment for Non-State Governmentally Owned or Operated Hospitals	($5,154,433)	$10,018,836	($43,032,528)
Inpatient Supplemental Payment for Private Hospitals	$0	$0	$0
Indigent Accident Fund Supplemental Payment	$0	$0	($49,620,628)
Outpatient Hospital Supplemental Payments	($2,731,590)	$2,801,111	($2,731,590)
Supplemental Payment to Free-Standing Nursing Facilities	($325,218)	$0	($26,268,283)
Enhanced Rates for Practitioner Services Delivered by the University of Nevada School of Medicine	$764,861	$0	($2,170,382)

Methodology and Limitations

Navigant obtained the most recent submitted UPL models from DHCFP to calculate the impact of various MCO expansion scenarios. We used the following UPL models in the analysis:

- Inpatient Non-State Government Owned and Operated Hospitals – SFY 2017 Model
- Inpatient Privately Owned and Operated Hospitals – SFY 2017 Model
- Outpatient Non-State Government Owned and Operated Hospitals – SFY 2017 Model
- Outpatient Privately Owned and Operated Hospitals – SFY 2017 Model
- University of Nevada School of Medicine Physicians and Other Practitioners – SFY 2016 Model
- Free-Standing Nursing Facilities – Payment Calculation Spreadsheet for the 2nd Quarter of SFY 2017

Additionally, DHCFP provided detail information by billing provider for services provided within each zip code within Nevada and the eligibility category for recipients receiving services. Below we describe the geographical indicators and the eligibility categories used in the MCO expansion scenarios.

Geographical Indicators

Currently, MCOs operate in the following zip codes within Clark and Washoe counties, according to the information provided by DHCFP.

City	County	Zip Codes
Blue Diamond	Clark County	89004
Boulder City	Clark County	89005-06
Henderson	Clark County	89002, 89009, 89011, 89012, 89014-16, 89044, 89052-53, 89074, 89077

City	County	Zip Codes
Las Vegas	Clark County	89101-105, 89106-166, 89169-70, 89173, 89177-80, 89183, 89185, 89193, 89195, 89199
Mesquite	Clark County	89024, 89027, 89034
Nellis AFB	Clark County	89191
North Las Vegas	Clark County	89030-33, 89036, 89081, 89084-87
Sloan	Clark County	89054
The Lakes	Clark County	88901, 88905
Reno	Washoe County	89501-13, 89515, 89519-21, 89523, 89533, 89555, 89557, 89570, 89595, 89599
Sparks	Washoe County	89431-32, 89434-36, 89441
Sun Valley	Washoe County	89433
Verdi	Washoe County	89439

Eligibility Categories

Currently, the following aid categories are eligible for mandatory enrollment into MCOs, according to the information provided by DHCFP. Certain groups are not required to enroll in MCOs even if they have one of the following aid codes (e.g., children determined severely emotionally disturbed, adults determined seriously mentally ill [unless they are part of the Medicaid expansion population], Native Americans), however because this information is not captured by the eligibility category, the analysis assumes all recipients in the following aid categories would enroll in MCOs.

Aid Category Code	Aid Category Description
AM	TANF Medicaid
AM1	AM Expanded Medicaid
AM5	TANF Medicaid - OBRA baby
AO	Aged Out of Foster Care Medical Only
CA	Childless Adult
CH	CHAP
CH1	CH Expanded Medicaid
CH5	CHAP - OBRA baby
EM5	Emergency Illegal alien – OBRA
SN	Sneede vs. Kizer
SN5	Sneede vs. Kizer - OBRA baby
TR	Transitional medical
TR5	Transitional medical - OBRA baby

Methodology of Reducing Supplemental Payments

The inpatient UPL for county-owned hospitals is the basis for payments made to these hospitals for CAH cost settlements and payments for direct graduate medical education, IAF and inpatient supplemental payments. When applying the MCO expansion scenarios to the UPL calculation, we used the following methodology:

- The inpatient UPL model provided by DHCFP included discharges increased by a growth factor from 2015 to 2017. We applied the same growth factor to the discharges in our calculation.

