From:	Proposal Development Inbox
To:	solicitation.questions
Cc:	Proposal Development Inbox; Brutsman, Debby
Subject:	CareSource Response to Request for Information (RFI) 014-21/22
Date:	Thursday, June 2, 2022 7:31:47 PM
Attachments:	FL AHCA_RFI 014-21-22 MMC_CareSource.docx FL AHCA_RFI 014-21-22 MMC_CareSource_Redacted.docx
Importance:	High

Mr. Massa,

CareSource is pleased to submit its response to the Agency's RFI 014-21/22 Re-Procurement of the Statewide Medicaid Managed Care Program.

Per the RFI instructions, CareSource is submitting one (1) electronic copy of our response and one (1) redacted, electronic copy of our response. The redacted response is marked as the "redacted" copy and also contains a transmittal letter authorizing release of the redacted version of our response in the event the Agency receives a public records request.

Please confirm receipt of this email at your earliest convenience. Should you have any questions or concerns, you can contact me directly at debra.brutsman@caresource.com. You may also email our Proposal Development inbox at proposaldevelopmentinbox@caresource.com which is monitored by our Proposal Development team.

Kind regards,

Debby Brutsman
AVP, Proposal Strategy

CareSource

230 N. Main Street Dayton, Ohio 45402
937.224.3300 | CareSource.com
c: 480.652.2878
debra.brutsman@CareSource.com

entities. Thank you.

Transmittal Letter

June 2, 2022

Cody Massa
Procurement Officer
State of Florida Agency for Health Care Administration
solicitation.questions@ahca.myflorida.com

Re: Request for Information (RFI) 014-21/22 Re-procurement of the Statewide Medicaid Managed Care Program

Mr. Massa:

CareSource appreciates the opportunity to submit this redacted response to the Florida Agency for Health Care Administration (Agency) Request for Information 014-21/22 Re-Procurement of the Statewide Medicaid Managed Care (SMMC) Program.

Per the RFI instructions and Chapter 119, Florida Statutes, CareSource has redacted and clearly marked all trade secret information contained in our RFI response. CareSource authorizes the Agency to release the redacted copy in the event the Agency receives a public records request.

Sincerely,

Debby Brutsman

Debby Brutsman
AVP, Proposal Strategy

Introduction

CareSource is pleased to submit this response to the Florida Agency for Health Care Administration (Agency) Request for Information 014-21/22 Re-Procurement of the Statewide Medicaid Managed Care (SMMC) Program. CareSource has the experience and proven approach to successfully deliver managed health and long-term care. Our established best practices and innovative business and service delivery programs assure Medicaid recipients receive equitable access to the diverse services they need.

CareSource is a nationally recognized, nonprofit, managed care organization (MCO) with more than 30 years of Medicaid managed care experience, a unique recipient-centric focus, and an established reputation as a leader in quality and operational excellence. Additionally, through The Columbus Organization (Columbus), a member of the CareSource family of companies, we have been a part of improving the quality of services offered to Floridians with intellectual disabilities through the provision of waiver support coordination services since 2019. We are currently serving individuals on the Consumer Directed Care and Home and Community Based Waivers in the Northwest, Northeast, Central, Suncoast, Southeast, and Southern Regions. We serve more than 2.2 million recipients across all of our lines of business in 10 states (Arkansas, Delaware, Florida, Georgia, Indiana, Kentucky, New Jersey, Ohio, South Carolina and West Virginia). Our experience includes Temporary Assistance to Needy Families; Children's Health Insurance Plan; Long Term Services and Supports (LTSS); Dual Eligible Special Needs Plans; Medicare Advantage; Medicare-Medicaid Plan (MMP) Demonstrations; Ohio Home Care Waiver; Ohio Specialized Recovery Services (SRS) program; re-entry programs in Indiana and Ohio; waiver support care coordination programs in Florida, Arkansas, Delaware, Georgia, Indiana, Kentucky, New Jersey, Ohio, South Carolina, and West Virginia; and other specialty programs.

II.A Respondent's Information

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).

Agency Requirement	Response
Respondent's Name	CareSource
Place of Business Address	230 N. Main St. Dayton, Ohio 45402
Web Site Address	https://www.caresource.com/
Point of Contact Name, Number, and Email	Debby Brutsman, AVP, Proposal Strategy (480) 652-2878 debra.brutsman@caresource.com or proposaldevelopmentinbox@caresource.com
Alternate Point of Contact Name, Number, and Email	Adam Beam, VP, Business Development (502) 724-3410 adam.beam@caresource.com or proposaldevelopmentinbox@caresource.com

II.B Description of Approach

A description of how the Respondent's approach will offer advantages or improvements over existing processes of the SMMC Program. The description should also identify known or potential concerns with the approach.

In the following response, we share innovative solutions and best practices for consideration as the Agency develops a scope of services that may be incorporated into the upcoming procurement and/or contract. We focus on the following areas of Agency interest, based on our experience working with state partners in Florida and other states to improve recipient outcomes, decrease readmissions, and assure that every person has the chance to live a life of opportunity, meaning, and value. CareSource has the ability to meet all 16 domains and ready to standby the Agency as a partner but we wanted to focus on these 5 innovations as we believe we offer demonstrative solutions.

- Leveraging 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
- Maximizing home and community-based placement and services through proactive aging-in-place strategies
- Improving integration of dental and primary care services for children and adolescents
- Increasing access to community-based pharmacists within prescription benefit manager networks
- Improving mental health outcomes for children and adolescents

We promote recipient choice and safety, improved health outcomes and access to quality care, and economic self-sufficiency and responsibility. We remove barriers to care and simplify systems so Medicaid recipients can enjoy a full life, achieve social inclusion, and contribute to their communities. Our approach is proven in other markets and our solutions are poised for customization in Florida’s SMMC Program.

Our innovative solutions and best practices also provide meaningful indirect benefits that are aligned with important policy goals:

- Reduction in poverty
- Successful job placement
- Greater individual self-reliance and self-sufficiency
- Improvements in population health—as suggested by a reduction in avoidable health care utilization in high-cost settings and the increase in desirable utilization of lower cost services that foster prevention and better management of chronic conditions

We serve complex and specialized populations with a deep understanding of their priorities and unique needs. We focus on “one recipient at a time,” helping them find the answers they need to address their unique circumstances and achieve maximum self-sufficiency, optimal socioeconomic advancement, and full community inclusion. We provide specialty care management strategies, disease management programs, motivational interviewing, health literacy, consumer education, engagement tools, fully integrated technology platforms, artificial intelligence (AI), peer supports, and tactical approaches that have demonstrated positive outcomes, including innovative, family-centered programs designed to help children with a variety of conditions and needs.

