Governor's Office of
PLANNING AND BUDGET
THE STATE OF GEORGIA

OFFICE OF HEALTH STRATEGY AND COORDINATION

October 3, 2022

Commissioner Noggle,

Pursuant to O.C.G.A. § 31-53-3(b)(7), the Office of Health Strategy and Coordination (OHSC) is responsible for reviewing the Medicaid care management organization (CMO) contracts and making recommendations to the Georgia Department of Community Health prior to the next procurement cycle. To help meet this statutory objective, OHSC retained Sellers Dorsey to help review and analyze the current CMO contracts and compile the attached report of recommendations spanning several topic areas for your consideration as you prepare to draft the Request for Proposal (RFP) for the new Medicaid managed care contracts and solicit feedback from stakeholders.

Sellers Dorsey is a national health care consulting firm with a deep understanding of Medicaid financing and policy and maintains an experienced team and staff comprised of former state Medicaid directors, state healthcare officials, policy advisors, and individuals with professional backgrounds as senior-level staff for private and public hospitals, health plans, and health information technology organizations. With Sellers Dorsey's assistance, we conducted a detailed analysis and review of the provisions in the current Medicaid managed care contracts, and performed a survey of current topics, programs, policies, and innovations in other states. These recommendations are based on national landscape research and identified trends and successes observed in other states' Medicaid managed care programs.

As you will see in this report, there are a number of programmatic considerations and opportunities to connect some of the broader aims of quality-based supplemental payment programs to value-based initiatives, reduce administrative burdens, improve care coordination, incentivize social determinants of health, implement health equity related goals, and adopt more prescriptive contract language that clearly lays out expectations in detail to support oversight of the Medicaid program as a whole. The report emphasizes that a clear articulation of goals is central to ensuring public trust in the program and providing more room to innovate, and we believe the RFP can accelerate this process by articulating innovative themes and goals in its construct and in its scoring rubric.

We hope that you find this report to be a helpful resource as you prepare for the upcoming procurement of the CMO contracts.

Sincerely,

Grant Thomas
Director
Georgia Office of Health Strategy and Coordination

Recommendations for the Georgia Department of Community Health's Care Management Organization Contracts

October 2022

Background

Georgia's last care management organization (CMO) procurement was in 2017 for Georgia Families, a full-risk mandatory Medicaid managed care program, and 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. Sellers Dorsey has worked with the Georgia Office of Health Strategy and Coordination (OHSC) in reviewing the current CMO contracts and providing strategic insight on national trends and the direction CMOs have taken to modernize and expand the person-centered nature of managed care Medicaid. Additionally, OHSC organized a general discussion with members of the executive leadership team at the Georgia Department of Community Health (DCH), the State's Medicaid agency, so that OHSC, with assistance from Sellers Dorsey, could better understand how certain provisions in the contract are currently working. We understand that, in the preparation of finalizing and releasing the request for proposal (RFP), DCH has been soliciting feedback from a host of stakeholders. Accordingly, we have included a detailed analysis and review of the current contract provisions by topic where applicable in this report. Moreover, we have provided our recommendations by topic area for DCH's consideration in the procurement of the next Medicaid managed care contracts. This report is intended to be a survey of current topics, programs, policies, and innovations that states across the country have pursued for DCH and the state to consider ahead of the upcoming procurement cycle.

Programmatic Considerations

Program Design

Because Medicaid programs, and their respective CMO contract designs, can vary significantly across the country, the State has latitude to modify and craft new contractual language that aligns with its priorities. There is no "gold standard" regarding the number of CMOs with which the State should contract to meet the needs of its Medicaid members, though there does appear to be a budding trend of states relying on fewer – and not more – CMOs[1]. 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 called Georgia Families 360. The upcoming re-procurement for which the observations and recommendations contained in this report relate will be for both the Georgia Families and Georgia Families 360 programs.

From conversations and research, we determine that the current number of CMOs serving the State is appropriate. Specifically, having three CMOs balances the State's interest of ensuring member choice while also encouraging competition between CMOs. This competition is ultimately for the betterment of the plan's members and the State's taxpayers. As discussed, though having two CMOs serving a state will allow the State to meet its member choice requirement, there is an inherit risk if something were to happen to one of the plans. The State may then be unable to meet its requirements under federal law requiring enrollee choice of CMO enrollment and may be unable to ensure adequate access to health care

[1] Kaiser Family Foundation: Total Medicaid MCOs

services for its population. Continuing to rely upon three CMOs allows for flexibility in the unlikely event of one CMO experiencing serious clinical, financial, and/or administrative concerns.

On the other end of the spectrum, while circumstances could support more than three CMOs across a state, those issues do not appear to be present in Georgia currently. However, should the State desire to increase the number of CMOs who are awarded a contract in the upcoming procurement, it would be particularly advisable for the State to be deliberate in developing a plan to ensure any non-incumbent CMO is able to enroll and retain a sufficient number of members to make them financially viable, especially in the early years of the contract. In fact, being intentional in the RFP about signaling DCH's plan for ensuring fiscal sustainability for any newly selected, non-incumbent CMO may entice more non-incumbent CMOs to bid on the contract. Additionally, should the State desire to award more than three CMOs the contract for Georgia Families, the State will need to be prepared for the additional administrative requirements placed on the Medicaid agency that are not currently demanded today.

Finally, we note that even if the State desires to continue awarding the contract to only three CMOs, the opportunity for a non-incumbent to unseat a current CMO is real, and the same concerns articulated in the paragraph above about ensuring that any such non-incumbent CMO can retain a critical mass of newly assigned enrollees is an important consideration. Therefore, we recommend the State be deliberate about its planning for this scenario and, where appropriate, signal to non-incumbents in the RFP its plan for helping any non-incumbent CMO acquire a critical mass of enrolled member lives as quickly as possible. Recommendations are included below for the CMO program design.

