From:	Warner, Kathy
To:	solicitation.questions
Cc:	Zayic, Garret; Gortner, Justin; Bonomo, Melody; McGlashen, Jenalynne
Subject:	AmeriHealth Caritas Florida Response to RFI 014-21/22
Date:	Thursday, June 2, 2022 10:59:44 AM
Attachments:	AmeriHealth Caritas Florida 2022 FL MMC RFI Response.docx

Good Morning Cody Massa:

On behalf of AmeriHealth Caritas Florida, Inc. (AmeriHealth Caritas Florida), I am pleased to submit our responses to select topics from the Agency for Health Care Administration's (AHCA) Request for Information 014-21/22 Re-Procurement of the SMMC Program.

We appreciate the opportunity to provide comments to AHCA and would welcome an opportunity to further discuss any of our responses or additional topics.

Thank you,

Kathy Warner

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II. RFI Response Instructions

A. The Respondent's name; place of business address(s); web site address, if applicable; and contact information, including representative name and alternate, with telephone number(s) and e-mail address(es).

Contact Information

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Promoting Economic Self-Sufficiency

Leverage the managed care delivery system, either through expanded benefits or other mechanisms, to promote sustainable economic self-sufficiency among Medicaid recipients in the short and long term.

AmeriHealth Caritas Florida supports the Florida Agency for Health Care Administration's (AHCA's) goal of promoting sustainable economic self-sufficiency among Medicaid recipients in the short and long term. As states across the country increasingly leverage the managed care delivery system to address social determinants of health (SDOH) impacting economic self-sufficiency, innovations and best practices are emerging. We have identified several promising approaches based on our experience in Florida and the experience of our affiliate Medicaid health plans in several other states.

Behavioral Health and Supportive Housing Assistance Pilot

In Florida, we are aware that the Behavioral Health and Supportive Housing Assistance Pilot in Regions 5 and 7 has produced early data that demonstrates assistance to Medicaid recipients with serious mental illness (SMI) and/or substance use disorder (SUD) and who are experiencing or at risk of homelessness. Expanding this program Statewide could help additional eligible Medicaid recipients access housing support services that help promote independence and economic self-sufficiency.

Cross-Agency Collaboration

There is also an opportunity for AHCA to work collaboratively across agencies and funding sources to address SDOH that impact economic self-sufficiency. For example, federal Family First Prevention Services Act funding can help children who are at risk of out-of-home placements remain with their families by providing services such as those related to mental health, SUD treatment, and parenting skills. These services can help stabilize and strengthen families and bolster their efforts for achieving economic self-sufficiency.

Healthy Opportunities Pilots

North Carolina's Healthy Opportunities Pilots is a promising model that Florida could consider adopting. In certain geographic regions of North Carolina, the North Carolina Department of Health and Human

Services procured contracts with entities known as Network Leads that assemble networks of human services organizations to deliver reimbursable Medicaid services in four domains to high-need Medicaid recipients meeting certain eligibility criteria. The four domains are housing, transportation, food insecurity, and interpersonal violence/toxic stress. This program operates under a CMS 1115 waiver and is intended to improve outcomes and reduce costs.

Helping Enrollees Access SNAP Benefits

In recognition of the importance of SNAP in improving food security and helping to keep families out of poverty, AmeriHealth Caritas Florida would like to share the experience of our affiliate Medicaid health plans in Pennsylvania, which receive a file with SNAP eligibility and enrollee information from the State to help facilitate access to this program for our enrollees. Our affiliate Pennsylvania Medicaid health plans use this information to help ensure enrollees connect to this important benefit.

Improving Birth Outcomes for Pregnant Enrollees and Infants

Improve birth outcomes for mothers and infants through and beyond 12-month postpartum coverage period.