From the beginning, CareSource has been changing the face of health care. As a national leader in managed care, we firmly believe the future of health care will be shaped by those who innovate and drive value for consumers. We achieve strong results by integrating SDOH and other non-clinical factors into every interaction with a recipient and proactively engaging recipients and communities to address barriers.

Innovative Ideas and Best Practices

Managed Care Delivery System

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.

Operational Strategies

To promote sustainable economic self-sufficiency among Medicaid recipients in the short and long term, CareSource recommends expanding benefits to include programs that directly address recipient SDOH, support recipient employment, and improve recipient financial literacy. In our experience, a focus on expanded benefits designed to improve quality of care, promote evidence-based care, and increase healthy behaviors to prevent or treat disease.

CareSource has been an early innovator in designing and implementing programs to address SDOH, such as our CareSource Life Services® program, which eliminates socioeconomic and health equity barriers often experienced by Medicaid recipients. [redacted] We target root causes that create barriers to health and well-being and seek solutions that address food, transportation, housing, employment, education, social connectedness, and access to care.

Studies demonstrate stable employment and socioeconomic status improvement directly correlate to improved health outcomes. Our employment support programs provide in-person and telephonic assistance to chart a pathway for recipients to full-time employment. [redacted]

[redacted]

SDOH challenges, including access to healthy food, contribute to health disparities and have a significant impact on health outcomes and economic self-sufficiency. We recommend offering all recipients, and parents or guardians of recipients, care coordination services to navigate the complexity of systems and help with self-management to the extent feasible for the recipient. We also recommend offering recipients access to social care referral platforms for on-demand access to local community resources. For example, CareSource recipients have the ability to search for organizations like food banks and obtain information in real time for

hours of operation, contact information, eligibility information, distance from the zip code where one lives, and directions to the organization and other locations nearby. [redacted]

Performance Metrics

We recommend measuring the following to assess economic self-sufficiency:

- Number of recipients and parents/caregivers who gain employment
- Recipient engagement
- Completion of the HRS
- Recipient and provider satisfaction
- Emergency department utilization
- Homelessness

Provider Network Requirements

Making progress on core challenges to improve recipient outcomes and community resilience will require concerted action and strategic investments in partnerships with local, regional, and statewide community-based organizations (CBOs). Our approach to addressing recipient SDOH needs includes community reinvestment and strong partnerships with CBOs including contractual incentives to increase collaboration and coordination of efforts in addressing SDOH challenges.

Best Practices for Maximizing Communication and Resources

We recommend encouraging recipients to take full advantage of enhanced benefits and incentives (and how to access them) at every opportunity including through the recipient handbook, a recipient web portal, welcome calls, recipient newsletters, call hold messaging, online messaging, text messaging, provider education, social media, email communications, and recipient-facing community events. Additionally, community health workers, community education representatives, care managers, recipient services representatives, and life coaches provide recipients with information and guidance regarding services useful for their unique circumstances. Depending on the type of service, recipients can enroll on their own or receive assistance from staff to connect with service options to meet their needs.

Implications for Integration with the Agency's FX Project and CMS Interoperability Rule

CareSource appreciates the Agency's work on the FX Project, making health information more easily available to recipients by leveraging a health information exchange platform that provides reliable data and insight related to population health, SDOH, and network and provider performance. We believe an MCO's ability to actively participate in these data sharing initiatives should be an important consideration in future procurements. CareSource is able to leverage our newly established IT interface capabilities created for CMS Interoperability compliance to facilitate the integration with the Agency's FX Project platforms. The integration established will promote sustainable economic self-sufficiency among Medicaid recipients by expanding benefits that include programs to directly address recipient SDOH, improve recipient financial literacy, and support recipient employment improves recipient health outcomes, in line with the Agency's FX Project and CMS Interoperability Rule.

Known or Potential Concerns with the Approach for the SMMC Program

CareSource routinely gathers input from experts in the areas of population health, quality, complex health solutions, finance, actuarial, and SDOH to evaluate our programs and expanded benefits. We also receive

feedback from stakeholders such as Medicaid recipients, community partners, and providers. Based on this feedback, we do not have knowledge of existing or potential concerns related to our approach of expanding benefits that promote sustainable economic self-sufficiency among Medicaid recipients.

Aging-in-Place Strategies

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

CareSource's recommendations related to maximizing home and community-based services (HCBS) through aging-in-place strategies are based on our depth of experience in successful targeted case management and care coordination strategies for complex health and dually eligible populations in Florida and in other states. Our experience includes our leadership, which has depth of experience both inside and outside of managed care doing work within the child welfare system, meeting the needs of individuals with intellectual or developmental disabilities, the Centers for Medicare & Medicaid Services (CMS) initiatives, and a number of advocacy efforts. Additionally, through The Columbus Organization, a part of the CareSource family of companies, we have experience providing targeted and intensive case management services to over 67,000 recipients with complex health needs across 10 states (including Florida, as well as Arkansas, Delaware, Georgia, Indiana, Kentucky, New Jersey, Ohio, South Carolina, and West Virginia). We have also been providing care management services for over 33,000 dual eligible recipients in Ohio through MyCare, a Medicare-Medicaid Plan (MMP) demonstration program through CCMI with a focus on ensuring all dual eligible individuals aged 18 or older have access to HCBS.

We remain steadfast in our commitment to help recipients live and age in their environment of choice. Nursing home transition and diversion programs have become an important part of our rebalancing efforts, using our best practice model of combining medical management and care management with a post-acute team led by a recognized leader in post-acute care. Our focus is on meeting recipients' needs, slowing progression of disease and complications, and creating home environments that have safe access through home modifications with a focus on prevention.

Approximately one-third of participating nursing facilities are reimbursed through value-based reimbursement (VBR) arrangements. CareSource partners with nursing facilities to assure recipients are in an environment most appropriate to their level of care by assessing every transition and ensuring we meet changes in recipients' needs, in addition to supporting transitions in and out of nursing facilities. The Center for Health Care Strategies (CHCS) recognized CareSource[1] for best practices in supporting integrated health plan services through community partnerships, including co-management of care management efforts, enhancing coordination channels between post-acute care staff and care managers, and executing performance-based contracts with CBOs to support transitions of care. Additionally, since 2013, we have administered the Home Care Waiver/Specialized Recovery Services (OHCW/SRS) program for the State of Ohio. This program provides services to recipients with complex care needs, including individualized placement, supported employment, and peer recovery support. The OHCW/SRS program allows individuals with physical disabilities and unstable medical conditions to receive care in their homes and communities instead of nursing facilities, hospitals, or rehabilitation facilities. CareSource has consistently received outstanding results in quarterly state audits with an average of 98% and accolades from the State of Ohio on our performance.