Recommendations:

- There should be at least three CMOs operating in the state for the reasons listed above. The State should also be deliberate in planning for scenarios in which one or more non-incumbent CMOs are awarded a contract and to signal this intentionally through the RFP in order to entice more non-incumbent CMOs to bid on this work assuming an increase in competition for these contracts is desirable to the State.

Preferential Assignment

Preferential Assignment is a term indicating that CMOs have the opportunity to 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.

In general, as new applicants are enrolled in Medicaid, states typically employ an auto assignment logic for those new members to CMOs, and this algorithm often attempts, over time, to balance the distribution of membership across all the State's CMOs. This assignment logic may also try to balance the distribution of members by category over time across all CMOs. The State's ability to manage, innovate, and budget for the program tends to be administratively less complex with populations of similar size and acuity across all CMOs.

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. Simply put, as CMOs perform well, they can earn a higher number of member assignments, or a percentage, when compared to other CMOs of assigned members. One example of how the State can use

preferential assignment is to preferentially assign members with certain medical needs and eligibility categories to a CMO with a track record of proven outcome enhancements or other performance metrics for members with those specific needs. Further, health needs that states could prioritize and tie to preferential assignment of certain member groups would be based upon the CMOs' outcomes for that same population. For example, children could be preferentially assigned to CMOs with the best Early and Periodic Screening, Diagnostic and Treatment (EPSDT[2]) screening rates in previous periods; members most likely to have certain chronic disease could be assigned to CMOs' with the best member outcomes for those members with the same diseases; or pregnant women and new mothers could be preferentially assigned to CMOs with the best prenatal and post-partum outcomes in a previous period. Preferential assignment can be leveraged to incentivize CMOs to pursue quality health outcomes and other innovations aggressively. Preferential assignment might also be used to reward CMOs following demonstrated improvement in connecting members to appropriate interventions based on social risk assessment screenings of their members or to CMOs with growing volumes of value-based contracting arrangements with providers. Either of these final two options, if included in the new RFP, would signal that the State anticipates social determinations of health (SDOH) and/or value-based arrangements to take on more significance over the life of the next contract.

It is our understanding that Georgia used preferential assignment prior to the implementation of the current contracts, but it was temporarily discontinued to ensure that a non-incumbent CMO obtained a critical mass of enrolled members after the last procurement cycle. In the past, auto-assignment in Georgia was dependent on the outcomes of quality metrics from six-month intervals and allowed for plans meeting these quality benchmarks to receive these randomly assigned members.

Based on national landscape research, many states are allowing for some type of preferential assignment opportunity within the more general auto-assignment logic. Because preferential assignment can be an effective tool to guide CMOs to achieve member-level outcomes and other priorities identified by the State, we recommend reinstating preferential assignment logic during the next CMO contract cycle when the State believes that all CMOs have obtained a healthy level of retained membership. Given DCH's use and familiarity with preferential assignment in the past, it will likely prove to be an effective tool for the Department to use with the CMOs. Though it may not need to be an element that CMOs respond to in the RFP, we do encourage that the preferential assignment terms be included in the *pro forma* contract within the RFP to signal to the respondents this opportunity that the State will provide to high performing plans.

We do note, however, that if the State awards a contract to one or more non-incumbent CMOs, it may be advantageous to suspend the implementation of preferential assignment until the State can be assured that the new CMO(s) have retained a critical mass of enrolled members that will ensure its continued financial viability. We recommend including this implementation delay option in the *pro forma* contract within the RFP to assure non-incumbent respondents that the State is committed to making their launch successful.

[2] The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive health care services for children under age 21 who are enrolled in Medicaid. States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed based on federal guidelines. (*Medicaid.gov: the official U.S. government site for Medicare | Medicaid*)

The following are recommendations with preferential assignment for contracted CMOs.

Recommendations:

- Preferential assignment should be carried forward to the next contract and the State should include these terms in the *pro forma* contract included in the RFP to signal to the respondent CMOs of the State's desire to align incentives between member health outcomes and the State's assignment of members to specific managed care plans.
- If a non-incumbent CMO is awarded, implementation of preferential assignment should be delayed or suspended until the new CMO has reached a critical mass of enrolled members for financial viability. This should be included in the RFP so that non-incumbent plans are not deterred from submitting a proposal.
- The State should spend time developing the appropriate types of preferential assignment logic that align with its anticipated program goals over the life the next contract and with the State's quality strategy. Additionally, this logic should focus on SDOH and VBP models that the state identifies as areas of priority over the next contract period.