- The inpatient UPL program for county-owned hospitals receives payments for direct graduate medical education, IAF payments and supplemental inpatient payments. To the degree possible, we maintained each payment type at its percentage of the UPL for the current FFS program (with no MCO expansion). We adopted this methodology due to the various funding sources used to make payments allowable under the inpatient UPL.
- We decreased IAF payments based on the percentage of payments paid to the hospitals under the current FFS parameters to the UPL calculated in the DHCFP model.
- We did not decrease the amount DHCFP receives from the IAF program since all remaining funds in the IAF program that could not be used to match federal funds were paid out to the hospitals as State-funded payments.
- We decreased direct graduate medical education payments based on the percentage of payments paid to the hospitals under the current FFS parameters to UPL calculated in the DHCFP model reduced by IAF payments.
- The inpatient private hospital payments made under the collaboration agreements were decreased if the remaining UPL after IAF payments was less than the amount of the initial payments under the collaboration agreements. However, the remaining UPL after IAF payments was never less than the amount of the initial payments under the collaboration agreements.
- We decreased the supplemental payments to county-owned hospitals for outpatient services based on the reduction of UPL under each MCO expansion scenario.
- We did not make adjustments for privately owned hospitals for outpatient supplemental payments because the hospitals do not receive any outpatient supplemental payments.
- DHCFP determines the supplemental payments to nursing facilities on a quarterly basis. For purposes of this analysis, we determined the impact of the three MCO expansion scenarios by annualizing DHCFP's calculations for the 2nd quarter of SFY 2017, because this was the most current model available for the nursing facilities.
- We calculated the impact of the three MCO expansion scenarios on the supplemental payments for practitioners associated with the University of Nevada School of Medicine by using the SFY 2016 model. The model determines the difference between the Medicare rate payment multiplied by an equivalent ratio less the amount paid by Medicaid. The Medicare rate payment was not provided in the detail data. Therefore, we determined a ratio of Medicaid payments to Medicare payments for each quarter and used the allowable payments from each quarter under the applicable MCO expansion scenario to determine the Medicare payments under the scenario.
- We identified in the detail data for the various models instances where an individual should have been considered in the current MCO program based on the category of service and the geographical location. We incorporated these individuals into our adjustments under the various options.

Funding of Supplemental Payments

We based the split between federal share and non-federal share for this analysis on one quarter of Federal Medical Assistance Percentage (FMAP) for Federal Fiscal Year (FFY) 2016 and

three quarters of the FMAP for FFY 2017.[115, 116] We used a combined FMAP of 64.74 percent in the calculation for all payment programs except for the supplemental payment program for practitioners associated with the University of Nevada School of Medicine. This program's data is provided by quarter, so we were able to apply the applicable FMAP percentages by quarter.

Currently, the non-federal share of the supplemental payments is generated from different sources as follows:

Supplemental Payment Program	Source of Non-Federal Share
Direct Graduate Medical Education	Clark County provides an IGT for the non-federal share of the direct graduate medical education payments. Based on the first two quarters of SFY 2017, Clark County pays an additional IGT to DHCFP for use as non-federal share for other Medicaid expenditures.
Inpatient Supplemental Payment for Non-State Governmentally Owned or Operated Hospitals	Clark County provides an IGT for the non-federal share of the inpatient supplemental payments. Based on the first two quarters of SFY 2017, Clark County pays an additional IGT to DHCFP for use as non-federal share for other Medicaid expenditures.
Indigent Accident Fund Supplemental Payment	The Board of the Nevada Association of Counties transfers "agreed upon amount of money each year from the [Indigent Accident] Fund to DHHS to include in the State Plan for Medicaid an enhanced rate of reimbursement for hospital care provided to recipients of Medicaid or to make supplemental payments to the hospital for the provision of such hospital care through increased federal financial participation."[117] DHCFP receives approximately $1,033,333 of funding from the IAF program for other Medicaid expenditures.
Outpatient Hospital Supplemental Payments	The counties that have non-State government owned and operated hospitals located with the county provide an IGT for the non-federal share of the inpatient supplemental payments. Based on the first two quarters of SFY 2017, these counties pay an additional IGT to DHCFP for use as non-federal share for other Medicaid expenditures.
Supplemental Payment to Free-Standing Nursing Facilities	A provider tax "is assessed on all free-standing nursing facilities within Nevada on all non-Medicare bed days at a rate which cannot exceed 6% of net revenues for all facilities. The proceeds of the tax are placed in a special fund and then used to pay out the monthly provider tax supplemental payments to all qualified free standing nursing facilities in Nevada."[118]
Enhanced Rates for Practitioner Services Delivered by the University of Nevada School of Medicine	IGT from the University of Nevada School of Medicine is used to support the non-federal share.