Operational Strategies

The following recommendations for maximizing HCBS placement and services through proactive aging-in-place strategies are based on CareSource's comprehensive experience as a leader in the complex health

[1] PRIDE PLAN PROFILE: CareSource (chcs.org), Center for Health Care Strategies, Inc, August 2018

space. CareSource encourages the State of Florida to prioritize the following strategies when awarding future managed care contracts focused on LTSS/HCBS.

- A strong person-centered planning process that is informed through exposure to a variety of experiences, service models, HCBS setting options, and supported decision making. Systems must offer flexibility in how people receive the services they need to achieve their life goals as articulated through a person-centered process, with greater attention being paid toward outcomes tied to the person-centered plan and recipient satisfaction over process. The participant directed option is an example of a more person-centered approach that has shown savings and improvement in recipient satisfaction.
- A qualified network of HCBS providers with a culturally diverse, skilled, and reliable workforce serves as the backbone for any adequate HCBS delivery system.
- Ongoing investments in provider and staff training, professional development, technical assistance and ongoing mentoring support of providers and direct care workers in the delivery of high-quality HCBS using the best available evidence and focused on the desired outcomes of individuals based on person-centered planning.
- An emphasis on health plan incentives that encourage prioritization of recipient outcomes related to improved SDOH, quality of life standards, optimal independent living, socioeconomic advancement, and full community inclusion. Incentives should be targeted at building of recipient competency and self-sufficiency for the purpose of recipients' achieving care related resources and ensuring successful aging in the most integrated setting of choice.
- Quality-based withholds and incentives for MCOs to support the State's rebalancing and institution/nursing home diversion goals.
- Provision of HCBS in the most integrated setting, supporting participants on an individualized basis to assure personal autonomy in choice and informed decision-making.
- Greater autonomy to health plans in determining which providers are included in their network, offering of value-based provider arrangements to reward high performers, and holding providers accountable for improving performance.
- Requirements to promote collaboration with other systems in coordinating care across funding streams, braiding resources across systems, and leveraging compatible services to both avoid duplication and maximize coverage (for example, vocational rehabilitation and housing).
- Pilots to test and validate new models and strategies focused on increasing individualized, fully integrated HCBS while simultaneously reducing the reliance on institutionalized placements and congregate care should be prioritized as a pathway to stimulating further innovation.
- Robust programs for preventing, monitoring, and addressing safety concerns (including fall risk, HCBS provider safety and security, home safety, etc.) and end of life planning and care.

Performance Metrics

Given the lack of a comprehensive, federal set of tested and validated quality measures, we recommend a continued investment in strengthening Florida's quality programs over time as more universal HCBS quality measures and standards become available. CareSource encourages a strong balance between access and quality in the future Florida Invitation to Negotiate (ITN). It is critical to have a sufficient number of providers across service options and make sure those providers meet high-level quality standards and are competent in the delivery of HCBS that are outcome-oriented and that embed the best available evidence.

Anticipation of CMS Recommended Measure Set: CareSource collaborates with federal partners and national entities in LTSS measure development to assure that our state Medicaid partners have access to the leading measures, tools, and strategies for improving the quality of Medicaid LTSS systems. We encourage

Florida to factor in the availability of CMS' first-ever HCBS Quality Recommended Measure Set (anticipated to be published by the end of 2022) and include it as an expected strategy for implementation in the ITN. Additionally, we encourage the State to review other HCBS quality measures in the pipeline that will likely be added to this set in the future, for example, NCQA's Person-Driven Outcome Measures, and measures currently being field tested by the University of Minnesota Research & Rehabilitation Training Center on HCBS Quality Outcome Measurement.

Greater Flexibility and Autonomy for Plans to Improve Quality: We suggest the agency consider offering health plans flexibility to improve the quality of the State's provider network by allowing them to:

- Initiate higher quality standards for providers to meet to remain part of a plan's network, i.e., timely delivery of services and claims filing, contract compliance, employee retention, electronic visit verification (EVV), and consumer satisfaction.
- Credential and monitor HCBS providers with a process for quality of care and service investigation, including evaluation of providers on their ability to absorb new recipients, which is a critical component of network adequacy, especially for smaller providers that may not be able to absorb additional recipients on a regular basis.
- Remove providers from the network who are not maintaining the plan's quality requirements, which can be done on the acute care side.
- Put in place an assurance process for growing a strong high-quality provider network while decreasing concern around limiting or minimizing choices in provider options.

Provider Network Requirements

Many community-based providers and organizations that are part of the State's federally funded aging and disability network would greatly benefit from ongoing technical assistance to assure improved business acumen related to basic functions of a managed LTSS system. Examples include understanding billing and claims requirements of the State, various ways to appeal denied claims, data elements, and reporting cycles to assure consistent and reliable data reporting within the construct of the State's electronic health record infrastructure. We also believe that providers require ongoing training and technical assistance to assure they are complying with state and federal regulations. The ITN should reflect solid requirements and guidance on the expectations of the State, and the State should give the plans appropriate funding to improve business acumen and support the operational evolution of LTSS providers, which is critical to assuring a seamless, reliable system for participants.

CareSource recommends the State allow plans to offer value-added benefits and services that support recipients on Florida's waitlist for Medicaid HCBS and allow plans to offer in-lieu of services that provide cost-effective alternative services not currently covered in the State plan or waiver program, as well as allowing presumptive enrollment. Additionally, the ITN could reflect strong performance-based incentives for plans that design comprehensive approaches toward meeting the SDOH needs of this population through offering cross-system resource braiding and service planning, thus using other resources outside of the Medicaid system.

The type of services and the providers offering various categories of services across different HCBS authorities can be vastly different. For example, network adequacy for supported employment might be assessed by outcomes and recipient satisfaction, while network adequacy for transportation may also factor in access and numbers served. We suggest that Florida consider offering a distinct set of network adequacy milestones and metrics for each type of delivery system (for example, the iBudget waiver under 1915(j) would benefit from a unique set of milestones and metrics rather than that for traditional provider service models offered through the State's other HCBS programs).

CareSource is not only focused on meeting network adequacy standards, but also prioritizes quality and user experience. This could be mitigated by applying a "technology first" approach to supporting HCBS participants in achieving maximum self-sufficiency and independence. Under this concept, the State could develop standards that require providers to demonstrate that they are providing access to technological solutions desired by individuals as part of HCBS provision that do not require an increase in staff headcount. CareSource suggests establishing network adequacy not solely by how many licensed and/or credentialed providers are in the network, but by providers who meet specific quality metrics based on evidence-based practice.