Value Based Purchasing Opportunities

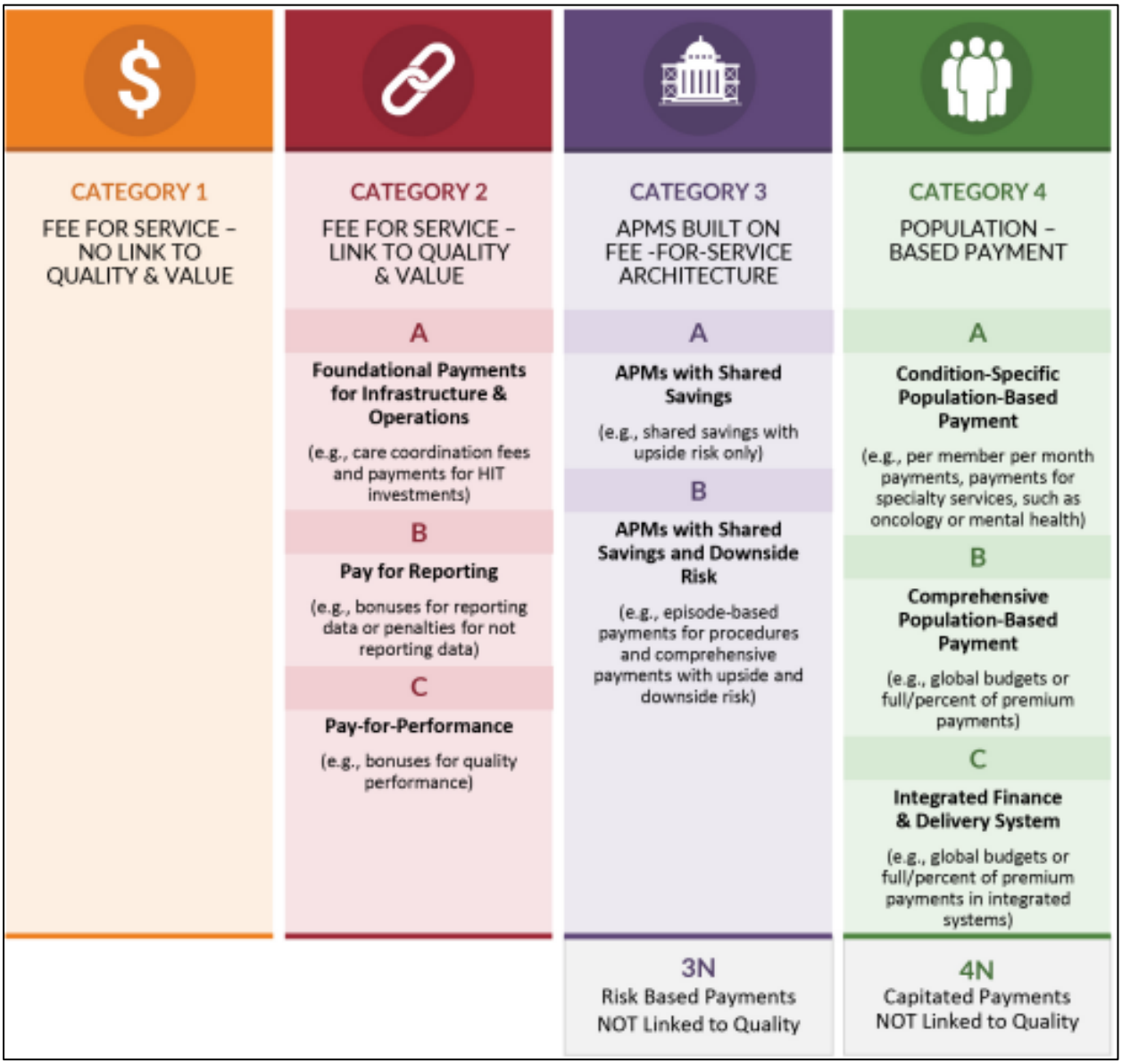
Value based purchasing (VBP) opportunities are strategies of payment that link financial incentives to performance measures[3]. According to Kaiser Family Foundation's October 2021 report, *Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022*[4], nearly half of responding states reported that delivery system and payment reforms remain a key priority.

Many states have used the Alternative Payment Model (APM) Framework created by the Health Care Payment Learning and Action Network (HCP-LAN) to classify VBP arrangements and are adapting this framework based on specific goals. The HCP-LAN APM framework is a useful guide to understand how payment approaches can be structured. To be considered value-based, payments must be tied to quality of care and/or health outcomes. Many models also include an element of financial risk to the contracting entity.

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

[4] Kaiser Family Foundation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022

Table 1. Health Care Payment Learning and Action Network (HCP-LAN) APM Framework[5]



Acronyms from table 1. HIT – Health Information Technologies

Before committing to a VBP approach, states should consider available resources and staff expertise for oversight, level of provider and CMO engagement in VBP in the State's current market (infrastructure capabilities), other payment reform activities in the marketplace, and alignment with the State's overall strategy and approach to Medicaid managed care (history of prescriptive requirements or of being more flexible).

Current requirements in the Georgia Families contract include a VBP withhold of five percent of the Contractor's capitation payment. To earn the five percent back, the Contractor is expected to meet performance metrics defined in Attachment U of the Georgia Families contract, which are primarily related to Healthcare Effectiveness Data and Information Sets (HEDIS) measures. The Contract also states

[5] HCPLAN: APM Framework

that health plans must "develop a plan" to share 50% of the incentive payments it receives from the Department with providers. However, there are no requirements related to how the Contractor and its providers may progress along a value or risk continuum over time. The current VBP requirements in the Georgia Families contract consist of a pay for performance program with a financial withhold based on five percent of annual capitation payments, which may be earned back for achieving performance thresholds on a set of quality measures. However, it is our understanding that the financial withhold has not been implemented as described in the 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 for Medicaid members to high quality hospital-based care. While there are base-level federal requirements that require those supplemental programs to drive DCH's quality strategy, there also may be some opportunities to connect the broader aims of these quality-based supplemental payment programs to the value-based care initiatives and other DCH policy priorities that may not be focused on hospital-delivered care. Top-to-bottom alignment of DCH's priorities can be a critical opportunity to maximize the return on taxpayer investment into the State's Medicaid program. It might also be an opportunity for DCH to serve as a convening state agency to help move the needle on other policy initiatives of the Governor, including increasing access to certain services and types of providers.

According to federal requirements, supplemental programs must drive the State's quality strategy. Supplemental payments are specific payments to providers. There are opportunities to make changes to the CMO contracts to address larger priorities within the State's quality strategy while also ensuring alignment between supplemental payment programs for providers and VBP arrangements in the CMO contracts. If there are some alignments in programs, funding can also be aligned in the disbursement of these funds.

Below are recommendations for VBP arrangements in future CMO contracts.

Recommendations:

- Implement the current 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 workgroup 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 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 robust VBP program prior to release of the RFP, the RFP could include a foundational expectation for the CMOs to partner with the State to carry forward and evolve the VBP program over the life of the 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 FY 2021:

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

Federal regulations require CMOs to conduct an initial screening of each enrollee's medical needs within 90 days of enrollment. The Georgia Families contract includes broad language that complies with the federal screening requirement but is not prescriptive regarding key elements of the screen. Some examples to bolster the language in the contract include assessing for SDOH needs, requiring specific interventions with members who were identified as having more complex conditions based on the screening, establishing the frequency of ongoing enrollee touchpoints, or mandating specific conditions/diagnoses that require higher levels of care coordination (substance use disorder, high emergency department usage, etc.).

