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

OFFICE OF HEALTH STRATEGY AND COORDINATION

July 28, 2023

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 State Health Benefit Plan (SHBP) contracts and making recommendations to the Georgia Department of Community Health (DCH) prior to the next procurement cycle. To meet this statutory objective, OHSC retained Sellers Dorsey to provide strategic insight and recommendations regarding the forthcoming procurement of the SHBP contracts. Sellers Dorsey's market research encompassed an extensive review of current SHBP contracts, past requests for applicants (RFAs), the state's SHBP website and other publicly available information, state data provided by OHSC, and national best practices and contracting trends across the country. The attached report contains recommendations spanning several key topic areas for your consideration as you prepare next steps for Georgia's SHBP procurement.

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 current SHBP 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 SHBPs in other states across the country.

As you will see in this report, Sellers Dorsey has noted areas of the current Georgia SHBP contracts which are consistent with national trends, innovations, and best practices. In these areas, Sellers Dorsey has made recommendations intended to evolve or even bolster those already well-designed program features or contract standards. Other themes emerging throughout this report include areas in which the contract standards can be improved upon or revised to meet current national best practices, popular innovations, cost containment opportunities, and oversight and administration improvements. The report emphasizes the need for an understanding of historical performance and clear articulation of state and health plan goals. Additionally, the report highlights the importance of utilizing data analysis to inform decisions and address deficiencies. These recommendations are meant to strengthen efforts for an upcoming procurement and ultimately lead to better health outcomes and experience for Georgia's SHBP members.

We hope that you and your team find this report to be a helpful resource as you prepare for next steps in the SHBP procurement process.

Sincerely,

Grant Thomas
Director
Georgia Office of Health Strategy and Coordination

sellers dorsey

realize the opportunity.

Recommendations for the Georgia Department of Community Health State Health Benefit Plan Contracts

July 2023

Executive Summary

With direction from the Georgia Office of Health Strategy and Coordination (OHSC), Sellers Dorsey has conducted a review and analysis of the state of Georgia's State Health Benefit Plan (SHBP). This assessment included a review of the current SHBP contracts, past requests for applicants (RFAs), the state website and publicly available information, state data provided by OHSC, and national best practices and contracting trends across the country. The following report summarizes Sellers Dorsey's analysis and recommendations for DCH and the state's consideration for the upcoming SHBP procurement cycle

Background

Georgia's SHBP is managed by the Georgia Department of Community Health (DCH), State Health Benefit Plan Division. The plan covers health insurance benefits for approximately 660,000 members including executive branch employees, state legislators, school district employees, retirees, and their respective dependents. The Georgia SHBP provides health care coverage through eleven different plan offerings provided by three different health plans.[1] The last state procurement for the SHBP's third party administrators (TPA) took place in 2014.

Table 1. June-August 2022 Enrollment Statistics[2]

Plan Type	Anthem Blue Cross Blue Shield	UnitedHealthCare	Kaiser Permanente	Total
Health Maintenance Organization (HMO)	217,996	18,884	39,637	276,517
High Deductible Health Plan (HDHP)	-	9,904	-	9,904
Medicare Advantage – Standard & Premium	7,858	121,672	-	129,530
Health Reimbursement Arrangement (HRA) – Gold, Silver, or Bronze	243,721	-	-	243,721
Total	469,575	150,175	39,637	659,672

Georgia offers a self-funded plan paid through premiums and monthly contributions from members. In addition, Georgia offers fully insured plan options through Anthem Blue Cross Blue Shield (BC/BS), UnitedHealthcare, and Kaiser Permanente. Medicare eligible members can choose standard or premium Medicare Advantage plan options from either UnitedHealthcare or Anthem BC/BS.[3]

Georgia's SHBP has also contracted with the following organizations for key plan components:

- Medical Claims – Anthem, UnitedHealthcare, and Kaiser Permanente
- Pharmacy Benefits Manager – CVS Caremark
- Wellness Program Administrator – Sharecare

[1] Georgia Department of Community Health – State Health Benefit Plan Member Report, August 2022
[2] Georgia Department of Community Health – State Health Benefit Plan Member Report, August 2022
[3] "Plan Options & Programs," State Health Benefit Plan, May 2023, https://shbp.georgia.gov/plan-options-programs

Methodology

To complete its analysis, Sellers Dorsey conducted a national landscape assessment to identify trends, best practices, and key areas of focus for SHBPs. OHSC and DCH provided Sellers Dorsey with the most recent RFAs for medical management, medical third-party administrator services, pharmacy benefits management (PBM), and the wellness program. The agencies also provided Sellers Dorsey access to the most recent contracts and budget details, related legislation, and additional PBM information. Additionally, Sellers Dorsey reviewed other SHBP requests for proposals (RFPs) and contracts from other states, other publicly available information and research, and various literature and reports to inform the recommendations provided in this report.