Geographic differences also require a separate set of strategies and standards between rural and urban areas. For example, in less densely populated regions of the State, it is not cost effective for plans to invest in the building of large provider options, but rather to look at more innovative, targeted models of service provision relying more heavily on self-direction or smaller, more nimble agency models. Additionally, allowing plans to implement an "agency by choice" model, in which recipients have the ability to hire and fire their direct staff but have an agency help them with payroll, taxes, benefits, etc., would likely attract more individuals into the self-direction options offered by the State.

We recommend allowing managed LTSS plans to partner with the State to ensure LTSS providers are well monitored by plans for the purpose of assuring greater quality, autonomy, and control resulting in higher standards for provider participation in plan networks. While there appropriately remains a high expectation among state Medicaid agencies regarding managed LTSS plan oversight of its participating providers, health plans are restricted in making decisions about adding or removing providers from their network based on the respective plans' quality metrics.

We also recommend requiring MCOs to place a percentage of HCBS providers in a quality enhancer or VBR program to improve outcomes, and we encourage the State to align or create a standard level of care assessment inclusive of all State programs, and align waiver codes and State plan codes inclusive of rates.

We recommend engaging with plans and other partners in ACO-type models to support expanded provider capacity in evidence-based best practices for HCBS. The following best practices are necessary components in support of efforts to expand and enhance HCBS and to rebalance or recalibrate LTSS systems from institutional to community-based care.

Use of ACO-type models with plans to spur greater capacity for building higher-quality services: Invest in the certification of providers in evidence-based best practices that have demonstrated improved HCBS outcomes for individuals with nursing home and institutional level of care needs, including but not limited to:

- Assertive Community Treatment Supports (for both youth and adults)
- Individualized Supported Living
- Independent Living
- Customized Employment
- Benefits Planning
- Financial Coaching/Literacy Training
- Individualized Supported Employment, Supported Retirement, and Other Community-Based Inclusive Occupational Contributions (volunteerism, for example)
- Assistive Technologies
- Use of Immersive Technologies to Promote Increased Independence/Growth

Emphasis on Compliance with Federal HCBS Regulations: In January 2014, CMS issued a new federal regulation effective March 17, 2014 (known as the federal HCBS rule) governing Medicaid-funded HCBS [42 C.F.R. 441.301(c)(4)]. The rule focuses on two significant systems-change goals: (i) ensuring that individuals receiving LTSS through Medicaid-funded HCBS programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate, and (ii) enhancing the quality of

HCBS and simultaneously assuring the provision of key protections and rights to participants. The federal HCBS rule requires states to demonstrate compliance in four key areas:

- Transparent person-centered practices in service planning and delivery, as well as ongoing case management, service coordination, and long-term support provision.
- Conflict-free case management protocols across various Medicaid HCBS systems to assure that individuals receive numerous options in terms of available services and potential providers to deliver desired services without bias or undue influence in the case management and service planning processes.
- Alignment of state policies, regulations, statutes, and other standards to reflect the requirements set forth in the federal HCBS rule.
- Adherence to the settings criteria and rights afforded to participants across every setting receiving Medicaid funding to provide HCBS.

These goals collectively reflect the most significant changes to Medicaid HCBS since Congress passed section 1915(c) of the Social Security Act in 1983, giving states the option to receive a waiver of Medicaid rules governing institutional care. As such, the federal HCBS rule spurs a critical opportunity for states to focus intentionally on modernizing and strengthening systems-change efforts to assure that individuals receive the services they need and desire, by the staff and providers they choose, to support the life goals they have set for themselves to live, work, thrive and enjoy maximum independence and self-sufficiency in their own homes and in typical community settings. It is our understanding that Florida is continuing to negotiate with CMS the final approval (and subsequent implementation) of its statewide transition plan. It is imperative that any future bidding process on the State's managed long-term care programs include a strong emphasis and appropriate resources for plans to prioritize working with providers to assure full compliance with the HCBS rule and settings criteria. Plans must also have support of the State to engage in corrective action plans with providers who fall out of compliance with the regulation. In addition, we recommend that there be designation for specific administrative overhead to focus on the recruitment and development of local staff focused on discovery, person centered planning facilitation, intensive care coordination, complex utilization management, and community transitions for this population.

Best Practices for Maximizing Communication and Resources

CareSource has successfully implemented person-centered best practices for community-based service delivery, built on an innovative provider support system that allows individuals to exercise their own rights, priorities, and preferences. Such support systems require a robust network of well-trained providers working together to fulfill the needs of recipients engaged in person-centered care.

Integrated Community Settings: CareSource recommends leveraging ongoing federal and state funding to partner with plans to expand individualized, integrated approaches to HCBS delivery in a collective effort to reduce their reliance on larger facility-based congregate care models. In most states, the focus of HCBS provision has continued to rely heavily on the contracting of service providers that can serve large numbers of HCBS participants simultaneously. However, to improve individual quality of life outcomes and SDOH access over time, HCBS systems must evolve to allow for more targeted, individualized HCBS options offered in typical integrated community settings. As such, the State should work with plans to support the creation of more innovative, individualized approaches to the provision of HCBS, allowing plans greater flexibility and financial incentives for offering more individualized service options as part of their overall network adequacy strategy.

Workforce Development: The ongoing national crisis in front-line direct care workforce shortages continues to be a challenge for states and the federal government. Federal regulations, including the Americans with Disabilities Act (ADA), the federal HCBS Settings Regulation, and the Workforce Innovation and Opportunity Act, have set forth standards aimed at making optimal independent living and self-sufficiency, full community

inclusion, competitive integrated employment, and socioeconomic advancement of people with disabilities a reality. The availability of a qualified, competent, and stable direct care workforce plays a critical role in supporting people to accomplish these goals. It is critical that direct care workers have the competence, confidence, ethical decision-making skills, guidance, empowerment, and latitude necessary to provide quality support, receive compensation that is commensurate with job responsibilities, and have access to a career path aligned with ongoing professional development.

Unfortunately, building and promoting an adequate, well-qualified, and competent direct care workforce is a particularly challenging task across HCBS systems, and a comprehensive statewide strategy is required to address what has become a workforce gap crisis in Florida (and beyond). Such a strategy could help propel direct care workforce development and retention and could assure that direct care workers have the capacity, competency, health, and ongoing supports to meet the growing demand for and provide the highest quality of HCBS to Medicaid LTSS participants.

CareSource recommends that, at a minimum, the state of Florida design a career pathway that incorporates the CMS core competencies and recommended rate methodologies as well as local labor market data to reflect the diverse skills and duties of the direct workforce.