Other states have been prescriptive about the initial screening conducted by the CMOs. Many states require the health plan's initial screen include assessment of SDOH needs in areas such as housing, employment status, food insecurity, physical safety, and transportation needs. Alternatively, Louisiana and Ohio require CMOs to reimburse providers for SDOH screenings and for submitting applicable diagnoses codes on claims.

There is ample opportunity for the Georgia Families contract to include more specific requirements regarding the elements and assessments to be included in the initial health screen and how enrollees identified as needing higher levels of care coordination should be treated. It should also require that the initial screening include screening for SDOH needs.

In addition to screening requirements, recent managed care RFPs in Kentucky and Oklahoma have included requirements for CMOs to incorporate SDOH in their quality assessment and performance improvement (QAPI) programs. Other states, such as Arizona and Ohio, are requiring CMOs to coordinate with community-based organizations and ensure closed-loop referral capability. Additionally, other states, specifically Louisiana and North Dakota, have included requirements for CMOs to provide training on SDOH to their staff.

The following are recommendations to be included in the RFP, all of which would bolster the SDOH language and intervention expectations that exist in the current CMO contracts.

Recommendations:

- Require staffing positions for the CMOs, such as a health equity director and/or housing coordinator.
- Outline SDOH-related expectations for CMOs 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[6], 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. As long as actuaries agree that the rates are actuarily sound, states can make decisions about how to account for SDOH expenses.
- 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 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 of its assigned populations.
- 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.

[6] 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.

- Review population-specific SDOH-related needs. For example, consider implementing care management for the maternal and post-partum populations during the extended 12-month post-partum period that the State anticipates implementing.

Implementing Health Equity Related Goals

States are using managed care procurements as an opportunity to articulate their health equity expectations and to advance related goals. This approach encourages the CMOs to conceptualize their approach to managed care within the context of advancing health equity and it is 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 CMO programming.

States, such as Louisiana, Ohio, Kentucky, as well as the District of Columbia, are also incorporating health equity into their quality management strategies, expecting evaluation of disparities and development of strategies to address them. For example, Ohio required its CMOs to implement the "Hypertension Control Improvement Project" informed by data showing higher rates of uncontrolled hypertension among Black patients as compared to white patients. The State launched the project in an effort to reduce this disparity and improve control of hypertension.

A few states have incorporated health equity principles into VBP requirements to address specific health disparities. For example, Pennsylvania has maternity care bundled payments which offer a financial incentive to reduce racial inequities in birth-related outcomes. Additionally, Nevada requires its CMOs to focus alternative payment models on incentivizing providers to address social determinants of health needs and on improving health equity in access to and delivery of health care services, including improvements in maternal and child health outcomes.

The State intends to extend the post-partum period of coverage for new mothers enrolled in Medicaid from six months to 12 months. This benefit extension has proven to be popular on a bi-partisan basis in recent years across the country. We recommend that the State consider how to articulate expectations for the CMOs to leverage this coverage period in a way that helps connect holistic care for these new mothers with a focus on integrating physical and behavioral health needs as well as identifying and addressing SDOH needs of this population.

In the current managed care contracts in Georgia, the State includes a cultural competency plan requirement and general provider network requirements, including the CHW program, but not a specific reference or section related to health equity. There is ample opportunity to develop and advance health equity initiatives within the State's managed care program.

In laying the groundwork for health equity policy development, states usually begin by establishing the Department's definitions of health equity and other key terms to guide the work. There are numerous definitions and terms (health equity, health disparity, health inequity), which can create confusion when

developing policies if a specific definition or term is not agreed to prior to policy development. Once agreement on terms is reached, it is important to identify and communicate equity as a strategic priority by integrating health equity into the agency's mission, strategic priorities, and goal statements. Identifying health equity as a strategic priority provides the framework within which the agency can pursue equity initiatives through the managed care program. Once the principles of health equity are more firmly grounded within the Department, Department staff can then set expectations of their contracted CMOs more deliberately and effectively. The following is a recommendation for the State as a starting point for including health equity in the CMO contracts.

Recommendation:

- The State should lay the groundwork for health equity policy development and strategize around it. An early part of this work includes establishing definitions for key terms and creating and communicating a mission, vision, and goal statements throughout the State. Once this is in place, the State can set expectations within the CMO contract and RFP. Doing so will also provide the State the opportunity throughout the next contract period to incorporate yet-to-be-developed programs and policies that are proven to reduce health care disparities across Medicaid populations.

Redeterminations

Since the onset of the public health emergency 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 from the federal government. As such, redeterminations may seem like an odd point to address in the upcoming RFP, but it is worth considering what role the State is comfortable with the CMOs playing in this ongoing activity once the public health emergency declaration is lifted. Regardless, CMS may 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.

One of the clearest advantages for having the CMOs play a part in the redetermination process is that their ongoing interactions and communications with members mean that they might generate a higher engagement rate of members engaging in the redetermination process than if the State managed this ongoing process on its own. Therefore, we recommend including in the *pro forma* contract and RFP specific expectations and requirements regarding ongoing outreach from the CMOs to their members who come up for redetermination during the life of the contract. One example is to include language in the *pro forma* contract requiring the CMO to proactively outreach to members for whom the State will be initiating redeterminations to increase the member participation rate in the redetermination process.

Additionally, we recommend that DCH consider what opportunities exist for improved information exchanges (daily, weekly, or monthly) from the CMOs to the State to ensure DCH has the most up-to-date contact information, or at least a secondary form of contact information, as well as considering how it can leverage any electronic communication opt-ins from members that the CMOs have on file to communicate more rapidly and consistently with Medicaid members. Finally, we recommend the State consider how it might be able to either incentivize or require CMOs to enhance their interaction with providers in order to leverage the providers to enhance the quality and accuracy of their member information. These recommendations for including redeterminations in the CMO contracts are listed below.

