Massa, Cody

From: Ben Browning <ben@fachc.org>
Sent: Friday, June 3, 2022 4:13 PM
To: solicitation.questions
Cc: Ben Browning
Subject: FACHC response to AHCA RFI 014-21/22
Attachments: FACHC Response to AHCA RFI 014-21-22 SMMC_June 2022.docx; FACHC Response to AHCA RFI 014-21-22 SMMC_June 2022.pdf

Good Afternoon.

Thank you for the opportunity to respond to this RFI.
Please find our organization's response attached.
I am available to answer any questions you may have after reviewing the document.

- Ben

Ben Browning, MPA
Vice President & COO
Florida Association of Community Health Centers, Inc.
2340 Hansen Lane
Tallahassee, FL 32301
(850) 942-1822 Office
www.fachc.org

June 3, 2022

Attn: Cody Massa
Procurement Officer
State of Florida Agency for Health Care Administration

On behalf of the Florida Association of Community Health Centers, Inc. (FACHC), I would like to thank the Agency for Health Care Administration (AHCA, the Agency) for providing the opportunity to submit comments and recommendations for the Statewide Medicaid Managed Care (SMMC) Re-Procurement.

FACHC is the state Primary Care Association (PCA), as designated by the Health Resources and Services Administration (HRSA). It is our mission to work in partnership with the Centers to ensure equitable access to quality primarey care. As the primary care safety net for Florida, federally qualified health centers (FQHC or CHC/community health center) provide medical, dental, behavioral, pharmaceutical, optical, and a wide range of other services to 1.7 million individuals, including 500,000 uninsured and nearly 700,000 Floridians enrolled in Medicaid (per 2021 data). Community health centers are a lifeline to local communities, providing $3B in economic impact and are responsible for over 22,000 jobs across the state. Their inclusion, sustainability, and role in any effort to maintain a healthy and vibrant state is vital to its success.

Below are select concepts that should be included within the discussions of the Agency as they frame the upcoming re-procurement process and negotiations.

FQHCs as Essential Providers

Per Florida Statute 409.975, the Agency has the authority to identify FQHCs as Essential Providers. Not only because FQHCs provide primary care to 1 in 7 Medicaid enrollees, but because of the quality and accountability standards they must meet and report that are placed on them by the State, the Plans, Accrediting Bodies, and the federal government, FQHCs should be included as an essential provider in SMMC contracting processes.

A requirement to open new locations, CHCs must operate in areas of underserved populations, which means their economic engine drives our state's economy to higher levels in more disadvantaged communities and is why they are so essential to the sustainability of a strong Medicaid program – they are located where no one else is willing or able to go. As such, they are essential to reaching and keeping connectivity to patients that may otherwise be difficult to reach. With over 720 locations across Florida, FQHCs provide care in each of the 67 counties, urban areas and rural. Where brick and mortar sites do not exist, there are 50 mobile buses that bring the care to the patient (including in schools).

Pharmacy Benefit Manager Reform

The current pharmaceutical environment that is dictated by the pharmacy benefit managers (PBMs) is not beneficial to the State, the patients, or the providers. It only benefits the PBMs and their vertically integrated partners. By allowing PBMs to dictate contracts and decide networks with little to no limitations, they are able to harm providers such as FQHCs and reimburse them at lower rates than others in the area, resulting in harm to patients' resources, affordability, and access to primary care services. Over a dozen states have already included protections against PBMs retaining for

themselves the 340B program savings intended by Congress through the 340B program to stay in the low-income communities.

Contracts should not be "take it or leave it" scenarios where "at least we got something" is the refrain. Providers and pharmacies should be reimbursed at a rate that is sustainable and fair to ensure the quality care is provided to patients, whether this is at the pharmacy counter or anywhere else in the care continuum. In the instances of CHCs, being reimbursed at a lower rate simply because those medications are purchased under the 340B program should not be allowed.