[115] The FFY 2016 FMAP for Nevada is 64.93 percent.
[116] The FFY 2017 FMAP for Nevada is 64.67 percent.
[117] Nevada Association of Counties. *Indigent Accident Fund (IAF).* Retrieved from: http://www.nvnaco.org/programs/indigent-accident-fund-iaf/.
[118] Division of Health Care Financing and Policy. *Provider Tax.* Retrieved from: http://dhcfp.nv.gov/Resources/Rates/RAPProviderTax/.

We made the following assumptions related to the non-federal share for this analysis:

- The percentage of additional amount of IGT funds paid by counties for hospital services will remain constant. Therefore, the decrease in supplemental payments results in a decreased need of non-federal share from the counties and a reduction in the amount that DHCFP can use for other services.
- The nursing facility provider tax must be used for supplemental payments to nursing facilities with one percent of the tax being used as an administrative charge to DHCFP for administration of the supplemental programs. Any tax paid by the nursing facilities that would not support payments under the MCO expansion scenario would be returned to the nursing facilities. This tax amount returned would include the one percent administrative charge related to the returned tax amounts.
- Funds transferred to DHCFP for the IAF would continue to be used to pay hospitals under the MCO expansion scenarios. Therefore, any non-federal share not used to make payments under the inpatient UPLs would be paid to the applicable hospital as a state funds only payment. No funds from the IAF would remain with DHCFP.
- Because the University of Nevada School of Medicine is a State agency, the non-federal share is reported as a state government obligation. Any reductions in the non-federal share would reduce the state government obligation.

Appendix N: Additional Information on Options for Replacing Revenues Lost Through Supplemental Payment and CPE Programs

This appendix provides additional information about the two potential options for replacing the revenues lost through supplemental payment and CPE programs, described in Section 7.

Option 1: DSRIP-like Programs

The following table includes examples of outcome- or quality-based programs approved in other states through Section 1115 demonstration waivers, including DSRIP programs.

Example Outcome- or Quality-Based Programs Approved through 1115 Demonstration Waivers

Program Name (Year of Approval)	Program Description
California Public Hospital Redesign and Incentives Program (PRIME) (2016)	• Builds on previous DSRIP program (approved in 2010) – PRIME entities include Designated Public Hospital systems and District/Municipal Public Hospitals – Program provides incentives to accelerate efforts among PRIME entities to change care delivery and strengthen the ability to successfully perform under risk-based alternative payment models[119]
California Global Payment Program (2016)	• Establishes a statewide funding pool for the remaining uninsured in California by combing disproportionate share hospital and uncompensated care funding • Select Designated Public Hospital systems receive payments calculated using a value-based point methodology that incorporates factors to shift the overall delivery of services to more appropriate settings and reinforce structural delivery system changes[120]
New Jersey DSRIP Program (2012)	• Hospitals develop DSRIP Plans that are consistent with the hospital's mission and quality goals and CMS's aims for improving health care through better care for individuals, better health for the population and lower cost through improvement[121] • DSRIP payments are not considered direct payments for services but "are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations and reducing per capita costs of health care"[122]
New York DSRIP Program (2014)	• Created DSRIP program for hospital and non-hospital safety net providers • Providers may select from projects focusing on system transformation and clinical and population-wide improvements, and receive incentive payments for meeting milestones and improvement goals

[119] California Medi-Cal 2020 Demonstration (11-W-00193/9). Demonstration Approval Period: December 30, 2015 through December 31, 2020.
[120] California Medi-Cal 2020 Demonstration (11-W-00193/9). Demonstration Approval Period: December 30, 2015 through December 31, 2020.
[121] New Jersey Comprehensive Waiver Demonstration (11-W-00279/2). Demonstration Approval Period: October 1, 2012 through June 30, 2017.
[122] New Jersey Comprehensive Waiver Demonstration (11-W-00279/2). Demonstration Approval Period: October 1, 2012 through June 30, 2017.

Program Name (Year of Approval)	Program Description
	• Program's objective is reducing avoidable hospital use by 25 percent over five years
Texas DSRIP Program (2011)	• CMS approved using UPL supplemental payments (along with DSH payments and managed care savings) to fund an uncompensated care pool and a DSRIP pool to incentivize improvements in service delivery • DSRIP program open to virtually all Medicaid providers, including community mental health centers, physicians, and local health departments[123] • DSRIP payments contingent on demonstrated improvements in care coordination and quality based on predefined metrics[124]

Option 2: Development of Enhanced Rates

We provide below an analysis of the impact of an enhanced rate on the current MCO program (with no MCO expansion) and the impact under each MCO expansion scenario for inpatient services for the county-owned hospitals. This impact assumes utilization and expenditures as seen in the current MCO program.