Provider/Staff Training and Technical Assistance: CareSource has extensive experience working with state Medicaid agencies to provide training and ongoing technical assistance for the purpose of building provider capacity and stimulating systems transformation toward improved access and quality of HCBS. Based on experience, we encourage the State to factor in the ongoing provision of intensive training and technical assistance for providers and front-line staff as part of any ITN. Other important strategies for the State to consider include leveraging federal resources to offer grant assistance and other funding opportunities focused on addressing specific knowledge gap areas, or value-based agreements with plans to stimulate outcome-oriented training and technical assistance focused on improving specific provider capacity challenges.

Value Based Partnerships: CareSource understands the critical importance of partnering with LTSS providers early and often to design, test, and validate VBR partnerships that accelerate scalability in evidence-based practices, quality improvements in service delivery, and enhanced quality of life outcomes for recipients receiving LTSS. We encourage Florida to support and prioritize the development of VBR partnerships with HCBS providers that demonstrate three core outcomes:

- Alignment with person-driven outcome measures and person-centered HCBS quality measures
- Demonstration of significant improvements among participants in optimal personal autonomy, full community inclusion, and socioeconomic advancement
- Solid improvements in access, quality, and cost savings

To be successful, we believe value-based partnerships must include both upfront and ongoing investments in building and sustaining provider capacity and scaling evidence-based strategies tying payment to desired outcomes. By providing comprehensive technical assistance (including training, coaching, ongoing trouble-shooting, and closed communication loops), technological supports, and enhanced funding flexibilities to support providers during the implementation phase of new VBR initiatives, providers are positioned to be optimally successful in these arrangements. Value-based partnerships must also be re-evaluated over time and include feedback from participants, family caregivers, front-line staff, and provider leaders to make improvements and necessary modifications over time.

As the State conceptualizes ways to promote VBR strategies moving forward, we suggest working with a well-experienced health plan such as CareSource to inform the design, validation, and scaling of alternative payment models driven by the person-centered services plan and attached to specific milestones and outcomes.

Implications for Integration with the Agency's FX Project and CMS Interoperability Rule

The Agency is modernizing its approach to overall agency functions in order to build better connections to relevant data sources and programs, as well as improve health care options and outcomes. The FX initiative is a multi-year transformation project to enhance the provider and recipient experience, improve access to health care data, and enhance data integration among State of Florida agencies. CareSource makes the following recommendations[2], related to maximization of HCBS and integration with the Agency's FX Project and interoperability.

Leverage 90/10 funding to support HCBS providers' engagement in electronic Health Information Exchange (HIE): CareSource encourages the Agency to continue to leverage 90/10 funding per SMDL #16-003[3] to establish electronic HIE with HCBS providers.

Reimburse the provision of ongoing technical assistance to HCBS providers to adopt and use State-required health IT: CareSource recommends development of a plan to support HCBS providers in adopting and using health IT within HCBS settings (e.g., regional extension center-like services).

It would also be beneficial to clarify in the ITN the approach for including the information-sharing needs of HCBS beneficiaries and HCBS providers based on the approved HCBS programs across the State. Interoperability across the diverse health IT ecosystem requires stakeholders to agree to and follow a common set of standards, services, policies, and practices that facilitate the appropriate exchange and use of health information nationwide; it does not limit competition. Once established, maintaining interoperability will also require ongoing coordination and collaborative decision making about future change.

Consistently prioritize integrated care in HIE decision-making processes: States are called to integrate IT functionality and interface programs across all their federally supported Medicare/Medicaid programs and activities to support the interoperable exchange of health information for all providers, to improve health outcomes, lower costs, and ensure privacy and security of health information. It is important to include LTSS providers in these initiatives. States have had success in driving interoperability and data sharing through state HIE activities, including pharmacy operations, third party liability, and future managed care operations.

Advancing the goals of the Medicaid enterprise requires states to follow a comprehensive approach to identity management and provider directories. Ultimately, any movement towards VBR and delivery system reform requires full documentation and understanding of which beneficiaries are served and which providers belong to the Medicaid program. This poses unique challenges and considerations for HCBS programs that focus on self-directed opportunities for beneficiaries. If created in a standardized manner, a provider directory can interact with other directories, sharing information or even allowing the systems to update one another with the most current information. For self-directed beneficiaries, the State could develop new apps that plug into the State's systems, with the data available in the ways most useful to all users, including beneficiaries, providers, and MCOs. We also suggest requiring MCOs to develop automation for provider sourcing tools for services and home modifications.

Within multiple HCBS programs across the country, MCOs and state Medicaid agencies are making inroads into digitizing person-centered service plans and creating API protocols for individuals and providers to access them. Putting the individual first is a fundamental goal of person-centered planning and service delivery. Person-centered HIE has the potential to improve self-management and enhance communication between providers and recipients. A simple way to operationalize support for individuals to seamlessly access their health information could include the State imposing a requirement to provide beneficiaries with a PHR-like

---

[2] CareSource's recommendations reflect key suggestions outlined by the U.S. Department of Health and Human Services' Office of the National Coordinator in its Home and Community Based Services HIT Toolkit that align and support the Agency's vision behind the FX Project. See CMS-ONC Health IT Toolkit for Medicaid Funded Home and Community Based Services (HCBS) Programs - State Toolkit for more information.
3 https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf

functionality as part of the HCBS MCO procurement solicitation. Moreover, Florida may also want to consider leveraging evolving consumer-directed exchange networks, such as those offered through the CARIN Alliance[4]. We recommend the State consider taking advantage of federal rebalancing incentives (Money Follows the Person, for example) to maximize funding resources in support of transitions to the community.

Known or Potential Concerns with the Approach for the SMMC Program

We do not have knowledge of existing or potential concerns related to our recommended strategies to maximize home and community-based placement and services through proactive aging-in-place strategies.

Dental and Primary Care Services for Children and Adolescents

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

CareSource successfully integrates dental and primary care services for children and adolescents through a variety of mechanisms that ensure the benefits of good oral health are available well into adulthood. For children and adolescents, oral health affects self-esteem, school attendance and performance, social well-being, and psychological and physical health. While good oral health is a precursor to overall health and quality of life, it is often clinically siloed, and gaps prevail between medical-dental coordination and collaboration in the health system. CareSource is an industry leader in providing recipient-centric health care coverage for whole person health in partnership with provider networks, dental administrators, and community partners. Based on our experience, we encourage the following innovative proactive approaches to better integrate and improve dental and primary care services for children and adolescents in Florida.

