Executive Summary: Recommendations for the Georgia Department of Community Health's Care Management Organization Georgia Families Contract

January 2023

Background

Sellers Dorsey has worked with the Georgia Office of Health Strategy and Coordination (OHSC) in reviewing the current care management organization (CMO) contracts and providing strategic insight on national trends and the direction CMOs have taken to modernize and expand the person-centered nature of Medicaid managed care. We have prepared a detailed final report ("Final Report") summarizing our recommendations, policy considerations, and applicable analysis. This report will serve as an Executive Summary for the Georgia Families contract to the Final Report. Georgia currently has two contracts for Medicaid managed care. Georgia Families is a full risk mandatory Medicaid managed care program that delivers health care services to members of Medicaid and PeachCare for Kids. Pursuant to DCH's website, "the program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). Georgia Families provides members a choice of health plans, allowing them to select a health care plan that fits their needs." Georgia's other Medicaid Managed Care contract is Georgia Families 360°, a program for children and adolescents in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system. Pursuant to DCH's website, Georgia Families 360° delivers health care services to "27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system." This Executive Summary is specific to the Georgia Families program recommendations contained in the Final Report. A separate Executive Summary containing recommendations for the Georgia Families 360 program can be found on the OHSC website.

Programmatic Considerations

Program Design

Currently, Georgia has three CMOs serving its traditional low-income Medicaid adults and children as well as those children eligible for the Children's Health Insurance Program (CHIP), PeachCare for Kids®, through a full-risk mandatory managed care program called Georgia Families. Georgia also has a single CMO serving its foster care, adoption assistance, and juvenile justice populations through the Georgia Families 360° program.

Recommendations:

- There should be at least three CMOs within the Georgia Families program to balance member choice and to ensure competition within the Medicaid managed care program. The State should consider the benefits and risks that are more fully articulated in the Final Report if the State is considering deviating from the current number of CMOs and should also develop a deliberate plan for assisting any non-incumbent CMO with acquiring a critical mass of enrolled member lives as quickly as possible.

Preferential Assignment

Preferential Assignment is a term indicating that CMOs can obtain special consideration for member assignment in the State's member assignment logic that is responsible for assigning newly enrolled Medicaid members into the CMOs. Further, preferential assignment can be a tool the State can wield to

incentivize and reward CMOs for improved outcomes of their members, or specific categories of members, in one period compared to a prior period.

Recommendations:

- Preferential assignment should be included in the Georgia Families program. Further, the State should work to align incentives between member health outcomes and the State's assignment of members to specific managed care plans.
- If a non-incumbent CMO(s) is awarded in the future, implementation of preferential assignment should be delayed or suspended until the new CMO(s) have (or has) reached a critical mass of enrolled members so that the plan is able to be financially viable.
- The State should develop the appropriate types of preferential assignment logic to align with program goals and the State's quality strategy. Additionally, this logic should focus on Social Determinants of Health (SDOH) and Value Based Purchasing (VBP) models that the State identifies as areas of priority.

Value Based Purchasing Opportunities

Value based purchasing (VBP) opportunities are strategies of payment that link financial incentives to performance measures[1].

Recommendations:

- Implement the current VBP program as described in the Georgia Families contract to hold the CMOs accountable for their performance on the selected quality metrics from now through the implementation of the new CMO contracts. Because it may not be feasible in the time remaining for the CMOs to recontract with providers and share 50% of incentive payments with those providers as required by the VBP withhold program, DCH should consider whether there is time to restructure the withhold amount and reduce the amount that is at risk for meeting the selected quality measures from five percent to three or two percent. The State could require the remaining two or three percent to be reinvested in approved State priorities such as addressing SDOH needs or advancing health equity initiatives. Alternatively, the remaining percentage could be used to invest in provider readiness to participate in VBP arrangements, such as data analytics capabilities and/or a uniform reporting system for providers.
- During this same time, the State should also convene a working group of stakeholders that consists of members of the Medical Care Advisory Committee, healthcare providers, CMOs, and representatives from the Georgia General Assembly to inform the next iteration of the VBP program and obtain stakeholder buy-in.
    - As part of the workgroup process, the State may present a program that aligns with the APM Framework or a similar structure with three or four categories that move the system along a risk continuum. For example, Category One would include pay-for-performance incentive payments or withhold arrangements, Category Two would include upside-only shared savings, and Category Three would include risk sharing (at least five percent for upside and downside risk) and/or global or capitated payments with full risk. Each category would have a specific target for the percentage of provider payments that must

[1] RAND: Measuring Success in Health Care Value-Based Purchasing Programs

be in the type of VBP arrangements outlined in each category. The State could gradually increase the percentage required in each category year over year for the duration of the new contract term.