Summary of Impact of Enhanced Rate for County-Owned Hospitals

Scenario	Estimated Payment Per Discharge[125]	MCO Discharges[126]	Estimated Payments[127]	Current Payments from MCOs[128]	Increased Payments to Providers from MCOs[129]
No MCO expansion	$14,416.05	4,907	$70,739,557	$27,029,536	$43,710,021
Scenario 1	$14,416.05	8,834	$127,351,386	$48,660,877	$78,690,509
Scenario 2	$14,416.05	10,011	$144,319,077	$55,144,219	$89,174,858
Scenario 3	$14,416.05	10,635	$153,314,692	$58,581,438	$94,733,254

This analysis indicates that the county-owned hospitals will receive an increase in payments from MCOs due to the enhanced rate. To illustrate the ability to reduce the impact of lost supplemental payments to the providers by adopting an enhanced rate, the following table

[123] MACPAC. (June 2015). *Using Medicaid Supplemental Payments to Drive Delivery System Reform.* Retrieved from: https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf.
[124] MACPAC. (November 2012). *Medicaid UPL Supplemental Payments*. Retrieved from: https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-UPL-Payments_2012-11.pdf.
[125] "Estimated Payment per Discharge" is calculated using the total inpatient UPL less Indigent Accident Fund payments and direct graduate medical education payments divided by total discharges.
[126] "MCO Discharges" under Scenario 1 through Scenario 3 include the current discharges paid by MCOs plus the discharges that would be transferred from FFS to MCO under the particular scenario.
[127] "Estimated Payments" are the estimated payment per discharge multiplied by the MCO discharges under each scenario.
[128] "Current Payments from MCOs" for the current MCO program is determined from data obtained from Milliman for the reported MCO discharges. "Current Payments from MCOs" for Scenario 1 through Scenario 3 is calculated as the payment per discharge under the current MCO program ($5,508.36) multiplied by the MCO discharges for the scenario.
[129] "Increased Payments to Providers from MCOs" is the difference between the "Estimated Payments" and "Current Payments from MCOs" columns and represents the increase in MCO payments due to the enhanced rates.

below shows that the county-owned hospitals would be able to maintain or increase the revenues from Medicaid recipients regardless of the MCO expansion scenario.

Summary of Impact of Enhanced Rate for County-Owned Hospitals, Considering Adjusted Supplemental Payments

Scenario	Adjusted Supplemental Payments[130]	UPL Supplemental Payments (Current MCO Program with No MCO Expansion)[131]	Variance[132]	Increased Payments to Providers from MCOs[133]	Adjusted Variance After Enhanced Payments to Providers from MCOs[134]
No MCO Expansion	$59,043,184	$59,043,184	$0	$43,710,021	$43,710,021
Scenario 1	$28,967,382	$59,043,184	($30,075,802)	$78,690,509	$48,614,707
Scenario 2	$17,489,520	$59,043,184	($41,553,664)	$89,174,858	$47,621,194
Scenario 3	$16,010,656	$59,043,184	($43,032,528)	$94,733,254	$51,700,726

The calculations in two above tables are the aggregate amount for the entire class of county-owned hospitals. Additionally, we used calculations per discharge for illustration purposes only; to be more precise, it is necessary to calculate hospital- specific enhanced rates using the current per diem methodologies outlined in Attachment 4.19-A of the Nevada Medicaid State Plan.

As discussed in Section 7, an enhanced rate methodology could be applied to private hospitals if a source of non-federal share of matching funds could be identified. One option is the creation of a healthcare related tax for private hospitals to fund the non-federal share of the enhanced payment. Several states have established a provider tax for private hospitals only. These include the following:

Examples of States with Healthcare Related Taxes on Private Hospitals Only

State	Private Hospital Tax	Governmental Hospital Mechanism
Alabama	Privately owned and operated hospitals in the State of Alabama have an assessment imposed at 5.50 percent of net patient revenue based on hospitals 2011 fiscal year. The Alabama Health Care Trust Fund is the depository fund for these taxes and	Code of Alabama §40-26B-77.1 details the intergovernmental transfer program for governmentally owned and operated hospitals as follows: "Intergovernmental transfers to the Medicaid Agency.