We are encouraged by AHCA's continued focus on improving birth outcomes for pregnant enrollees and infants. AmeriHealth Caritas Florida's recommendation to help further improve birth outcomes for pregnant enrollees and infants is for AHCA to cover doula services under the standard benefit. With maternal morbidity and mortality continuing to be a major challenge, especially in certain regions and among Black women, states must consider more effective ways to deliver support services to pregnant Medicaid enrollees to create better health outcomes. Doula care is among the most promising approaches to supporting pregnant enrollees and infants. People receiving doula care have been found to have improved health outcomes for both themselves and their infants, including higher breastfeeding initiation rates, fewer low birth weight babies, and lower rates of cesarean births. Doulas can also help reduce disparities in health care for pregnant enrollees by providing individually tailored, culturally appropriate, and patient-centered care and advocacy. A doula's presence in the delivery room has been reported to combat disparities in maternal health and birth outcomes. Establishing doula services as a standard covered benefit, with a coverage policy and standardized fee schedule that includes codes and rates, would contribute to the development of a full doula provider network for enrollees to access.

Utilizing Value-Based Payment

Utilize value-based payment designs to simultaneously increase quality and reduce costs.

AmeriHealth Caritas Florida leverages value-based care to increase quality and reduce costs, while aligning with AHCA's priorities and promoting provider collaboration. Our activities to build a stronger foundation for value-based programs have proven effective in Florida. We believe there is greater opportunity to advance the adoption of value-based payment, and we encourage AHCA continue to support provider and health system participation whenever possible. Based on the experience of our affiliated Medicaid health plans in other states, provider and health system engagement increases when state Medicaid agencies encourage collaborative value-based payment design and implementation.

Maximizing Home and Community-Based Services

Maximize home and community-based placement and services through proactive aging-in-place strategies.

AmeriHealth Caritas Florida takes a holistic view of the medical and non-medical needs of our enrollees, and we support efforts that emphasize health, wellness, and prevention; help enrollees make

community connections and access peer-to-peer supports to help change health behaviors; and enable enrollees to age independently and according to their priorities. We have identified the following aging-in-place strategies as opportunities for AHCA to advance its goal of maximizing home and community-based placement and services:

- **Support caregivers** — Develop resources to support local and long-distance family caregivers, offer workplace solutions for employed caregivers, and support older adults without family caregivers. Caregiver support can also include caregiver respite and training. Working with family caregivers and other caregivers to help ensure Medicaid enrollees with increasing needs have the opportunity to remain in their homes and communities can also be an important strategy. This may include working with assisted living facilities as part of care transitions or implementing a diversion strategy to help enrollees avoid a stay in a more restricted or institutional setting.
- **Leverage technology enhancements to support independent living** — Maximize smart home technology and remote monitoring to support Medicaid enrollees' ability to remain independent in their homes.
- **Home-based interventions/diversion programs** — Embrace programs that offer services and supports in the home setting that help enable Medicaid enrollees with complex needs to avoid or delay the need for an institutional setting and/or to assist with the transition from an institutional setting to the home. Examples may include Medicaid MCO collaborations with home care and Personal Assistance Services agencies to monitor changes in medical condition so proactive intervention can take place prior to the enrollee needing a higher level of care or suffering declines; to assign care team members at high volume acute care facilities to identify at-risk enrollees and assist in transitioning them to home; and to redirect plans of care so that enrollees can receive support in their home through, for example, a house call program.
- **Create coalitions/partnerships with county-based organizations and safety net programs** — Implement comprehensive reach and integrated data exchange and communications systems with medical home and social service system.
- **Align incentives** — Coordinate among all providers of quality care to the extent possible to align incentives to support enrollees in their homes and communities of choice.
- **Address workforce challenges** — Work with applicable State agencies and the Florida Legislature to create and support programs to educate and train the future workforce, incentivize caregivers, and improve person-centered care. Strategies that show promise in other markets where our affiliated Medicaid health plans operate include adding incentives for mentoring, utilizing career ladder programs in long-term care programs, and training and certifying family caregivers as certified nursing assistants across licensure types.

Additionally, data analytics such as clinical profiling and stratification can identify enrollees whose patterns of clinical diagnoses, utilization, functional limitations, and changes in key social factors suggest they could have emerging long-term services and supports (LTSS) needs. Additional mechanisms for identification may include enrollee assessments, hospital discharge data, provider referrals, and enrollee or caregiver self-referrals. By monitoring this type of information, we can proactively identify and support enrollees with health, wellness, or other prevention strategies. AHCA could help support this effort by making applicable data available to the health plans from Area Agencies on Aging and other social service agencies.

