Massa, Cody

From: Clay Meenan <claym@fha.org>
Sent: Friday, June 3, 2022 3:57 PM
To: solicitation.questions
Cc: Kim Streit; Michael Williams; David Mica
Subject: FHA Response - Medicaid Procurement RFI
Attachments: FHA Comments on SMMC RFI 06.03.2022.pdf

Follow Up Flag: Follow up
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Good afternoon,

Please see the attached letter from the Florida Hospital Association in response to the Medicaid Procurement RFI, due today. Please reach out to us if you have any questions or concerns.

Best regards,

Clay Meenan
Government Affairs Manager

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June 3, 2022

Cody Massa
Procurement Officer
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Dear Mr. Massa,

Thank you for the opportunity to respond to the Agency for Health Care Administration's (AHCA) Request for Information on the Statewide Medicaid Managed Care (SMMC) Program and provide recommendations for opportunities to improve the program in the next procurement which is set to begin in the fourth quarter of 2022. We commend the Agency on soliciting input from those with experience in the SMMC program to identify opportunities for improvement, explore potential best practices and innovations in operations and service delivery for Medicaid managed care. We are submitting these comments on behalf of the Florida Hospital Association's (FHA) 200+ member hospitals and health systems.

When the State of Florida shifted the responsibility for Medicaid treatment from fee for service, largely to managed care, the goals were to improve access to care, contain costs and enhance quality.[1] FHA commends those goals and believe that as AHCA continues to address issues in the SMMC program there will be continued opportunity for improvement. As AHCA considers changes to the SMMC program FHA would encourage the agency to focus on the following areas:

- Reduced administrative burden – as discussed below, plan requirements for provider credentialing, prior authorization, claim payments, and clawbacks have resulted in unnecessary increases in program costs as providers are required to dedicate staff and resources to ensure compliance.
- Transparency – As AHCA considers program improvements it will be critical to develop mechanisms to track plan compliance with program requirements. In turn, AHCA and program stakeholders will be able to identify pain points and program inefficiencies to improve the delivery of care.
- Network adequacy – As AHCA continues to identify ways to improve access to care it should prioritize network adequacy requirements and ensure plans meet coverage standards imposed by the SMMC program.
- Improving patient outcomes – To achieve the goal of increasing quality, AHCA should address challenges in the delivery of services which impact patient outcomes.

Improving Provider Experience

The implementation of the SMMC program has resulted in increased administrative costs for providers and, ultimately, Medicaid. Additional staff and resources were necessary to ensure compliance with reporting requirements set forth by each of the plans under contract with the state. The costs associated with Medicaid are much greater because of the administrative complexities unique to each plan. Recommendations listed below are opportunities to improve efficiency and reduce administrative burdens association with the SMMC program.

1. **Streamline Credentialling of Providers and Shorten Time to Load Providers**
   Currently, each plan has a method to credential providers. The distinct plan requirements, which include varied templates and input methodologies, creates delays in

[1] Staff analysis of HB7107 h7107b.APC.PDF (flsenate.gov)

getting providers approved and loaded into the various health plan systems to allow those providers to see Medicaid members. While the Agency set forth standards for providers to be credentialed and loaded within 60 days, these timelines are not always met, resulting in a reduction of patient access to care.

FHA Recommendations:

a. If a provider is credentialled by Medicaid, plans should not require separate credentialling of that provider.
b. Align the Medicaid recredentialling timeframe with national standards For example, Medicaid credentials providers for five years while CAHQ requires every three years. This results in unnecessarily duplicative recredentialling efforts by providers.
c. Require plans to load providers within 30 days of confirmation of the provider's credentials to allow new providers to treat patients sooner.
d. The Agency should develop a mechanism to monitor and validate whether plans are meeting the loading timeframe set forth in the contract.
e. Those not meeting those requirements should be required to submit a publicly available corrective action plan.

2. Reduce the delays and administrative burdens associated with prior authorization

Prior authorization, a tool ostensibly used to control costs by ensuring the necessity of treatment, has, with greater frequency, been used to create roadblocks to the delivery of care and reimbursement to providers. While we understand there are times that prior authorization might be necessary, it is used frequently to delay care and deny payment. FHA member hospitals report delays in authorization processing for DME items, with some having an average wait time of two months. Additionally, delays occur for authorizations granted for pediatric hearing aids and for pediatric and adult physical, occupational and speech therapy. Use of third-party vendors for authorization by some of the plans is creating confusion and delays in Medicaid members receiving necessary care.