- If the State is not able to fully develop a new, robust VBP program prior to the end of the current contract, the State could convey an expectation for CMOs to partner with the State to implement a meaningful VBP program over the life of the next contract.

Alignment of Program Goals with Goals of Supplemental Payment Programs

DCH has several supplemental payment programs in place that are quality-based and geared toward increasing access to high quality hospital-based care for Medicaid members.

Recommendation:

- Pursue alignment of DCH's programmatic priorities with all existing or newly pursued supplemental payment/directed payment programs, including any new initiatives implemented through the next Georgia Families contract.

Incentivizing Social Determinants of Health

Over two-thirds of states with Medicaid managed care programs responding to KFF's *Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022* stated that they have included provisions relating to social determinants of health (SDOH) in their managed care contracts. More than half of responding managed care states reported the following requirements were in place in FY2021:

- Screening enrollees for behavioral health needs
- Providing referrals to social services
- Partnering with community-based organizations (CBOs)
- Screening enrollees for social needs

Recommendations:

- Require staffing positions for the CMOs, such as a health equity director and/or housing coordinator.
- Outline SDOH-related expectations for population health management programs such as collecting and analyzing social needs data, understanding social risk factors underlying racial and ethnic disparities, and expanding access to community health workers.
- Require QAPI strategies and targeted Performance Improvement Projects (PIPs) that address specific populations with SDOH needs.
- Provide guidance on offering services outside Medicaid covered benefits such as value-added services, in lieu of services[2], and activities that improve health care outcomes and define how a CMO may get credit for those services in the calculation of rates or medical loss ratios. If actuaries agree that the rates are actuarily sound, states can make their own decisions about how to account for SDOH expenses.

[2] In lieu of services are alternate services that are not included in the state plan or otherwise covered by the contract but are medically appropriate and cost-effective substitutes for services included in the contract.

- Tailor incentive and withhold arrangements to reinforce State priorities relating to SDOH and whole person care models.
- Incentivize or require CMOs to invest in community reinvestment activities. See Arizona, North Carolina, Oregon, and Ohio as examples.
- Allow, where permissible, expenses for SDOH-related interventions to be included in the medical loss ratio (MLR) numerator for each CMO (see West Virginia as an example).
- Require CMOs' care management and care coordination programs to incorporate SDOH needs and track the health impact of any SDOH need that the CMO meets for that member over time.
- Mandate that CMOs use a closed loop referral system for SDOH-related referrals. States have used outside vendors to manage a closed loop referral system between the CMO and community organizations. The State could procure such a vendor and require the CMOs to participate with and use that vendor for all its assigned populations or could require the CMOs to collaborate to select a single vendor.
- Carry forward the Community Health Worker (CHW) program that is identified in the current contract and re-implement the program with clear expectations about how this health care workforce can be leveraged to enhance the cultural competency of the services made available to the State's members.
- Review population-specific SDOH-related needs. For example, consider implementing care management and care coordination programs for the maternal and post-partum populations during the extended 12-month post-partum period that the State has implemented.

Implementing Health Equity Related Goals

States are using managed care contracts as an opportunity to articulate their health equity expectations and to advance related goals as a logical extension of the efforts to screen for and address SDOH. Such approaches may leverage SDOH-related data and use it to drive better health outcomes across populations based upon what their unique environmental and non-clinical needs may be.

To this end, some states are articulating cultural competency requirements across CMO functional areas, such as care management and member outreach, and requiring a diverse and culturally competent workforce. This is in line with the recommendation mentioned above that recommends bolstering the design of the community health worker program outlined in the current contract. In fact, Kentucky expects cultural competency to be a core component of its CMO programming.

Recommendation:

- The State should prioritize laying the groundwork for health equity policy development and strategize around it. To this end, the State should include definitions for key terms and create and communicate a mission, vision, and goal statements pertaining to its health equity goals in the CMO contract.
- The State has extended the post-partum period of coverage for new mothers enrolled in Medicaid from 6 months to 12 months. We recommend that the State consider how to articulate expectations for the CMOs to leverage this coverage period. This can assist with connecting holistic care for new mothers with a focus on integrating physical and behavioral health needs as well as identifying and addressing SDOH needs of this population.