Improving Dental and Primary Care Integration

Improve integration of dental and primary care services for children and adolescents.

To improve integration of dental and primary care services, AmeriHealth Caritas Florida supports including carved-in dental services as part of the Statewide Medicaid Managed Care (SMMC) Program, should that option become available. We believe the best approach to this issue is fully integrating dental benefits with other Medicaid benefits managed by the Medicaid MCO in conjunction with physical and behavioral health benefits.

Aligning Quality and Outcomes With the Florida State Health Improvement Plan

Align quality metrics and outcomes with the Florida State Health Improvement Plan.

AmeriHealth Caritas Florida supports AHCA efforts to align quality metrics and outcomes with several areas of particular concern identified in the Florida State Health Improvement Plan (SHIP). We suggest AHCA continue using NCQA's proven measures when possible. A strategy based on key measures with national benchmarks allows MCOs to synchronize efforts with NCQA accreditation requirements and apply greater focus on sustained improvements over time. Additionally, rather than aligning with all SHIP priorities, we recommend focusing on the specific goals and outcomes for the following priorities:

- Chronic Disease and Conditions.
- Maternal and Child Health.
- Mental Well-Being and Substance Use Disorders.
- Transmissible and Emerging Disease.

We believe the recommendations provided in the Recommended Quality Measures to Align With Select SHIP Objectives and Goals table would have the greatest positive impact on Floridian Medicaid enrollees' overall health.

Recommended Quality Measures to Align With Select SHIP Objectives and Goals

SHIP Objective	HEDIS® Measures	State-Specific Measure/PIP
SHIP Goal: Reduce new cases of cancer and cancer-related illness, disability, and death.		
Increase the percentage of Floridians aged 45 to 75 years old who have fully met the USPSTF recommendation for colorectal cancer screening from 70.4% to 80% or higher.	Colorectal Cancer Screening (COL).	N/A.
Reduce the percentage of late-stage breast cancer diagnoses from 43% to 30% among African American women.	Breast Cancer Screening (BCS).	N/A.
Increase percentage of Florida's youth who are up to date with the HPV vaccination series from 51.6% to 80%.	Adolescent Immunizations (IMA).	N/A.
SHIP Goal: Improve cardiovascular health by reducing new cases, disability, and death from heart disease, stroke, and other related illnesses.		
Increase enrollment of Floridians in hypertension self-management programs from 24% to 84%.	• Controlling Blood Pressure (CBP). • Statin Therapy for Patients With Cardiovascular Disease (SPC) - Received Statin Therapy.	N/A.

SHIP Objective	HEDIS® Measures	State-Specific Measure/PIP
SHIP Goal: Reduce the burden of diabetes and improve quality of life for all who have or are at risk for diabetes.		
Reduce hospitalizations from diabetes and its complications from 2,314 per 100,000 population to less than 2,000 per 100,000 population.	• CDC - HbA1c Control <8. • CDC - Eye Exam. • Kidney Health Evaluation for Patients with Diabetes (KED). • Statin Therapy for Patients with Diabetes (SPD) - Received Statin Therapy.	N/A.
SHIP Goal: Improve respiratory health.		
Reduce the number of childhood asthma-related emergency room visits from 38,808 to 25,704.	Asthma Medication Ratio (AMR).	Potentially Preventable Events (PPE).
SHIP Goal: Promote the attainment and maintenance of health through nutrition, physical activity and supportive lifestyle behaviors.		
N/A.	• WCC – BMI. • WCC – Counseling for Physical Activity. • Counseling for Nutrition. • Controlling Blood Pressure (CBP).	N/A.
SHIP Goal: Increase access to quality primary, preventative, and subspecialty care for infants, children, and adolescents.		
Increase the percent of children and adolescents ages 3-17 years, with a mental/behavioral health condition who received treatment from 45.4% to 50.0%.	• Well child Visits (WCV). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH). • Follow-Up With Children Prescribed ADHD Medication (ADD).	N/A.
SHIP Goal: Reduce infant morbidity and mortality.		
Reduce the hospital average length of stay for infants diagnosed with neonatal abstinence syndrome (NAS) by 15% from 14.0 days to 11.9 days.	Prenatal and Postpartum (PPC).	NAS measure.
Reduce the Black infant mortality rate by 10% from 10.7 per 1,000 live births in 2020 to 9.6.	Prenatal and Postpartum (PPC).	Birth Outcomes PIP Measures (NAS, Pre-Term, and C-Section).