Operational Strategies

Medical-Dental Collaborative: Over the past decade, compelling evidence has linked the presence of periodontal and oral disease with physical and mental health. We recommend coordinated care through programs such as our CareSource MedDental™ Partnership for Whole Person Health program, which identifies recipients with specific medical, behavioral, or physical conditions, such as diabetes, heart disease, asthma, pregnancy, or behavioral disorders, who will benefit from specific care support for disease prevention and management.

CareSource is in support of the dental home model as a best practice approach, as it provides an opportunity for recipients to receive an annual preventive dental visit. Establishing a dental home means that a child's oral health care is managed in a comprehensive, continuously accessible, coordinated, culturally effective, and family-centered way by a trusted licensed dentist (primary dental provider) assigned or chosen by that recipient. The concept of the dental home reflects the American Academy of Pediatric Dentistry and American Dental Association best principles for the proper delivery of quality oral health care, with an emphasis on initiating preventive strategies.

Supporting Dental Recipients with Complex Medical and Special Needs: CareSource recommends best practice coverage models for children and adolescents with complex medical, mental, or psychological needs necessitating general anesthesia or sedation. The most common indications for sedation or general anesthesia are lack of cooperation, multiple morbidities, and pediatric autism. [redacted]

4 https://www.carinalliance.com/

[redacted]

Performance Metrics

We suggest the following metrics when measuring integration of dental and primary care services for children and adolescents:

- [redacted]
- [redacted]
- [redacted]

We have seen a 15% improvement in HEDIS® Annual Dental Visit Measure in our current markets as a result of a consistent source of dental in a 12-month period. The model promotes inter-professional collaboration and integration between patient-centered medical homes (PCMH) and patient-centered dental homes by using our PCMH model and other programs to educate primary care providers on EPSDT and well-child screenings, which include oral screenings.

Provider Network Requirements

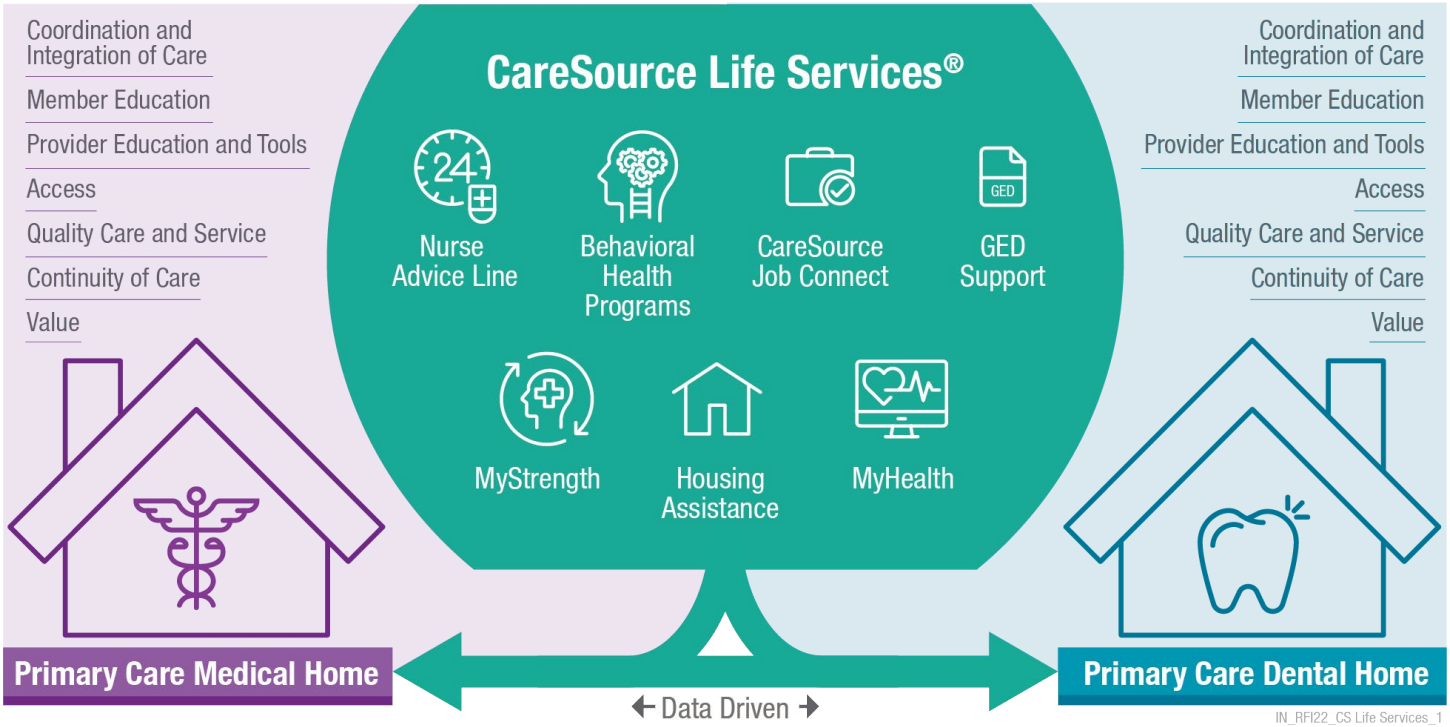
According to the Health Resources and Services Administration, 43 of Florida's 67 counties are experiencing a dentist provider shortage. Working with the state's dental administrators is a best practice to address access to care, our programs help identify alternative dental delivery systems, technology, and workforce models. Opportunities include integrating oral health into primary care settings, working with allied schools and stakeholders on oral health workforce models to provide preventive services in dentally underserved communities, and incorporating teledentistry within scope of practice acts. For example, we recommend a training program for pediatricians to provide fluoride programs in their offices, which is especially helpful for rural access to oral care. We also suggest working with nurses though various modalities to integrate oral health screenings.

Best Practices for Maximizing Communication and Resources

We collaborate with our contracted dental administrators or state administrators to ensure our primary care provider networks have up-to-date inter-professional rosters for dentists within their respective communities to whom they can refer Medicaid recipients. We also collaborate with the dental administrators on their referral models and programs for medical care and well-child visits to the PCMH. We support inter-professional collaboration with value-based incentives and promote preventive dental visits with recipient rewards and incentives. CareSource care managers and trained recipient advocacy representatives assist in coordinating care. We provide a platform of recipient oral health educational resources, including oral health tips for pregnant women, infants, toddlers, children, and teens and the importance of preventive dental visits.