Recommendations:

- Review any existing opportunities for improved periodic information exchanges within the State and CMOs even before the re-procurement cycle.
- In the new contract, require that the CMOs play a role in the redetermination process by leveraging their relationships and periodic contacts with members to ensure the State has the most up-to-date contact information for members. This will help to increase the likelihood of engaging more members in the process. We recommend leveraging and including specific expectations and requirements regarding these interactions in the *pro forma* contract and RFP.
- In the new contract, create incentives in the CMO contracts for the CMOs to improve interaction 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 need, 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). Please see below for more information.

Members with one of the following are assigned to level 2 care coordination:

- Co-morbid health conditions;
- High emergency room use, defined as three (3) or more emergency room visits in thirty (30) days;
- A mental health or substance abuse condition causing moderate functional impairment;
- Requiring assistance with two (2) or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) and living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues;
- Poly-pharmaceutical use is defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class; and
- High risk pregnancy including pregnant members who are eighteen (18) years and younger.

Members with one of the following are assigned to level 3 care coordination:

- Who are medically complex or fragile, as defined by the contractor;
- Excessive emergency room use as defined as four (4) or more emergency room visits in a twelve (12) month period;
- With a mental health or substance abuse condition causing high functional impairment;

- With untreated substance dependency based on the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or other functional scale determined by the State;
- Requiring assistance with two (2) ADLs or IADLs living in the community at medium to high risk;
- With significant cognitive deficits; and/or
- With contraindicated pharmaceutical use

In review of both contracts, the Georgia Families contract language is not as prescriptive in its care coordination requirements for the CMOs as the Georgia Families 360 contract. The Georgia Families contract is vague and leaves much discretion to the health plans. As a result, there is likely to be significant variation among each of the CMO's care coordination programs. Further, the lack of prescriptive requirements makes it difficult for the Department to enforce contract provisions as each CMO has broad flexibility in their interpretation of the contract.

The following are recommendations for care coordination in both the Georgia Families and Georgia Families 360 contracts.

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. CMOs typically assign members to levels of risk and intensity of care coordination needed, then develop a care plan. States such as Texas and New Mexico use three levels or tiers to identify levels of need.
- Include prescriptive requirements for care coordination in the managed care contracts. Beneficiaries should be assigned to established and specific tiers of care coordination. Further, activities and benefits assigned to each care coordination tier should be specific and prescriptive.
- 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

include requirements in the *pro forma* contract to 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, which can be incorporated into the upcoming RFP and *pro forma* contract.

State Medicaid Quality Strategy

The current State Medicaid quality strategy in Georgia is operational through 2023, and the current quality strategy continues with many of the same goals and objectives of the previous five quality strategies. The quality strategy and the most recent external quality review organization reports identify specific areas for quality improvement that should be considered as the new CMO RFP and agreement are developed. This will present the best opportunity for the State to select the CMOs that demonstrate proven interventions and innovations to meet the State's quality goals.

The quality strategy and CMO contracts identify current quality goals and objectives. Within the 2021-2023 Quality Strategy[7], Appendix D Goals and Tracking Table sets goals around four pillars: access, quality, service, and stewardship. Table 34, titled Georgia Medicaid Progress on Goals and Objectives, includes data for performance and measures included within the 2016-2020 Quality Strategy. Georgia has a public facing CMO performance dashboard for 2020[8]. This type of public facing report is a positive in keeping the public informed about how the CMOs are performing in order to accomplish the State's Pillars and Goals. The dashboard was last updated in 2021 and would be a good source to identify areas where improvements have been made and continued opportunities exist.

[7] DCH 2021-2023 Quality Strategy PDF

[8] 2020 CMO Performance Dashboard | Georgia Department of Community Health

From the Pillar of Quality, the public facing dashboard shows lower performance in the areas of diabetes care, controlling high blood pressure, asthma medication adherence, and percentage of low-birth weight babies. These areas represent significant chronic and costly conditions that require concerted and ongoing prevention and management. It also appears that the CMOs are performing at or below the HEDIS 25th percentile benchmark indicating areas for improvement as well as opportunities for stronger quality performance and improvement oversight on the part of the State. While some of this performance is likely skewed due to the ongoing public health emergency, DCH could consider additional performance requirements associated with the current 5% capitation withhold to incentivize quality improvement. While not reflected in the Pillar of Stewardship, these conditions drive significant costs.

While there have been several changes that occurred within the program and populations, there are quite a few quality measures that decreased over the period of 2014 through 2019. Some of these decreases appear to be material. There is no indication of measurement between the period of 2014 through 2019, and many of the measures have no data reported. This presents an opportunity that needs to be addressed in the next Georgia Families contract. The current contract specifies liquidated damages up to $100,000 per violation for a CMO's failure to achieve the performance target for each quality performance measure and more specific sanctions and damages for certain measures. While these may be appropriate steps to hold the CMOs accountable for improvement, it would be good for the State to confirm if there have been any liquidated damages assessed, if the Department has been actively monitoring and enforcing these penalties. Furthermore, it would be prudent for the Department to determine whether the thresholds and penalties should be revisited in order to drive performance.

The quality program does rely on HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics, which are industry standards. However, the baselines and benchmarks set for performance seem to be at a minimum level for a program that is as mature as the Georgia Families program. In some instances, the benchmarks have been set below current performance levels. Increasing the benchmarks will provide an opportunity for the State to drive continued incentives for the CMOs to innovate and improve over the life of the next contract. Some best practices to consider include both penalties and incentives for not meeting baseline performance, reduced performance, and incentives for percentile improvement once meeting the HEDIS 90th percentile.

DCH seems to primarily rely on the annual reviews performed by their EQRO, with additional CMO reports that are required to be submitted to DCH. However, the quality strategy is not clear about how DCH uses these CMO reports to manage and ensure that the CMOs are implementing their Program Improvement Plans (PIPs) or their overall Quality Assessment and Program Improvement (QAPI) programs. DCH's Medical Assistance Program Performance and Care Management Office has primary oversight of the quality and performance program within the Georgia Families managed care program. Having a regular reporting calendar and clear expectations regarding how the reports will be used is critical in demonstrating that data is being captured. More frequent meetings between the individual CMOs and DCH to assess how interventions are being implemented to address quality improvement and performance may also be considered. These meetings are an opportunity for the CMO to demonstrate whether programs, policies, and/or procedures that they have in place are helping to accomplish their intended purpose, and if not, what the CMO may do to adjust or apply other interventions/innovations.