SHIP Objective	HEDIS® Measures	State-Specific Measure/PIP
SHIP Goal: Reduce maternal morbidity and mortality.		
Reduce the pregnancy-related mortality rate by 10% from 20.9 per 100,000 live births to 18.8.	Prenatal and Postpartum (PPC).	N/A.
Increase the percent of mothers with Medicaid who attend a postpartum care visit with a health care provider from 7 to 84 days after delivery by 10.5% from 72.4% to 80.0%.	Prenatal and Postpartum (PPC).	N/A.
SHIP Goal: Improve preconception and interconception health.		
N/A.	• Well child Visits (WCV). • Prenatal and Postpartum (PPC). • Chlamydia Screening (CHL).	Birth Outcomes PIP Measures (NAS, Pre-Term, and C-Section).
SHIP Goal: Reduce the impact of the adult mental, emotional and behavioral health disorders.		
Reduce the rate of hospitalizations attributable to mental disorders for adults 18 years and older from 1009.2 per 100,000 to 908.3 per 100,000.	• Adult Access to Preventative Care (AAP). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH).	Potentially Preventable Events (PPE).
Reduce the percentage of adults ages 18 years and older who had poor mental health on 14 or more of the past 30 days from 12.3% to 9.2%.	• Adult Access to Preventative Care (AAP). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH). • Identification of Alcohol and Other Drug Services (IAD).	N/A.
Decrease the number of adults 18 years and older with involuntary examinations (Baker Act) from 173,119 to 121,183.	• Adult Access to Preventative Care (AAP). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH).	N/A.

SHIP Objective	HEDIS® Measures	State-Specific Measure/PIP
SHIP Goal: Reduce the impact of pediatric mental, emotional, and behavioral health disorders.		
Reduce the number of children under age 18 with involuntary examinations (Baker Act) from 37,873 to 26,511 (30%).	• Well child Visits (WCV). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH).	N/A.
Reduce the percentage of students who feel sad or hopeless over the last two weeks from 34.3% to 29.6%.	• Well child Visits (WCV). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH).	N/A.
Increase the percentage of children 3–17 years old with a mental/behavioral condition who receive treatment or counseling from 45% to 55%.	• Well child Visits (WCV). • Follow-Up After Hospitalization for Mental Illness (FUH).	N/A.
SHIP Goal: Reduce substance use disorders and drug overdose deaths.		
Reduce inhaled nicotine prevalence in Florida youth aged 11–17 years from 14.4% to 11.1%.	Well child Visits (WCV).	N/A.
Reduce inhaled nicotine prevalence in adults from 23.4% to 19.3%.	Medical assistance with smoking and tobacco use cessation.	N/A.
Reduce deaths caused by opioid overdose from 29.9 per 100,000 to 15 per 100,000.	• Pharmacotherapy for Opioid Use Disorder (POD). • Risk of Continued Opioid Use (COU). • Use of Opioids from Multiple Providers (UOP). • Use of Opioids at High Dosage (HDO).	N/A.
SHIP Goal: Reduce suicide behaviors and deaths.		
Reduce the number of high school students who indicate they have attempted suicide from 7.9% to 5.4%.	• Well child Visits (WCV). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH).	N/A.
Decrease the rate of suicide deaths for adults 65 and older from 19.1 per 100,000 to 15.5 per 100,000.	• Adult Access to Preventative Care (AAP). • Follow-Up After Emergency Department Visit for Mental Illness (FUM). • Follow-Up After Hospitalization for Mental Illness (FUH).	N/A.
SHIP Goal: Reduce STI infection rates.		
Reduce the rate of chlamydia among females 15–24 years of age by 3% from 3,545.3 per 100,000 to 3,440.4 per 100,000.	Chlamydia Screening (CHL).	N/A.