Additionally, the provider often receives no information in instances where the PBM excludes them from the pharmaceutical elements of patient care or are not allowed to dispense a medication through the patient's chosen pharmacy because it is required to go through a mail-order arrangement, one that is often vertically integrated with or owned by the PBM. In many of these instances, providers (the core care givers) are not informed as to if the patient (1) received the meds, (2) was counseled on the meds, or (3) had any adverse reactions to the meds – until they either present back in their office or potentially in an emergency room with complications. Under this disjointed system, a patient's care and health outcomes are no longer a priority, but the bottom line is.

This scenario must be addressed to ensure pharmacies of the patient's choice are allowed into networks and that pharmacies are compensated at reasonable, fair rates.

Integrated Care at CHCs

This underlying premise is the root of every FQHC since the program's inception many decades ago. To ensure that a patient is treated from head to toe is a mandate and a mission for these providers.

Community health centers are exactly what their title says – they are the center of communities' health care access. Over the years, this has expanded to include a wide range of over 40 different services. CHCs are required to either provide these services themselves or contract for them to ensure a continuity of care that tracks back directly to their patient centered medical home. This builds the trust and the care continuum necessary to identify, maintain, and monitor progress of whole person care.

For CHCs, this is a core tenet by which they operate and is something that many locations are able to operationalize on a scale not available in almost every other provider type outside of hospitals. By employing doctors, dentists, behavioral health specialists, pharmacists and more all under a single roof (at a minimum under the same employer) , this allows for an integrated care model that most Medicaid providers cannot match: same day, same system services.

While it is true that not every CHC site has every service, the opportunity and potential are already ingrained in how they have done business for decades. It is a matter of providing the appropriate incentives and policies to allow for this to happen. For example, reimbursing a psychologist, LCSW, or LMHC for a 15 minute visit with a patient's primary care provider in the room strengthens the bond between patient and provider and integrates the care to ensure better outcomes for that patient. Another example may be a dentist who finds a medical concern while performing a routine exam – and can then walk the patient down the hallway to see a medical provider. These are models that exist. These are models that work.

Unfortunately, current AHCA policy and rules limit the ability of the providers to collaborate in such ways. In some cases providers considered to be "specialty" (chiropractors, podiatrists, etc.) are not offered contracts with the Plans, so the patient may need those services, but must walk past that provider's office on their way out the door to one that is in network unless they wish to pay out of pocket.

Addressing these barriers should be a priority to ensure optimal patient health and outcomes, as well as provider success and satisfaction, with all being able to explore the full reach of their capabilities with access not being stifled.

Whole Person Care

Enabling services are the answer to aligning patients with solutions to the social determinants of health (SDOH) that they face. Individuals are best served when their whole person is treated – not just their body and mind, but also their environment. The CHCs actively provide the connective tissue (again – centers of *community* health) by building a strong workforce of case managers, patient education specialists, community health workers, eligibility assistance workers, and clinical pharmacists to name a few.

However, there should be a means by which this vital service and function is able to be maintained and expanded. Building incentives into provider contracts to offset the expenses of employing these individuals and working in collaborative partnerships to connect patients to resolve their underlying health issues that are beyond the traditional care provider is imperative to improving the overall outcomes of patients.

If a patient is not able to access healthy food, let alone enough food, having a partner in the CHC to connect them to resources such as food banks has proven to improve the focus of the patient on their own health. Getting a patient in touch with insurance coverage –including Medicaid – is a significant barrier to health and care that these staff can help them overcome. Working with local government and other partners to establish healthy spaces such as safe parks and recreation facilities and then linking the patient to those opportunities is a key to moving the state's health in the right direction. And AHCA can play a cornerstone role in making these changes happen.

As a component of this re-procurement conversation, the investment into the health and well-being of the patient should be considered a paramount focus. This is true not just inside the four walls of any contracted provider or insurance plan, but also outside of those buildings, in the communities – the communities in which the CHCs are established as the primary care safety net, medical home, and health hub for hundreds of thousands of Medicaid lives.

We appreciate the opportunity to share recommendations for the upcoming re-procurement. Should you have any questions about the topics discussed in this document, please do not hesitate to reach out to me at Ben@fachc.org or through our office at (850) 942-1822.

Sincerely,

Benjamin Browning, MPA
Vice President and Chief Operating Officer
Florida Association of Community Health Centers, Inc.