FHA Recommendations:

a. The Medicaid program should identify a standard list of procedures to require prior authorization and update at least semi-annually based on the review of data on the types of requests for prior authorization and the resulting approval and denial rates. All plans participating in the program would be required to waive prior authorization requirements for the Agency list of services.
b. Timeframes for prior authorization should be shortened to 24 hours for an urgent request as determined by the ordering physician and three days for standard requests.
c. Require plans to adopt a "gold card" program to exempt providers consistently meeting prior authorization requirements.
d. Require the use of portals to standardize the requesting, tracking and monitoring of the prior authorization process. This would ensure compliance by plans and any third-party vendor they are using to provide a subset of services such as transportation, behavioral health, DME, home care, etc., and reduce administrative costs by limiting variance among plans in the prior authorization process.

e. Require monthly reporting of key prior authorization statistics and publicly report by plan, and any third-party vendor used by a plan, on the Agency website. Statistics tracked and validated would include percent approved, percent denied, percent successfully appealed, time frames for approval. Those not meeting the standards or with a high rate of denials should be reviewed and required to adopt a performance improvement plan.
f. Adopt standard waivers of prior authorization during state and federal public health emergencies to remove any barriers for discharging, admitting, and providing timely services to patients

3. Claims payment

Payment delays, denials for care authorized, and retrospective recoupments place a financial burden on providers and staff resources to monitor and appeal. Lack of timely provider loading is resulting in denied claims and delayed payments. Claims are denied for authorization when no authorization is required. Plans may pay claims then later, sometimes years later, recoup the payments in error for coordination of benefit issues. Frequently these are overturned, and the plans pay the claim after several months delay and a lot of effort on part of the hospitals. Resolution of these issues requires a significant amount of staff time, extensive follow up and physician peer to peer discussions to get these payment issues resolved. While these issues are unresolved, payment delays significantly impact the hospital's cash flows.

FHA Recommendations:

a. The Agency should closely monitor adherence with the contractual payment timeframes, denials, appeals and those overturned to understand the care that has been provided, whether the claim is paid or not.
b. Plans with high denial rates should be evaluated and required to submit a corrective action plan to determine the causes of high denial rates and steps to reduce the number of denials.
c. Reconcile the denied claims to determine how they impact the quality goals set for the program and whether those claims are included in the encounter data to determine the actuarial cost of the program.
d. Prohibit plans from denying claims when prior authorization was granted.
e. Prohibit plans from denying claims for not meeting timely filing requirements if it is an adjusted claim

4. Medical Policies set by Medicaid

Knowing coverage, authorization and payment policies is important to ensure all processes are followed. Historically, Medicaid medical policies have been updated regularly and are available for providers to access to know whether something is covered, documentation required and the level of payment. With Medicaid managed care plans, medical policies vary by plan. This creates significant administrative challenges for providers and results in payment denials and resources to appeal these denials.

FHA Recommendation: Medicaid medical policies should be reviewed annually, and updates or confirmation of the policy should be publicly available. Medicaid managed care plans should be required to follow Medicaid policy and not be allowed to create plan specific policies impacting care delivery.

5. Provider Complaints and Resolution

While providers try to get problems and issues addressed with the plans directly, many times these cannot be resolved. The Agency put in place the complaint portal for providers to submit issues for review and resolution. This is the only escalation process available to providers other than legal action. Unfortunately, that process has been less than useful in getting systemic issues resolved. Additionally, there is a lack of transparency of the complaints being filed, trending those complaints, resolution status and use of the data for process improvement within the Medicaid managed care program.

FHA Recommendations:

a. Improve the complaint submission process by creating clear procedures, rules and requirements for submission and escalation of unresolved complaints.
b. Allow providers to submit bulk batches of similar issue complaints to reduce the burden on providers by requiring individual complaint submissions.
c. Create a better process to determine the status of complaints, how they are resolved and whether this is a problem for multiple providers or multiple plans.
d. Increase transparency of the complaints being filed, trends in the types of complaints and steps take to resolve the complaints.