The 2021-2023 Quality Strategy includes recommendations based on the most recent EQRO report. Several areas of note within the recommendations are related to areas that include compliance with

grievance notification and resolution timelines as well as notices of adverse benefit determinations, more commonly referred to as "denials." It is not clear what level of monitoring and oversight DCH performs, but this is an area that helps to provide insight into the policies and practices of the CMO that tend to create public perception and support for the CMOs. When members and providers are dissatisfied, this creates unfavorable views related to the CMOs and the managed care program. Having data and information about the types and numbers of grievances and appeals from both providers and members and how quickly they are resolved allows the agency to demonstrate oversight and timely resolution that builds additional credibility and support for the managed care program.

Quality performance and improvement should be a significant area of focus for the upcoming CMO procurement. States are beginning to score bidders on their ability to achieve higher percentiles against HEDIS measures. States are also asking bidders to describe the interventions that they have put in place and provide data to show how those interventions achieved sustained quality improvement and outcomes.

Below are recommendations on how to better utilize the State's quality strategy.

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 good to confirm if there have been any liquidated damages assessed and whether the thresholds and penalties should be revisited in order 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 above, it appears that the current benchmarks are low for a program as mature as Georgia Families.

Behavioral Health Related Coverage and Coordination in Medicaid

As we continue to come out of the public health emergency, most Medicaid programs are seeing 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. We recommend that the State consider bolstering these efforts by including express requirements and expectations for the

CMOs in the upcoming RFP. Additionally, to drive access and coordination, there may be opportunities for the State to revisit provider credentialing requirements, grievance/appeal requirements, and other administrative actions between the CMOs and their in-network behavioral health care providers. Any efforts that the State exerts in pushing the CMOs to reduce provider abrasion for behavioral health care providers will likely go a long way in increasing access to these services for the State's members. To this end, we note that in section 4.11 of the current contract, the State outlines what the CMOs are required to report to the State in terms of provider network/access, coverage policies, the behavioral health care status of members, and the CMOs efforts of better engaging the members and coordinating their services within the broader behavioral health care system. We recommend the State carry forward these requirements into the next contract.

We also recommend that the State include additional opportunities for the CMOs to evolve their focus on behavioral health care access, including requiring one of the PIPs to be undertaken by the CMOs during the life of the contract by being behavioral health focused, creating value-based payments for providers based on year-over-year increases in behavioral health outcome measures for their populations, and/or creating more explicit instructions requiring EPSDT screening rates for certain behavioral health care services for the CMOs' child and adolescent populations. The State should also consider being more prescriptive requiring data exchanges with local schools who may be providing a level of behavioral health care to students enrolled in Medicaid. This way, the CMOs will be able to enhance their member profiles for these children and will be able to better coordinate the holistic care the children are receiving from their network of physical and behavioral health care providers.

Whatever new opportunities the State pursues for the managed care behavioral health benefit, we recommend that the State also determine if there should be any enhancements to the fee-for-service behavioral health offerings the State has for its applicable enrolled population as well.

Recommendations for behavioral health related coverage are included below.

Recommendations:

- The State should continue to bolster efforts in coordination of care by including express requirements and expectations for the CMOs in the upcoming RFP. The State should also revisit the provider credentialing requirements, grievance/appeal requirements, and other administrative actions between the CMOs and their in-network behavioral health care providers.
- Currently in section 4.11 of the current Georgia Families contract, 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. The State should carry forward these requirements into the next contract.
- 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.

- We recommend that the Department include psychiatric hospitals as an eligible facility type for providing Inpatient Psychiatric Facility Services for persons under the age of 21 years enrolled in Fee-for-Service Medicaid. This change will ensure that individuals on FFS Medicaid have access to the same facilities for inpatient behavioral health services as those members on managed care plans.

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 their CMOs. These standards must be enforced well. In New Mexico, for example, the Medicaid agency worked with the behavioral health agency to provide oversight through a provider manual that laid out all the services requiring prior authorizations. This allowed for uniformity in the process and reduced administrative burden for providers. In addition, the financial penalties for providers should be upheld and be substantial enough to mean something to the CMOs involved.

Centralized credentialing is another method to reduce administrative burden. It allows the State to use a system to credential every provider. CMOs can use these lists and review who they would like to use. From information gathered through discussions, it appears that Georgia uses centralized credentialing.

We also recommend that the State consider creating more uniformity, where possible, with the prior authorization, appeals (provider and member), and other review processes, such that all process are as similar as possible across all CMOs. Once the State has determined where it is possible for these types of functions to be uniform, or at least similar, across the CMOs, the State will then need to determine the appropriate way to ensure compliance with these requirements, which could include liquidated damages and penalties. Finally, as the State considers taking steps to achieve better uniformity of administrative processes, we recommend it holds listening sessions and asks for suggestions from providers so that the efforts that the State and CMOs are undertaking will deliver desired results to the impacted providers.

We also recommend that DCH reconsider its stance on not allowing federally qualified health centers (FQHCs) and rural health centers (RHCs) to provide routine physical exams unless related to an EPSDT service. While it is a laudable goal for the State to want to incentivize primary care and family practice groups relocating and thriving in areas that may have an under-representation of these provider types, the FQHCs and RHCs are critically important provider types that, generally, share an enhanced reputation for how well they can serve their members. We also recommend that the State, as it reviews its benefit offerings across managed care and fee-for-service (FFS) for items like durable medical equipment, takes the opportunity to enhance that congruency through this new contract. Currently, there are DME exclusions for blood pressure monitors, incontinence supplies, portable oxygen units, nutritional supplements, and specialized formula. These seem to be significant items that can be utilized for the purposes of maintaining and preventing further exacerbation of needed care, and we recommend that the Department consider covering these items under FFS Medicaid.