Redeterminations

Since the onset of the public health emergency (PHE) and consistent with federal law since early 2020, Medicaid agencies have not moved forward with redeterminations in exchange for a temporary increase in the federal matching assistance percentage (FMAP) from the federal government. On December 23, 2022, Congress passed the "Consolidated Appropriations Act of 2023," also known as the omnibus bill and President Biden signed the bill on December 29, 2022. The bill includes several provisions on the PHE including the sunsetting of the continuous Medicaid and CHIP coverage requirements on April 1, 2023, phasing down enhanced Federal Medical Assistance Percentages (FMAP) over calendar year 2023, requiring states to publicize reports and maintain compliance or be subject to FMAP penalties, and providing CMS greater enforcement tools. CMS has the potential to also play a more prescriptive role through regulation or sub-regulatory guidance in how states should best leverage CMOs in the future to assist with ongoing redetermination requirements. The State should use its managed care program to leverage CMOs in the future to assist with the PHE unwinding related redetermination requirements as well as its ongoing redetermination requirements during the life of the contract.

Recommendations:

- Review any existing opportunities for improved periodic information exchanges within the State and CMOs.
- In the new contract, require the CMOs to play a role in the redetermination process by leveraging their relationships and periodic contacts with Medicaid members to ensure that the State has the most up-to-date contact information for its Medicaid members. This will help to increase the likelihood of engaging more members in the process.
- In the new contract, create incentives for the CMOs to improve interactions between themselves and providers in order to enhance the quality and accuracy of information.

Care Coordination

State Medicaid agencies have focused on several strategies to establish robust care coordination programs that include using risk assessments to set a baseline determination for care coordination needs, identifying the qualifications of care coordinators, and setting minimum standards for reaching out to enrollees to coordinate their care.

Several states have also used a tiered approach for coordination efforts. For example, the New Mexico managed care contract requires that the health plan stratify members who meet specific criteria into care coordination levels 2 or 3, which includes assignment to a specific care coordinator and touchpoints with the member at specified intervals (monthly, quarterly, or annually).

Recommendations:

- Develop a standard approach to health risk assessments and more comprehensive needs assessments to ensure consistency across CMOs.
- Assign beneficiaries to appropriate level of care coordination based on initial screens. Include prescriptive requirements for care coordination in the managed care contracts, including assignment of beneficiaries to specific tiers of care coordination within their CMO.

- Require CMOs to designate a specific care coordinator for each member assigned to care coordination so beneficiaries know whom to call with questions and the type of services that are provided by care coordinators.
- Establish policies and systems to facilitate information sharing among providers to support care coordination. These approaches include processes to share care plans, which can help beneficiaries and providers better coordinate care, to make referrals to specialists and community-based organizations to address SDOH needs, and to ensure that referrals are closed, and results are communicated back to the referring provider.
- Leverage existing quality measures to monitor and assess the impact of care coordination.
- Define specific care coordination activities that are deemed medical (face-to-face meetings) and counted on the medical side of the Medical Loss Ratio and those that are deemed administrative (health risk assessment).
- Be prescriptive about whether CMOs or providers (medical homes) are responsible for the provision of care coordination or a combination of both. New Mexico requires that the health plans serve as the lead for delivery of care coordination but allows for delegation of the provision to certain providers with clearly delineated responsibilities between the two entities.
- Outline specific requirements for the health risk assessment process, including frequency (at initial enrollment only, annually, or upon change in condition) and develop a uniform assessment for use across all health plans that includes assessing for certain SDOH needs. The State could require the CMOs to participate in the development of a standard assessment or the State could separately develop the assessment and require its use, like in North Carolina.
- Develop requirements for how members are assigned to levels of care coordination and include expectations for types and frequency of member touchpoints within each level.
- Require the health plans to assign a specific care coordinator to each member in higher levels of coordination and develop staffing requirements for level of education and types of training the health plans must conduct, as well as establishment of appropriate case load ratios.
- Set expectations or develop common elements for a more comprehensive needs assessment by the health plan once a member is assigned to a higher level of care coordination or case management.
- Create timelines for completing comprehensive needs assessments and individualized care plans.
- Develop more robust requirements for ongoing care coordination activities, including identification of members who may become eligible for higher levels of coordination, monitoring of utilization of care plan services, and monitoring of changes in members' condition/risk.
- Because the Georgia Families 360° contract includes more prescriptive care coordination requirements, assess how best to align the requirements across managed care programs to ensure consistency in policy and implementation. Include an evaluation of the Georgia Families 360° care coordination program in the External Quality Review Organization's (EQRO) scope of work that will assess the current CMOs' compliance with care coordination requirements. The evaluation results can be used to leverage best practices and successful program outcomes that are identified.