6. **Standards and Accountability for third-party vendors**

Plans carve out and contract with third-party vendors for a variety of services required to be covered under the Medicaid contract. These include behavioral health, audiology services, transportation, durable medical equipment, home health, and physical, speech and occupation therapy. These vendors have their own prior authorization requirements, some require submission of paper claims, and many times they do not have the expertise or services needed by the Medicaid patient. Many do not have specialty care and equipment specifically designed for the pediatric population, resulting in significant delays in getting care for these children. When these services are carved out, hospitals are prevented from providing services such as therapy and audiology, unless they contract directly with the third party vendor for rates lower than what they would receive directly from the plan. Additionally, many of the plans contract with the same vendors resulting in network adequacy issues and significant delays in getting services and care.

FHA Recommendation:

a. Health plans must submit a list of all the third-party vendors they are using and the Agency should review to determine if network adequacy is met as multiple plans are using them in their networks.
b. Third party vendors should be held to the same standards as the Medicaid plan, including reporting adherence to contractual obligations for timeliness of services. For example, transportation companies should have to report certain statistic to AHCA to ensure the time requirements are being met.
c. Performance of the Third-Party Vendors should be tracked and publicly reported along with the contracting plan.
d. Hospitals should not be required to subcontract with third party vendors to provide those services which would be covered by the plan if the plan was paying for those services directly.

Improving timely access to providers and services

One of the goals of the program was to increase access to services for the Medicaid population. While the contracts set for requirements for network adequacy and timeframes for services, it is unclear how this is monitored, validated and tracked. Recommendations to improve timely access to providers and services are below:

1. **Adopt a more comprehensive approach to tracking and monitoring network adequacy**
   Ensuring plans have the appropriate number of providers is key to serving the Medicaid population. While there are some standards set forth in the contract, we believe there is opportunity for a more comprehensive methodology to monitor and track network adequacy. Many of the plans contract with the same providers. On an individual plan basis, it appears they meet the state requirements. However, if it is evaluated holistically, the networks might not be adequate because of the overlap of providers in the different plans. For post-acute care, this issue is particularly challenging since many post-acute providers (home health, skilled nursing, long-term acute care, behavioral health) limit the number of Medicaid managed care patients they will accept due to the low reimbursement, denials, or administrative burden. Having an adequate network for services covered under the Medicaid program is key to members getting timely access to care and services.

   Recommendations:
   a. Adopt more comprehensive reporting to determine network adequacy including information on the range of services provided by providers and appropriateness to the population covered by the plan. This would include third party vendors who have been contracted to provide certain services.
   b. Monitor overlap of network providers in multiple plans to ensure providers have capacity (this includes SNF and other post-acute care providers
   c. Address issues with lack of home health providers and monitor service timeframes and no-show rates
   d. Develop time standards for home health, DME, and monitor compliance with those along with transportation vendor performance. The Agency should develop an audit process to ensure the accuracy of the data reported. (AHCA should audit)

2. **Shorter authorization timeframes and monitoring compliance to ensure timely access to services for the Medicaid member**
   Hospitals have reported significant issues and delays with getting care authorized for Medicaid patients. For the pediatric population, this is particularly impactful given any delay in care might result in permanent long-term disabilities. This includes delays in authorizing durable medical equipment, physical, occupational and speech therapy, home health services.

   FHA Recommendations: See the list in Section 2 of “Improving the Provider Experience”

3. **Increase access by reducing delays in credentialing providers**
   Delays in credentialling and loading the providers into the system creates significant access issues for the Medicaid population. If a provider is not in the system, they can not obtain authorizations or receive payment until they are in the system. Improvements in this area will help increase timely access to providers.

Recommendation: See the list in Section 1 of "Improving the Provider Experience"

4. **More oversight and monitoring of third-party vendors**
   When services are contracted out to third-party vendors, the requirements for authorization might be different and the network of providers could be more limited. For example, hospitals are reporting it is taking a significant amount of time on the phone to get transportation arrangements made and they are given a 3–5-hour window of when the patient can be transported. When transportation arrives, they may not have adequate training or experienced in transporting complex patients, they show up in the wrong mode of transportation and many do not have child seats available for the pediatric patients. And at times, they do not show up at all. It is not clear how the plans are monitoring their compliance with performance standards, but these delays are causing significant access issues.