We support recipients through our coordinated care model, recipient outreach, education and health coaching, expanded benefits, self-management tools, and social support services through CareSource Life Services® to address SDOH needs. We provide toolkits and training to promote inter-professional collaboration, improve medical-dental-behavioral health referrals, and focus on the common risk factors approach to addressing both chronic medical disease and oral disease. Oral health professionals who know how to perform medical health assessments (e.g., vital signs, tobacco use) are a key touchpoint for medical referrals to help prevent the development of chronic conditions. They also support healthy habits of children and adolescents moving into adulthood through education regarding the consequences of unhealthy behaviors. Conversely, our network of physicians, OB/GYNs, nurse practitioners, and behavioral health providers are key clinical touchpoints for oral health screenings and assessments for dental needs and referrals.

Figure 1: Addressing SDOH to Increase Dental Utilization



Implications for Integration with the Agency's FX Project and CMS Interoperability Rule

As stated above, CareSource understands the importance of making health information more easily available to recipients by leveraging a health information exchange platform that provides reliable data and insight related to population health, SDOH, and network and provider performance. We recommend future contract inclusions of innovative technology strategies that promote collaboration between MCOs and dental administrators, as well as inter-professional collaboration. Our CareSource mission is improving health care quality, access, and outcomes through partnership driven and analytics enabled transformation. [redacted] Through actionable data, the Agency can create an inventory

This page contains a trade secret as defined in Section 812.081, Florida Statutes. This/these redaction(s) contains information, which is for use, or is used, in the operation of CareSource's business and which provides CareSource a business advantage, or an opportunity to obtain an advantage, over its competitors who do not know or use it.

of quality initiatives for both providers and recipients to improve overall health. We identify opportunities to promote and collaborate in a manner that maximizes desired outcomes.

Known or Potential Concerns with the Approach for the SMMC Program

We do not have knowledge of existing or potential concerns related to our recommended strategies to improve integration of dental and primary care services for children and adolescents.

Access to Community-Based Pharmacists

Increase access to community-based pharmacists within prescription benefit manager networks.

CareSource recognizes that access to community-based pharmacists is a critical component of holistic, integrated health care. We have demonstrated success in the administration of pharmacy benefits for our recipients and the oversight of our pharmacy benefits managers. We optimize recipient health outcomes through provider and recipient-centric pharmacy programs and services, which promote recipient access to safe, effective, and medically appropriate prescription medications, certain over the counter drugs, and pharmacy supplements.

Operational Strategies

CareSource recommends active participation in a community-based pharmacy network, such as the Community Pharmacy Enhanced Services Network (CPESN), to build strong relationships during recipient interactions at the pharmacy, increase access to community-based pharmacists, and enable pharmacists to provide high quality care and disease management, including tobacco addiction and diabetes. Active participation in a community-based pharmacy network provides recipients with an additional care provider able to answer questions, provide education, and make medication therapy recommendations. These pharmacists create care plans and foster a longitudinal relationship with recipients.

We recognize that by properly compensating pharmacists to practice at the top of their license, beyond filling prescriptions, they are better able to support recipients in the community. Critical services include point-of-care HbA1c testing, blood pressure screening, diabetes education, full review of all medications and appropriateness of their therapy, the opportunity for medication synchronization or other adherence improvement opportunities, and vaccination evaluation and delivery. Additional services that may be included depending on the circumstances are diabetic foot exam, referral to other providers, and coaching on diet and exercise. We believe that a relationship built between the recipient and their local pharmacist improves the recipient's ability to live a healthy lifestyle with diabetes, fills care gaps for these recipients, and improves their health outcomes. [redacted]

CareSource also recommends establishing incentives to encourage retail and clinical pharmacies to proactively close care gaps through interventions that pharmacists can easily identify at the point of dispensing without need for additional alerts or post-fill reminders. Incentives are tied to metrics, such as asthma controller adherence, hypertensive adherence, diabetes adherence, omission of statin therapy for recipients with diabetes, and generic dispensing rates, to name a few. [redacted]

[redacted]

We encourage collaborating with pharmacists and prescribers as part of the care continuum to reduce adverse events and improve adherence through a medication therapy management (MTM) program. MTM is more than refilling a medication on time or using a computer algorithm to target recipients. Our MTM platform removes the need for pharmacists to figure out billing or complex data files, often the rate-limiting step for any new idea. CareSource does the heavy lifting so that community pharmacists can focus on clinical care and recipient outcomes, allowing pharmacies to receive reimbursement for their consultative services outside of traditional MTM services, while providing critical information for HEDIS® measures.

[redacted]

Performance Metrics

Recommended performance metrics to measure effective recipient access to community-based pharmacists include:

- Recipient experience (access/availability, ease of getting a prescription filled, overall experience)
- Reduced inpatient and emergency department utilization
- Level of provider satisfaction
- Referrals
- Medication adherence
- Percentage of point-of-care services including vaccinations
- Medication reconciliation post discharge
- Generic dispensing rates

Provider Network Requirements

There are no additional provider network requirements above an active participation in a community-based pharmacy network.

Best Practices for Maximizing Communication and Resources

We recommend encouraging recipients to take full advantage of pharmacy benefits (and how to access them) at every opportunity including through the recipient handbook, a recipient web portal, welcome calls, recipient newsletters, call hold messaging, online messaging, text messaging, provider education, social media, email communications, and recipient-facing community events. Additionally, community health workers, community education representatives, care managers, and recipient services representatives should provide recipients with information and guidance regarding pharmacy services and availability.

Implications for Integration with the Agency's FX Project and CMS Interoperability Rule

We recommend future contract inclusions of innovative technology strategies that promote collaboration between MCOs and community-based pharmacists, including those that allow recipient interaction with community-based pharmacies through integrated platforms.

Known or Potential Concerns with the Approach for the SMMC Program

We do not have knowledge of existing or potential concerns related to our recommended strategies to increase access to community-bases pharmacists.

Mental Health Outcomes for Children and Adolescents

Improve mental health outcomes for children and adolescents.

CareSource is committed to facilitating access to whole-person care. Through our integrated care approach, we expand access to behavioral health services and improve mental health outcomes for children and adolescents within primary care settings by providing training and billing guidance to encourage screening for and intervening with mental health and substance use conditions. Our integrated care management approach means our care coordination staff is trained to address physical and behavioral health needs in one care plan. Our policies and procedures require communication between providers across disciplines and along the care continuum. We integrate physical and behavioral health by increasing communication between providers through data exchange, promoting screening and referral of behavioral health conditions by a primary care provider, and encouraging fully collaborative approaches to care.