State Medicaid Quality Strategy

The quality strategy and the most recent external quality review organization reports identify specific areas for quality improvement that should be considered for the next contract.

Recommendations:

- Have clear intentions and expectations on how reports and data will be utilized by the State. Having regular reporting calendars and frequent meetings with each of the CMOs are important aspects of addressing quality and performance improvement. The dashboards and reports are good indicators on where improvements and opportunities exist.
- Add additional performance requirements associated with the current 5% capitation withhold to incentivize quality improvement.
- Hold CMOs accountable for improvement based on current contract requirements. For example, as mentioned above, the current contract specifies liquidated damages of up to $100,000 per violation for the CMOs failure to achieve the performance target for each quality performance measure and more specific sanctions and damages for certain measures. These may be appropriate steps to hold the CMOs accountable for improvement, but it would be prudent to confirm if there have been any liquidated damages assessed and whether the thresholds and penalties should be revisited to drive performance. Sometimes liquidated damages do not have the intended incentivizing effect on operations, so an analysis into whether they have been effective in the current contract period could be instructive about how and to what extent these types of liquidated damages should be carried forward in the next contract.
- Include both penalties and incentives for not meeting baseline performance, reduced performance, and incentives for percentile improvement once meeting the HEDIS 90th percentile.
- Set baselines and benchmarks that are realistic and attainable. As mentioned in the full report, it appears that benchmarks are low for a program as mature as the Georgia Families program.

Behavioral Health Related Coverage and Coordination in Medicaid

Since the Public Health Emergency (PHE) began, most Medicaid programs across the country have seen an increased demand for behavioral health care services as well as an opportunity to enhance the coordination of services provided by physical and behavioral health care providers.

Recommendations:

- The State should continue to bolster efforts in coordination of care by including express requirements and expectations for the CMOs in the managed care contracts.
- The State should revisit the provider credentialing requirements, grievance/appeal requirements, and other administrative actions between the CMOs and their in-network behavioral health care providers.
- The State should carry forward the requirements in Section 4.11 of the current contract into the next contract. In Section 4.11, the State outlines what the CMOs are required to report to the State in terms of provider networks and access, coverage policies, the behavioral health care status of members, and the CMOs efforts to better engage the members and to coordinate their services within the broader context of the behavioral health care system.

- There should be additional opportunities for the CMOs included in the contracts to evolve their focus on behavioral health care access, including requiring one of the performance improvement plans to be undertaken by the CMOs during the life of the contract. This plan should be behavioral health focused, create value-based payments for providers based on year-over-year increases in behavioral health outcome measures for their populations, and/or create more explicit instructions requiring EPSDT screening rates for certain behavioral health care services for the CMOs' child and adolescent populations.

Reducing Administrative Burden

There is an opportunity to drive more uniformity through the review process and to ensure that contractual requirements regarding timelines and turnaround times are met. Many states have implemented service level agreements for appeals and penalties with CMOs. These standards must be enforced well.

Recommendations:

- Require a more uniform process, when possible, across all CMOs, for prior authorizations, appeals, and other review processes.
- Convene listening sessions and request suggestions from providers for more cohesive efforts on issues important to providers.
- Evaluate the fiscal impact and likely corresponding health impact of covering annual dental exams for any enrolled population for whom dental services are not currently a covered benefit.

Medical Loss Ratio Related Requirements

Currently, there are no Medical Loss Ratio (MLR) provisions in the Georgia Families contract, although an 85% MLR will be in effect as of July 1, 2023, pursuant to recently enacted legislation, House Bill 1013.

Recommendations:

- Establish standards, in conjunction with the Office of the Commissioner of Insurance and Safety Fire (OCI), regarding allowable medical and administrative elements of the MLR and define such a standard (if established) in the next contract.
- The MLR should be considered with the State's quality program in mind.
- Evaluate whether it is in the State's best interest to authorize certain SDOH-related expenses by the CMOs to count toward the numerator in the MLR calculation.