5. **Telehealth coverage**
   During the public health emergency, adoption of telehealth services helped to increase access when provider offices were closed or there were concerns about seeking in-person care.

   FHA Recommendation: Continue the flexibilities for telehealth allowed during the PHE and adopt parity payment policies to support the offering of these services.

Improving Recipients' Experience with the SMMC Program

Many of the recommendations above would improve Medicaid recipients' experience with the program since these issues ultimately impact their ability to get care, result in concerns with they see payment is denied or a service isn't covered.

Utilize Value-Based Payment Designs to Increase Quality and Reduce Costs

Adoption of value-based payment design could significantly help reduce costs and improve quality, in addition to addressing some pain points listed above. Currently, most of the value-based arrangements are with physicians, not the hospitals or health systems. Given challenges with ensuring timely access to care, VBP approaches would allow the hospitals to address those directly instead of dealing and navigating challenges with third party vendors.

FHA Recommendations:

1. The Agency should create measurable goals around adoption of VBP and track progress towards those goals
2. The Agency should create a standardized framework, measures, and guidelines for a VBP model within the SMMC program that aligns with models being used in the Medicare and commercial areas. The framework could include several different approaches such as:
   - Incentive payments for meeting certain metrics
   - Shared savings models
   - Accountable care organizations
   - Models should consider the type of provider organizations and their unique nature
3. There should be regular reporting on specific metrics related to VBP programs
   - Set up standard reporting
   - Require quarterly
   - Post results on AHCA website

4. A standard attribution approach and identification of key data need to manage the patient population should developed in collaboration with those participating in the VBP programs.
5. Timely, accurate encounter data should be provided to all those participating in VBP programs.

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

The AHCA Stakeholder and Health Plan Workgroup on Birth outcomes convened to identify common solutions to improving birth outcomes and identified opportunities for improvement to reduce pre-term birth rates, babies born with neonatal abstinence syndrome and primary cesarean rate. Among these opportunities are improved coordination of care, need for screenings and early intervention and addressing social needs in addition to medical needs to support the goals of pathways out of poverty. With the waiver approval to permanently extend post-partum care for 12 months after delivery, there is a significant opportunity to improve birth outcomes for mothers and infants.

FHA Recommendations:

1. Require MMA plans to adopt a maternity medical home model (MMH) for high-risk mothers. The Agency should develop consistent standards and components for the MMH and metrics to track performance.
2. The Agency should adopt standard metrics/tools for MMA plans to meet to improve birth outcomes
    - Prenatal visits
    - Screenings for other health issues
    - Risk screenings for infants
    - Follow up visits after delivery
3. Eliminate barriers to address other health issues of the mother by requiring plans to allow direct referrals from OB providers to other providers (cardiologist, MAT) without having to go to primary care provider
4. The plans should be required to develop incentive programs for providers to increase screenings and referrals to treatment

Improve mental health outcomes for children and adolescents

Access to behavioral health services for children and adolescents is a challenge in general and even more challenging under Medicaid managed care. The shortage of providers, low payment rates and potential barriers through authorization requirements or use of third-party vendors has created delays in care and have made it more difficult for children and adolescent to receive care. Florida is below the national average for follow up visits within 7 days after hospitalization for mental illness for Medicaid recipients 6 to 17 years of age.

FHA Recommendations:

1. Incentivize the integration of behavioral and primary care within provider organizations by offering integrated contracts at enhanced rates for providers who are providing integrated care. This would include incentives for

    a. Children and adolescent wellness visits and screenings
    b. Timely follow up after hospitalization for a behavioral health issue
    c. Assignment of case managers for those children and adolescents diagnosed with behavioral health issues

2. Utilize value-based contracting within a shared risk model for providers who are willing to contract under a sub-capitated model.
3. Develop pilots to incentivize onsite behavioral health diversion services within emergency departments.
4. Adopt market-based rates to help enhance payment to staff and clinicians in order to alleviate workforce shortage.
5. Develop and monitor specific network standards for children and adolescent behavioral health providers and services.

We appreciate the opportunity to provide a response to this Request for Information and look forward to working with AHCA throughout the procurement process. If you have any questions, please do not hesitate to contact Michael Williams at MichaelM@fha.org.

Sincerely,

Michael Williams

General Counsel & SVP of Federal Affairs

Florida Hospital Association