The following are processes that are recommended for reducing administrative burden for the CMOs.

Recommendations:

- Require a more uniform process, when possible, across all CMOs, for prior authorizations, appeals, and other review processes across all CMOs.
- Have the State convene listening sessions and request suggestions from providers for more cohesive efforts on issues important to providers.
- Allow FQHCs and RHCs to provide primary care without restriction. Specifically, we recommend that the Department make any necessary changes to allow for FQHCs and RHCs to provide routine physical exams and preventative care to all Medicaid members.
- Review State benefits offered across the managed care and fee-for-service delivery systems for durable medical equipment to ensure that they are consistent in allowing for coverage of durable medical equipment including blood pressure monitors, incontinence supplies, portable oxygen units, nutritional supplements, and specialized formula.
- The State should evaluate the fiscal impact and likely corresponding health impact of covering annual dental exams for any enrolled population within Medicaid 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 State legislation, House Bill 1013.

The federal Affordable Care Act establishes an MLR of 85%. There is no requirement for states to establish such a standard. However, if a state chooses to impose an MLR, it must be at or above the federal standard of 85%. Such standards drive significant scrutiny of medical versus administrative costs. While this concept appears straightforward, care coordination efforts, quality improvement, and data analytics can arguably be considered in both categories.

The MLR can be impacted constructively through the percentage itself and/or by managing the elements that are included in the calculation. For example, West Virginia includes certain community investments and costs associated with addressing SDOH in the numerator of the MLR calculation. Such provisions give the CMO latitude to provide more of these services while still meeting any new MLR requirements. Federal law gives states significant discretion in this regard.

The State should consider whether it is appropriate to establish a similar standard, likely in collaboration with the Office of the Commissioner of Insurance and Safety Fire. Elements to be considered medical and administrative can be defined in the RFP and in the subsequent contracts. However, if the State is pursuing an aggressive quality and accountability program, the potential impact and magnitude of an MLR becomes less critical. Nonetheless, it can be used as a mechanism by the State to drive cost management.

An MLR must also be considered in conjunction with the overall aim of the State's quality program, especially with respect to any quality-related capitation payment withholds the State may impose on the CMOs. Below are recommendations when considering MLR requirements.

Recommendations:

- Establish standards, in conjunction with the Office of the Commissioner of Insurance and Safety Fire, regarding allowable medical and administrative elements of the MLR and define such a standard (if established) in both the RFP and *pro forma* 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[9], the program has continued to 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.

There are additional recommendations as noted above to increase the value that future CMOs may bring to the Georgia Medicaid managed care program and Medicaid members related to quality, value-based care and payment, and increased focus on member assessment, care and disease management, and provider networks and support. These recommendations could be paired with future opportunities to include more complex members and services within the managed care program. Assuming the State's procurement laws allow for it, the upcoming procurement could foreshadow this by including language that allows the State to include additional populations and services within the scope of the contract without the need to further reprocure the program (*e.g.*, an extension of post-partum care from six months to 12 months). By including "phase in" language, the State could potentially add additional populations without needing to procure again. One example of such language is for the State to reserve the right in the RFP to enroll additional populations into managed care under the contract being procured. Specifically, the State should make clear that upon receiving federal and state authority to phase-in additional managed care populations, it will amend the CMO contract to account for the various program requirements pertaining to these new populations. In addition, the language should make clear that the State will work with the CMOs to establish a readiness review/go-live cadence as well as establishing actuarily-sound capitation rates for the new populations. As states and their CMO partners demonstrate success in their ability to manage more medically complex individuals, such as the aged, blind and/or disabled population (ABD) and/or those receiving supplemental security income (SSI) benefits, they should consider other more highly complex populations for their managed care program, such as those who qualify for and receive home and community-based waiver services. In most instances, states prepare and plan out the way they introduce populations to managed care. Including these populations would be a natural next step for the Georgia Medicaid program. Georgia could consider the

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

inclusion of SSI adults or SSI children first, or both SSI populations. Aged individuals are generally those that also have Medicare ("dual eligible") and may present additional complexities associated with care management coordination and responsibilities, making them the next logical group to consider for transition.

Once the basic Medicaid eligible populations are included, further consideration regarding the inclusion of additional acute, institutional, and behavioral health services should be explored. Of course, if the State were to choose to pursue this path, Georgia would need to work closely with the nursing home industry before making the determination as to whether or not to include these services and providers in the managed care program or have them remain carved out and paid on a fee-for-service basis.

Adding new populations to managed care will require the State to continue building trust and attaining buy-in from stakeholders. One way to assist this process is to refine and enhance the program for currently covered populations through the procurement opportunity. This will highlight the State's commitment to continuous improvement and member centricity. Further, the State should use data to demonstrate the current state and past successes of the managed care program in order to demonstrate how complex populations will get their needs met and tie improvement to the members and providers. Allowing others, like advocates, providers, and constituents, to help garner support for managed care is important. This level of stakeholder buy-in takes good data and transparent public reporting that shows where the issues are and how the agency has good tools and oversight in place to respond to issues that are raised.

Recommendations:

- As described above, 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 RFP should therefore be used to continue to refine and enhance the program to showcase the State's commitment to improvement and member centricity.
- A unified preferred drug list (PDL) for all drugs in Medicaid, including the PDL that will be developed and recommended by the OHSC 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, and the State should re-enforce the importance of its expectations in this regard in the RFP.

Managed Long Term Services and Supports Considerations

In 2021, there were 40 managed long-term services and supports (MLTSS)[10] programs operating across 24 states with varying program and service design elements. The following are the most common:

- Comprehensive managed care program that includes long-term services and supports (LTSS) and non-LTSS benefits. Some states limit enrollment to populations eligible for LTSS while others include all populations.