Areas of Interest for the Future

Implementing Coverage for New Populations

Georgia has limited the current Georgia Families managed care program to low-income families and children, and for the most part has excluded adults and children who are aged, blind, and/or disabled. While the Georgia Families managed care program has existed since 2004[3], the program has continued to

[3] Microsoft Word - GF Contract - Generic.docx (georgia.gov)

exclude some of the costliest and medically complex adults and children who may benefit from the type of care coordination and management that managed care plans can offer. Kaiser Family Foundation's most recent report on *10 Things to Know About Medicaid Managed Care* identifies that almost all (36) of the 41 states using the managed care delivery system include all beneficiary groups and about half (19) of the 41 states are including the elderly and disabled populations within their managed care contracts.

Recommendations:

- The State should be intentional as additional populations are introduced into managed care. The State should take a phased approach and introduce populations gradually to ensure success for each population.
- The State should focus on building trust and being transparent with stakeholders regarding the successes of the managed care program during the life of the next contract.
- The unified preferred drug list (PDL), including the PDL that was developed and recommended by OHSC and Mercer Government Human Services Consulting for mental health and substance use disorder drugs, is another opportunity for the State to leverage and build consistency and ease between the CMOs and the providers.

Managed Long Term Services and Supports[4] (MLTSS) Considerations

In 2021, there were 40 managed long-term services and supports (LTSS) programs operating across 24 states with varying program and service design elements. The following are the most common:

- Comprehensive managed care program that includes LTSS and non-LTSS benefits. Some states limit enrollment to populations eligible for LTSS while others include all populations.
- Plans that provide only LTSS benefits while acute/primary care or behavioral health services are delivered by another CMO or from the State's traditional FFS program.
- Single comprehensive plan that covers Medicare and Medicaid benefits for individuals who are dually eligible for Medicare and Medicaid, such as those offered through financial aligning incentive (FAI).

Recommendations:

- In establishing a MLTSS program, the following key factors need to be considered when adding populations to managed care in the future:
    - Allowing significant lead time for MLTSS planning and transition strategies.
    - Engaging continuously with stakeholders in the planning, implementation, and oversight of MTLSS to facilitate buy in.
    - Building confidence with the stakeholders and CMOs on coverage of more complex populations before moving to include LTSS.
    - Additional costs associated with the transition as the CMOs take on the responsibility for assessment, care plan development, service delivery and provider network contracting.

[4] Medicaid Section 1115 Demonstrations Summative Evaluation Report; MACPAC – MLTSS: Status of State Adoption and Areas of Program Evolution; MLTSS Institute – Demonstrating the Value of Medicaid MLTSS Programs

This generally creates some additional costs before moving to bend the cost trends for this high-cost population.

- MLTSS programs should only be implemented after coverage, and success in providing that coverage, of more complex populations has occurred. It requires significant planning and transition strategies as well as stakeholder engagement, and the State should use this next managed care contract to build trust, credibility, and transparency in the effectiveness of managed care in Georgia before embarking on launching an MLTSS transition. The first LTSS population the State should add to manage care is the population based upon SSI eligibility. Within the SSI-eligible groups, SSI children and adults would be the best first populations to phase-into managed care. Then, once the State demonstrated success in managing the care for these SSI individuals, the State can better assess and prioritize the other populations to bring into managed care.

Enforcement of Contract Provisions

Innovation requires a strong foundational Medicaid program that enjoys trust with the members and families it is serving as well as other important stakeholders. Once the program has the trust of these stakeholders, it then earns the ability to innovate. This means claims must be paid on time, provider networks are stable, provider credentialing is timely and smooth, and prior authorization processes are transparent and well-understood by providers. In other words, the basics must be performed and clearly articulated, with potential penalties for noncompliance. Additionally, no matter how much trust the current program enjoys because of its history of undertaking these activities, contract enforcement should continue to be a priority for the agency, including in the next contract period.

Recommendations:

- Ensure that the basics in running a trusted and strong foundational Medicaid program in a transparent manner are described prescriptively because often only then is there an appetite for innovation in the program. The "basics" include but are not limited to claims paid on time, stability of provider networks, smooth and timely provider credentialing, and transparent and understandable prior authorization processes for providers.
- Improve the level of public trust and project the ability to successfully operate a program that performs the fundamentals listed above while pushing innovation in strategic, prioritized elements of the program.
- Build momentum for the State to pursue innovations in the future by focusing on areas where meaningful progress can be made in helping families in the transition of eligibility categories for their children.
- Hold CMOs accountable based on current contract requirements. For example, the current contract specifies liquidated damages of up to $100,000 per violation for the CMOs failure to achieve the performance target for each quality performance measure and more specific sanctions and damages for certain measures. These may be appropriate steps to hold the CMOs accountable for improvement.