SHIP Objective	HEDIS® Measures	State-Specific Measure/PIP
SHIP Goal: Reduce vaccine-preventable deaths across the lifespan for all people.		
Increase the percent of infants born in the State of Florida who receive their first dose of Hepatitis B vaccine within one day after birth by 16.4% from 48.6% to 65.0%.	Childhood Immunization Status (CIS).	N/A.
Increase the percent of children ages 9–13 years who receive their first dose of HPV vaccine by 13.2% from 31.8% to 45.0%.	Adolescent Immunizations (IMA).	N/A.

Improving Medicare and Medicaid Programs Coordination of Care

Improve coordination of care for individuals enrolled in both the Medicare and Medicaid programs.

AmeriHealth Caritas Florida supports integrated models as an approach to improve care coordination for individuals enrolled in both the Medicare and Medicaid programs. Our affiliate health plans serve the dual eligible population in Pennsylvania, South Carolina, and Michigan, and provide LTSS in Delaware, North Carolina, and Pennsylvania. Based on the experience of our affiliate health plan in Pennsylvania, the largest managed long-term services and supports (MLTSS) health plan in that state aligned with statewide Dual Eligible Special Needs Plans (D-SNPs), we can offer several best practices integral to achieving enhanced coordination between Medicare and Medicaid for the dual eligible population. These best practices include:

- **Integration Approaches with D-SNPs (aligned and non-aligned)** — MLTSS plans have opportunities to integrate/coordinate whether a member is enrolled in an MCO's companion D-SNP, Medicare Fee for Service, or a D-SNP operated by another health plan. For enrollees in an aligned D-SNP, a single, integrated care team between the D-SNP and MLTSS plans can help ensure greater and more effective coordination of care, including arrangement and delivery of Medicaid and Medicare services, with special attention to transitions in care, caregiver participation, and a focus on SDOH. When working with enrollees who are in Medicare fee-for-service or a D-SNP operated by another health plan, data exchanges that support care coordination help to ensure that benefits are being managed holistically. For example, for the purpose of coordinating Medicare- and Medicaid-covered services between settings of care, the D-SNPs currently notify the MLTSS plan of hospital admissions for at least one group of high-risk, full-benefit dual eligibles.
- **Information Sharing** — Robust data sharing in a unified IT platform is essential to supporting care in a holistic way, sharing comprehensive information with the multidisciplinary care team in order to make well-informed decisions and plans and to report data to the Medicaid agency.
- **Default Enrollment** — Where aligned D-SNPs exist, enrollment and assignment processes can steer enrollees to benefit configurations that allow for higher levels of integration. For example, Pennsylvania sought and received approval from CMS for continued passive enrollment or seamless conversion of Medicaid-managed care members that has allowed dual eligibles to enter into a Medicaid MCO's companion D-SNP when they become Medicare eligible (i.e., at age 65). Passive enrollment has helped ensure a smooth transition from Medicaid-only coverage to highly integrated coverage for the dual eligible population and enabled greater continuity of care and support for enrollees.

Improving Provider Experience

Improve providers' experience with the SMMC Program.

AmeriHealth Caritas Florida recommends that AHCA consider removing the primary care provider (PCP) site visit requirements, a change that NCQA and several other state Medicaid agencies have made in

recent years. Removing the PCP site visit requirement alleviates duplicative site visits and mitigates administrative burden for primary care practices. PCPs are struggling to maintain clinical staffing and are becoming more hesitant to participate with multiple MCOs due to the site visit requirement for every location, every three years, by every health plan. With the removal of the PCP site visit requirements, resources allocated for site visits could be shifted to focus on PCP quality and preventive care services that positively impact outcomes for Medicaid enrollees.

