FLORIDA HEALTH JUSTICE PROJECT, INC.

June 3, 2022

Cody Massa
Procurement Officer
Submitted via email to: solicitation.questions@ahca.myflorida.com

Re: 2022 SMMC Re-Procurement

Dear Mr. Massa:

The Florida Health Justice Project (FHJP) submits the following suggestions for improvements in the existing processes of the SMMC Program. We do not need to redact anything in this document.

FHJP is a nonprofit health advocacy organization whose mission is expanding access to healthcare with a focus on Florida's most vulnerable populations. Accordingly, we have prioritized work on behalf of low-income frail and disabled seniors who require home and community-based services (HCBS) in order to remain safely at home and out of an institution and who are enrolled in the Long-Term Care (LTC) Waiver. We also prioritize work for vulnerable children and pregnant women. All of these populations are enrolled in SMMC.

Need for ensuring notices and fair hearing rights are meaningful

We applaud the Agency for the pro consumer language regarding fair hearing rights in the recently approved LTC 1915(c) renewal request. *See*, 1915(c) renewal request, Appendix F-1: Opportunity to Request a Fair Hearing at 212. (The language in the core current contract governing both LTC and MMA is also excellent. *See* AHCA Contract, Attachment II, Scope of Service-Core Provisions, 89-91.)

However, the number of enrollees who are able to exercise their due process rights in a meaningful manner is exceedingly low. We are in the process of reviewing 161 hearing decisions for all fair hearing decisions in LTC appeals over the course of one year: June 3, 2020 to June 3, 2021. To date, we have reviewed 90 decisions, over 50% of the total. Only two (2) had an attorney. Not surprisingly given the challenges facing pro se litigants and the immense advantage enjoyed by the plans who are well represented at the hearing level, only 9 of the hearings (10%) reviewed to date were decided in favor of the petitioner (an additional 7 prevailed on part and lost on part).

Suggestion:

Accordingly, we would urge that the template Notice of Adverse Benefit Determination include reference to the availability of free legal assistance and an updated link to local legal aid providers. Significantly, there is state precedent for including information regarding free legal services in the Notices of Case Action provided by the Department of Children and Families.

This suggested improvement will likely generate additional hearings. We would urge that the cost of those additional hearings be borne by the plans. The procurement process should include discussion of how that additional cost should be equitably allocated among the plans.

While the hearing data above pertains only to LTC hearings, including legal services contact information on Notices of Adverse Benefit Determination (ABD) should be required in all SMMC program ABD notices.

Need for ensuring that the plans' standards for coverage of required services are no more restrictive than the Agency's standards and that medically necessary services are actually provided. Two examples illustrating the need for this improvement are described below.

Home delivered meals (HDM)

In the course of representing LTC clients whose services have been denied, reduced or terminated, we have identified circumstances in which the plan is employing a coverage standard more restrictive than AHCA's. For example, one plan terminated the home delivered meals (HDM) for 2 of our clients, notwithstanding the fact that the enrollees' health had declined, and they were receiving no new additional support, either through plan services or informal support.

When we reviewed the plan's coverage requirements for HDM, it was clear that the plan's standards were more restrictive than AHCA's, e.g. the plan policy excluded from coverage: *those who do not reside alone or who spend long periods of time alone; and those who reside with a family member.* These exclusions from coverage do not appear in AHCA's standard.

We assume that there are others who, like our recent clients, are also being denied HDM based on the plans' overly restrictive coverage parameters. The plan in our cases settled both HDM appeals before we could explore these questions through discovery, and the Agency has not yet responded to our request for specific corrective actions.

Panty liners:

Our client, who suffers from incontinence and receives coverage for adult diapers, was denied coverage for panty liners (a service which had previously been provided to her). Our client's daughter even offered to receive fewer diapers if she could get panty liners for her mother. She explained to the case manager that panty liners are much easier to change than diapers, and that the ability to change more frequently and keep her mother drier diminishes her mother's ongoing risk of urinary tract infections (UTIs).

The daughter was told by the case manager that panty liners are "no longer covered" by the plan, even though they are cheaper than diapers. To our knowledge, there are no written policies in which the plan excludes coverage of panty liners.