[130] "Adjusted Supplemental Payments" equals the "UPL Supplemental Payments (Current MCO Program with No MCO Expansion)" column less the reduction in UPL supplemental payments for each MCO expansion scenario.
[131] "UPL Supplemental Payments (Current MCO Program with No MCO Expansion)" equals the UPL less Indigent Accident Fund payments and direct graduate medical education payments under the current MCO program with no MCO expansion.
[132] "Variance" equals the difference between the "UPL Supplemental Payments (Current MCO Program with No MCO Expansion)" column and the "Adjusted Supplemental Payments" column.
[133] "Increased Payments to Providers from MCOs" is the increase in MCO payments to providers.
[134] "Adjusted Variance After Enhanced Payments to Providers from MCOs" is the "Increased Payments to Providers from MCOs" column less the "Variance" column and adjusts the increased MCO payments for the reduction in the UPL supplemental payments.

State	Private Hospital Tax	Governmental Hospital Mechanism
	payments from this fund must be used as follows: • To make inpatient and outpatient private hospital access payments • To reimburse moneys collected by the department from hospitals through error or mistake[135]	(a) Beginning on October 1, 2013, publicly owned and state-owned hospitals will begin making intergovernmental transfers to the Medicaid Agency. The amount of these intergovernmental transfers shall be calculated by the Medicaid Agency to equal the amount of state funds necessary for the agency to obtain only those federal matching funds necessary to pay state-owned and public hospitals for direct inpatient and outpatient care and to pay state-owned and public hospital inpatient and outpatient access payments. (b) These intergovernmental transfers shall be made in compliance with 42 U.S.C. §1396b(w).”
California	The California Hospital Assurance Fee provides funding to privately owned and operated hospitals for supplemental payments under Medicaid FFS and to increase capitation rates to Medicaid MCOs for increased reimbursement rates for privately owned and operated hospitals.[136] Exempted hospitals for the tax include public hospitals;[137] a tax-exempt non-profit hospital licensed to and owned by a local health district; a hospital designated as a specialty hospital that is not a hospital in the Charitable Research hospital group; a long-term acute care hospital per Medicare guidelines; and a small and rural hospital as specified in Section 124840 of the Health and Safety Code.[138]	Public hospitals in California are divided into designated hospitals and non-designated hospitals. Non-designated hospitals participate in the Non-designated Public Hospital Intergovernmental Transfer Pool (Non-designated Public Hospital IGT Pool). This pool “shall be calculated based on the room under the federal UPL in the category of Non-State Government Owned Hospitals (Inpatient) which the department has determined is both attributable to the non-designated public hospitals.”[139] As part of this program, the State of California retains “9 percent of each IGT amount to reimburse the department, or transfer to the General Fund, for the administrative costs of operating the Non-designated Public Hospital Intergovernmental Transfer Program and for the benefit of Medi-Cal children's health care programs.”[140]

[135] Code of Alabama §40-26B
[136] Per California Welfare and Institutions Code §14169.53, additional uses of funds from the Hospital Quality Assurance Revenue Fund include administrative expenses for administering the program and healthcare coverage for children.
[137] California Welfare and Institutions Code §14105.98(a)(25) defines a public hospital as the following: “licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.”
[138] California Welfare and Institutions Code §14169.51(l)
[139] California Welfare and Institutions Code §14165.55(m)
[140] California Welfare and Institutions Code §14165.57(j))

State	Private Hospital Tax	Governmental Hospital Mechanism
Wyoming	Privately owned and operated hospitals pay an assessment fee determined by Wyoming Department of Health "on a prospective basis and shall be based on the percentage of net hospital patient revenue needed to generate an amount not to exceed the nonfederal portion of the upper payment limit gap plus" a 1 percent administrative expense to the department for administering the program.[141]	Governmentally owned and operated hospitals participate in the Qualified Rate Adjustment (QRA) Program and the Secretary of the Department of Health has authority under Wyoming Statute §42-4-104(b)(ix) to "[e]nter into intergovernmental transfer arrangements with qualifying facilities in which all federal funding received as a result of the intergovernmental transfer arrangements shall be distributed to participating facilities."

[141] Wyoming Statute §42-9-104(b)