Another opportunity to improve providers' experience relates to current requirements around the administration of provider satisfaction surveys. While the decision to standardize both the template and timeline for release across all MCOs as a means of easing administrative burden for providers is sensible, it has led to some unexpected consequences. In particular, we have noticed a softening of the provider response rate to these surveys. We believe part of the issue is that providers are receiving numerous, near-identical surveys from multiple Medicaid MCOs at the same time, which creates a scenario where it is easy for them to miss responding to all the survey requests received and where they may unintentionally ignore surveys from all Medicaid MCOs as they appear duplicative. To help address this issue, we encourage AHCA to allow Medicaid MCOs the ability to determine when to administer the provider survey (e.g., staggered release dates) to improve response rates and the quality of provider feedback.

Improving Member Experience

Improve recipients' experience with the SMMC Program.

AmeriHealth Caritas Florida believes there are opportunities to improve administrative processes that would meaningfully impact enrollee experience with the SMMC Program. Today, many of our enrollees prefer digital methods of communication (e.g., email, text messaging). We recommend that AHCA facilitates the review of the Medicaid enrollment process to include the ability for Medicaid MCOs to contact enrollees digitally at the point they apply for benefits. This information could then be shared with health plans via the enrollment file. Incorporating the opt-in language in the enrollment process would remove a barrier that impedes Medicaid MCOs' ability to contact and educate enrollees on available benefits and programs to support them along their health journey. Effective communication with enrollees using their preferred method is vital to successful engagement and improved enrollee experience. AmeriHealth Caritas Florida would welcome the opportunity to collaborate with AHCA and the Department of Children and Families (DCF) to develop this opportunity for Medicaid enrollees. We believe that a greater ability to contact enrollees through digital methods would have a significant positive impact on multiple initiatives that benefit enrollees.

Increasing Timely Access to Providers and Services

Increase timely access to providers and services.

AmeriHealth Caritas Florida supports implementing tools and strategies to improve timely access to providers and services. Specifically, we strongly encourage the continuation of telehealth flexibilities permitted during the COVID-19 public health emergency that expand the types of providers who can deliver telehealth and the types of services that can be delivered via telehealth. These flexibilities maintain and increase access to care where clinically appropriate, and we have observed providers integrate telehealth into practice workflows as an additional site of care. Telehealth also reduces the barriers to access care such as transportation, travel time to and from a provider's office and childcare arrangements. Moreover, telehealth improves access to care in rural and other areas with limited

provider availability. We encourage AHCA to continue to promote the use of telehealth as it becomes fully integrated into the care delivery system.

Achieving Cost Savings

Achieve cost savings throughout the SMMC Program.

AmeriHealth Caritas Florida has identified several opportunities for AHCA to reduce administrative burden for MCOs, providers, and itself, which in turn could help achieve cost savings. These opportunities include:

- **Partner With DCF and MCOs to Address Data Integrity of Enrollee Contact Information** — The MCOs cannot adequately and consistently deliver benefits, services, and programming to enrollees if MCOs cannot effectively contact enrollees. There is significant waste of financial resources and time as well as lost opportunity associated with failed attempts to contact enrollees that is caused by inaccurate enrollee contact information. By improving the accuracy of enrollee contact information, MCOs can improve communication with enrollees.
- **Streamline Monitoring and Oversight to Avoid Duplication of Efforts** — Opportunities for AHCA to increase efficiency and better avoid duplication of efforts with other entities include: no longer monitoring requirements that are also monitored by NCQA through their accreditation process; revise the approval requirements for subcontractors by only requiring approval of vendors who perform clinical services or have enrollee-facing functions; review only the base provider contract templates for approval; reduce the frequency of AHCA reviews of provider waivers from monthly to quarterly.
- **Minimize Provider Abrasion by Removing Burdensome Site Visit Requirements** — To reduce the burden on providers, we suggest that provider site visits for every PCP at each location, every three years, be eliminated. Other states have removed this requirement from their Medicaid program, as it creates an undue administrative burden on the provider offices who must accommodate this request from every plan with whom they contract.
- **Clarify When Fee Schedules Are Administered** — We appreciate the option and benefit of utilizing AHCA's standardized Medicaid Fee Schedules. To help mitigate confusion for providers, AHCA should consider adding clarifying information when drafting Fee Schedules that explains when they will go into effect so providers can easily see that information and set their expectations accordingly.