As with HDM, after we filed the hearing request and were about to commence discovery, the plan reversed its denial and approved coverage. The Agency has not yet responded to our request for specific corrective actions to ensure that other enrollees in this plan are not similarly denied coverage of panty liners.

Suggestion:

Pursuant to the Agency's authority and responsibility to ensure that the coverage policies of managed care plans comport with governing federal and state authority, we are suggesting that the following corrective actions be integrated as part of the procurement process.

First, establish coverage standards for all services, e.g. HDM, panty liners, etc. These standards should be uniform throughout the SMMC program. These uniform standards should be published on AHCA's website and in hard copy member handbooks provided to enrollees. This will help ensure that plans are no longer able to create their own coverage policies that are more restrictive than AHCA's (as in the HDM example above). It will also protect against plans implementing unpublished policies and practices excluding coverage of a service altogether (pantyliner example).

Second, the procurement process needs to ensure that plans are clearly subject to liquidated damages for a policy and/or practice of excluding medically necessary covered services, and/or implementing a coverage policy or practice that is more restrictive than AHCA's.

Need for ensuring that subcontractor policies and practices do not adversely impact access to medically necessary services for enrollees.

In the course of assisting children needing pediatric therapies, e.g. speech therapy, we have found issues adversely impacting access to medically necessary services due to subcontractor policies and practices that, *inter alia*, result in lack of network adequacy.

Suggestion:

We urge that the Agency incorporate consumer safeguards ensuring that subcontractors' policies and practices do not adversely impact access to medically necessary services for enrollees. The re-procurement process presents an opportunity to ensure that contract language is adopted requiring that subcontractors comply with medical loss ratio requirement applicable to MCOs; make all subcontractor audited statements, including audited MLR reports, publicly available; and ensure that subcontractors not be allowed to essentially transfer the "risks of capitation" to the subcontractors' network providers.

Need for ensuring that plans address Social Determinants of Health

It is now well understood that patient health outcomes depend not just on excellent care, but also on the myriad social determinants of health. We strongly encourage the Agency to use the procurement process as an opportunity to put Medicaid to work to address social determinants of health.

Suggestion:

All plans should be required to screen for social determinants of health, and then to actively connect members to available resources. Plans should also be encouraged to maximize the reimbursable role of caseworkers and social workers who support enrollees/patients in addressing social determinants of health, e.g. housing insecurity, food insecurity, lack of access to transportation.

Need for ensuring improved maternal health:

Florida receives a D+ from the March of Dimes for maternal health. At the same time, important work is being done by academics and practitioners to move the needle. Florida houses a wealth of expertise on improving maternal health, including addressing disparities.

Suggestion:

We encourage the procurement process to include consultation with providers who have proven track records of improving outcomes. Among those who should be consulted, midwives, and particularly Black midwives serving Black women and birthing people, can provide vital input regarding best practices and models to be encouraged via the procurement process.

Procurement and future contracts must emphasize not just improving maternal health outcomes but decreasing persistent disparities in maternal health outcomes. Key to reaching these goals: reducing C-section rates, increasing access to culturally and linguistically congruent providers, including midwives and doulas, and addressing provider bias. We note that in 2020 FHJP undertook a "secret shopper" survey of available midwives for all plans serving the Miami-Dade region and found few in-network midwives who were accepting new member patients. The survey findings were not new. The lack of adequate midwife provider networks is longstanding and the procurement process should require higher numbers of midwives.

The low rates of plan midwives are attributable in part to low reimbursement rates, and in part to the extensive bureaucratic hurdles faced by many small providers. We understand, anecdotally, that birth centers and home birth midwives are regularly seeking payment for claims a full year after services were provided. The procurement process should require timely reimbursement and an appeals process for providers facing undue delays in reimbursement.

Similarly, while every plan has stated that they are covering doula services, the on-the-ground reality is that only a couple of plans have in fact put in a mechanism for reimbursement. Doulas, and the midwifery practices that sometimes employ them, must be provided with clear fee schedules from plans, and a timetable for reimbursement, along with an opportunity for appeal in the case of non-compliance.

Thank you very much for considering these suggestions for improving the existing SMMC Program. We look forward to hearing from you on how we can continue to engage as a

stakeholder in the procurement process. Please feel free to contact us if you have any questions about our response to the Request for Information.

Sincerely,

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Cc: ***VIA EMAIL***
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