Operational Strategies

[redacted]

An internal committee that includes behavioral health (BH) care coordination, analytics, child and family health, and utilization management team members guides model development and monitors outcomes. CareSource also partners with BH providers and CBOs to provide families with complex in-home treatment support, respite services, after school programming, housing support, and peer support services. Our dedicated treatment team provides regularly scheduled case conferences to support care coordinators and ensure all appropriate services are offered to the children and families. We also work with adolescent residential programs to create specialized programs to prevent admittance to the psychiatric residential treatment facility (PRTF) level of care. Many children and adolescents who require PRTF level of care must travel a great distance to attain available

care. Our specialized programs keep adolescents in their communities, in their schools, and with their families. The adolescent residential program gives families access to licensed clinicians, intensity and frequency of services based on need, care coordination, 24-hour access to clinicians, and individual and family treatment with evidence-based models. By supporting and teaching caregivers' new skills to use with their children, these programs have stabilized youth in their homes.

CareSource recommends having recipients actively participate in their health care experience to promote better outcomes. [redacted]

To increase teen and young adult engagement in mental health care, CareSource suggests implementing a teen-centric digital BH platform that encourages self-care. CareSource uses BeMe Health to help improve the BH and emotional well-being of our adolescent recipients. BeMe Health has three components including technology, coaching, and clinical treatment to increase teen engagement through personalization, digital relevance, self-care resources, and automated check-ins. The platform contains compelling content about adolescent BH issues as well as the capability for teens to receive texts with tailored, pertinent content from BH coaches and licensed clinicians to support them with their own emotional concerns.

This tech and touch solution aims at meeting adolescents where they are, when they need support the most. The tech component consists of a highly personalized user experience, complete with regular/daily check-ins, and personalized digital resources. BeMe Health serves as an early intervention program to reduce teens' crisis intervention and to help them engage in outpatient BH services.

[redacted]

To reduce the rate of suicide, CareSource recommends implementing a program using artificial intelligence (AI) to analyze speech and identify recipients at-risk of suicide. [redacted]

Capitalizing on the popularity of social media, CareSource encourages the use of social media campaigns to promote SUD resources. For example, we recently initiated a SUD social media campaign to increase awareness of our coverage of naloxone due to increased rates of overdoses during COVID-19. Our BH and marketing teams jointly created content for social media platforms. This educational content gives links to CareSource resources including the phone number for our BH Crisis Line and CareSource PeerConnect™ peer warm line as well as contact information for SUD treatment and our naloxone pharmacy benefit.

CareSource supports a comprehensive approach to preventing substance misuse and opioid overdoses, especially in youth. As we continue to see opioid overdose death rates climb in the most recent years, it is even more imperative that models align with the Centers for Disease Control (CDC) and Department of Health and Human Services (HHS) guidelines to prevent opioid use disorder, improve opioid prescribing, treat opioid use disorder, and reverse opioid overdose for our recipients. We recommend using a multi-pronged approach that encompasses overdose prevention, misuse prevention, increased recipient awareness and resources, increased provider awareness and resources, and provider monitoring of prescribing.

To ensure leftover medications are not accidently in the hands of youth or others, we distribute complimentary medication disposal packages to our recipients that can be requested from our website or directly through care management. These medication disposal packages are delivered to our recipients at their residence and can be completed easily and disposed of in their own home.

[redacted]

Performance Metrics

Recommended performance metrics to measure improved mental health outcomes for children and adolescents include:

- Reduce the number of children removed from their homes
- Reduce inpatient and emergency department utilization
- Reduce residential placements and/or length of stay in those placements
- Increase home and community-based service utilization
- Increase engagement in care coordination

Provider Network Requirements

CareSource recognizes the importance of school-based health centers (SBHC) and recommends working closely with SBHCs to implement programs aimed at improving mental health outcomes for children and adolescents. SBHCs are an important part of the education system because healthy students are better learners. [redacted]

The focus is on SBHCs across the state and the health partners contracted to provide such services as comprehensive dental care, vision care services, well-child exams, immunizations, and BH services. SBHCs assess students for BH issues including depression screening and follow up treatment services ranging from individual counseling to family therapy to case management. In the past year, SBHCs have started to integrate telemedicine for on-site BH visits, which has improved medication compliance.

SBHCs also play an important role in addressing SDOH needs including risk assessments for food insecurity, homelessness, substance abuse, domestic violence, and poverty. SBHCs have provided students living in higher poverty areas with access to quality healthcare that leads to improved social support, improved graduation rates, better attendance rates, improved school success, and decreased reliance on emergency department visits for acute illnesses.

[redacted]

[redacted]

Best Practices for Maximizing Communication and Resources

We recommend a dedicated team of community health workers responsible for reaching out to recipients to increase recipient engagement in adherence to follow-up appointments after an inpatient behavioral health admission. Community health workers assist recipients through the following interventions:

- Calling recipients to remind them of their 7-day and 30-day appointments
- Confirming the recipient kept their follow-up appointment with qualified outpatient providers
- Assisting recipients who miss their follow-up appointment to reschedule with their provider
- Addressing social barriers, such as transportation, to support recipients in attending appointments
- Assisting recipients to connect with a tele-behavioral health provider, based on needs and preferences, especially during the COVID-19 pandemic

Additionally, we recommend encouraging recipients to take full advantage of benefits (and how to access them) at every opportunity including through the recipient handbook, a recipient web portal, welcome calls, recipient newsletters, call hold messaging, online messaging, text messaging, provider education, social media, email communications, and recipient-facing community events.

Implications for Integration with the Agency's FX Project and CMS Interoperability Rule

We recommend future contract inclusions of innovative technology strategies that promote collaboration between MCOs and physical health and behavioral health providers, as well as inter-professional collaboration. We recommend supporting providers through state-of-the-art provider portals and direct data interchanges as will be supported through our interface updates established through interoperability compliance. We recommend data dashboards to produce real-time analytical reports to support provider integration.

Known or Potential Concerns with the Approach for the SMMC Program

Chronic workforce shortages throughout the mental health system increase system strain and trauma for vulnerable children and youth. Our innovative programs and proposed solutions for Florida's SMMC Program were designed to help to alleviate this problem. We would not anticipate any concerns with our approaches.

Conclusion

Our unique multi-state nonprofit heritage enables us to go beyond what other MCOs deliver, thoughtfully creating strategies that are in the best interest of our recipients not shareholders. We proactively engage recipients throughout their journey to address barriers, assessing recipient social needs, proactively coaching and integrating those needs into the recipient's care plan, and connecting the recipient with resources to improve outcomes. Our innovative solutions expand access to care, address health disparities, incorporate SDOH needs, and create efficiencies across the healthcare delivery system.

We welcome the opportunity to discuss our programs with the Agency and explore a partnership that builds upon current strengths and successes to create further efficiencies and even better outcomes for SMMC recipients.