[10] 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

- Plans that provide only LTSS benefits. Acute/primary care or behavioral health services are delivered by another CMO or from the State's traditional FFS program. This program design choice is driven by:
    - The expansion of MLTSS after an established acute care managed care program is in place.
    - Legislative or gubernatorial directives for separate programs.
    - Interest in contracting with CMOs that specialize in LTSS.
- 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).

For instance, Pennsylvania had a mandatory Medicaid managed care program that included low-income adults and children and those eligible for SSI for 25 years prior to considering implementing an MLTSS program. After significant stakeholder input, the State developed a separate managed care program following the model described in 1 above that included all acute and LTSS services for aged, dual eligible, and those adults with physical disabilities eligible for and receiving HCBS waiver services into managed care. The program was implemented regionally in three phases, beginning in January 2017 to address lessons learned throughout the statewide implementation before it was fully completed in January 2020. Similarly, after operating a Medicaid managed care program for low-income children and adults, Indiana has continued to expand to other more complex populations, including the Affordable Care Act expansion population. In 2019, Indiana engaged in a robust stakeholder process to design and develop an MLTSS program. Indiana will begin implementation of its MLTSS program in the first quarter of 2024[11].

In establishing a MLTSS program, Georgia, like other states, would need to consider the following key factors when adding populations to managed care:

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

Recommendations:

- 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. We would recommend that the first LTSS population the State should add to manage care is the population based upon SSI eligibility. Within the SSI-eligible groups, we believe the SSI children and adults

[11] House Enrolled Act 1001-2021 – MLTSS Report; Medicaid Advisory Committee – LTSS Reform; Status of LTSS Reform Activities

would be the best first populations to phase-into managed care. Then, once the State demonstrated success in managing the care for these children, 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 in the RFP, with potential penalties for noncompliance. Additionally, no matter how much trust the current program enjoys because of its history of doing just these sorts of things, these root basics should continue to be a priority for the agency, including in the next contract period.

To set the table for innovation, the Medicaid program can 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.

While many Medicaid programs publish various quality metrics and financial data, greater clarity and transparency can build public trust. A clear articulation of goals is central to increasing this trust and correspondingly giving the program more room to innovate. This RFP can accelerate this process by articulating these themes and goals in its construct and in its scoring rubric.

VBP, care coordination, and incorporation of SDOH are only a few initiatives where innovation and broad State goals converge. Another opportunity to build trust with the members (and public at-large) is to set expectations with the CMOs regarding the amount of time and intentionality with which the State and the CMOs plan for transitions of care, including articulating how and when CMOs should be engaging families of children aging out of coverage under the child category. These times of transition can, at times, be fraught with confusion and lack of understanding of the differences in benefit limits imposed on adults as compared to children. One way to help build the momentum for the State to pursue innovations in the future is to focus on these areas where meaningful progress can be made in helping families in the transition of eligibility categories for their children. CMOs have significant expertise for these conversations that the State can leverage and working with the CMOs while also holding them to relatively high standards can foster innovative and thought-leading programs for Georgia families facing these times of transition for family members.

Where desirable, the State can advance this level of collaboration by, in the new contract, extending or making permanent certain beneficial flexibilities that were temporarily granted during the public health emergency, such as those granted for telehealth.

Recommendations:

- Ensure that the basics in running a trusted and strong foundational Medicaid program in a transparent manner are described prescriptively in the RFP because often, only then, is there an appetite for innovation in the program.

Specific Recommendations for the Georgia Families 360 Contract

The Georgia Families 360 contract was reviewed against the Texas STAR Health contract[12], the equivalent of the Georgia Families 360 contract in Texas, to identify opportunities. There are several key topic areas, such as care coordination and electronic medical records, that could use more specific and prescriptive language. We recommend that DCH consider adopting more prescriptive requirements across these and other key functional areas to provide opportunities for better state control and oversight and to clarify and codify state expectations to the managed care organization. The following are areas of consideration for Georgia to strengthen language.

Recommendations:

- *Coordination with child protection agency*. The Georgia Families 360 program may benefit from implementing similar, prescriptive contract language to define the CMO's roles and responsibility vis a vis the Georgia Division of Family and Children Services (DFCS). When comparing the Georgia Families 360 contract to Texas's STAR Health contract, Texas's contract has numerous specific requirements around how the CMO must coordinate with the State's child protection agency. The Georgia Families 360 program could benefit from more specificity in these program requirements about cross-agency coordination between DCH and DFCS.
- *Care coordination/case management.* Requirements for staffing are found in other state contracts. For example, the Texas STAR Health contract has requirements that their health plans are sufficiently staffed to meet members' needs, requires (to the extent feasible) co-location of physical and behavioral health staff, and requires warm transfers. The Georgia Families 360 program may benefit from incorporating contract language holding plans accountable for its care coordination/case management staffing model and operational processes, as members will gain the support required for effective care coordination.
- *Electronic Medical Records (EMRs).* The Georgia Families 360 program may benefit from setting specific, detailed expectations pertaining to EMRs in its contract language moving forward. The Texas STAR Health program requires its MCOs to develop and maintain a Health Passport for its members. The STAR Health contract language provides specific, extensive details on the State's expectations of plans regarding EMR security, features, and reporting requirements.
- *Substance Use Disorder (SUD) and residential treatment facilities.* Both the STAR Health contract and the Georgia Families 360 contract demonstrate room for improvement in their expectations regarding SUD and residential treatment facilities, as neither provides detailed protocols in either of these fields. The Georgia Families 360 program may benefit from setting detailed expectations regarding SUD and residential treatment facilities in its contract language.
- *Trauma-informed care*. Texas' STAR Health contract contains numerous requirements related to trauma-informed care, including requirements related to MCO staff training and provider network development. Using trauma-informed care as a lens for these and other managed care functions may help strengthen the Georgia Families 360 contract.

[12] The Texas STAR Health program serves children in conservatorship, children in Adoption Assistance or Permanency Care Assistance program transitioning to STAR or STAR Kids, youth aged 21 years and younger in Extended Foster Care, and youth age 20 years and younger who are Former Foster Care Children. (*STAR Health | Texas Health and Human Services*)