As part of this assessment, Sellers Dorsey determined key SHBP focus areas based on relevance to the program design, impact to program cost, member satisfaction, and improvement of health care quality. Sellers Dorsey conducted a series of information sessions with OHSC staff to provide background on these focus areas including how these key components factor into Georgia's current SHBP as well as national trends and recommendations for consideration in its upcoming procurement cycle.

The report's recommendations are intended to assist DCH in the upcoming SHBP procurement. Therefore, recommendations may include suggested metrics to include in an RFP or skills for consideration so that the agency can evaluate and assess potential contractor capabilities through the RFP. Other recommendations include specific RFP language to communicate direct and specific contract requirements and standards. Recommendations include suggested required performance guarantees, questions to ask, and requests for data and information from potential contractors that demonstrate proven capabilities to further the state's priorities and initiatives.

Finally, DCH may consider issuance of a request for information (RFI) ahead of the RFP. As opposed to an RFP, an RFI is intended to gather information from potential contractors and stakeholders on pre-defined topics ahead of an RFP. DCH can then use the information gathered through the RFI process to inform the drafting of the RFP. Additionally, an RFI can provide insight to the pool of potential RFP respondents,their capabilities, and the overall competitive landscape in which the RFP will be released. Trends and innovations are noted throughout the report and incorporated into the recommendations outlined below.

Summary of Recommendations

Throughout the report, Sellers Dorsey has noted areas of the current SHBP contracts which are consistent with national trends, innovations, and best practices. In these areas, Sellers Dorsey has made recommendations intended to evolve or even bolster these already well-designed program features or contract standards. Other themes emerging throughout the report include areas in which the current contracts can be improved upon or revised to meet current national best practices, popular innovations, cost containment opportunities, and oversight and administration improvements. Assessment of current contractor performance and the need for additional data collection is a recurring recommendation throughout many sections of the report. Understanding historical performance of the current contractors through data analysis is critical to informing decisions, addressing potential deficiencies, and developing an RFP that will meaningfully improve the operation of the SHBP and ultimately, the health status of its members.

Background

SHBPs often provide state employees with generous health and pension benefits compared to their private sector counterparts. Many states report paying between 80-100% of an employee's premium costs; a valuable benefit for public sector employees.[4] Additionally, SHBPs tend to be one of the largest employer purchasers of healthcare in the state. In March 2021, state and local governments employed 14.9 million full-time workers in the United States.[5] SHBPs tend to be the second largest cost driver for a state's health care expenditures, after Medicaid, and therefore Georgia's SHBP plan can serve as a method for Georgia to contain costs and drive quality.[6] The operations, implementation, and structure of SHBPs can greatly influence rising health care costs and state cost containment efforts.

Sellers Dorsey has worked with the Georgia OHSC to review the current SHBP contracts and provide strategic insight on national trends and direction for consideration in Georgia's next procurement of its SHBP contracts. Sellers Dorsey identified key areas that would have the greatest impact on improving member satisfaction, quality and health, and reducing costs. These are highlighted for consideration in the procurement and contracting process in order for Georgia SHBP to align with national trends, improve quality and health outcomes for Georgia's employees, and contain costs.

These areas include:

- Provider Networks
- Value Based Payment and Quality
- Chronic Conditions and Disease Management
- Value Added Services and Wellness Programs
- Oversight
- Performance Guarantees
- Medicare and Medicare Advantage
- Pharmacy Benefits
- Cost Containment

Provider Networks

Georgia's SHBP currently includes Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), and High Deductible Health Plan (HDHP) network options among its plan offerings. It does not currently have any provider network design initiatives implemented within any of its plans. However, provider network design in SHBPs is a potential

[4] Corlette, Sabrina, et al., "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability," Georgetown University Health Policy Institute, 2021. https://sehpcostcontainment.chir.georgetown.edu/documents/SEHP-report-final.pdf

[5] Saxon, Nicholas, et al,. "Annual Survey of Public Employment & Payroll Summary Report: 2021," United States Census Bureau, May 25, 2022, https://www.census.gov/content/dam/Census/library/publications/2021/econ/aspep-2021_final.pdf

[6] "State Employee Health Benefits, Insurance and Costs," National Conference of State Legislatures, May 1, 2020. https://www.ncsl.org/health/state-employee-health-benefits-insurance-and-costs

area to contain costs, increase member access, and improve plan performance. Table 2 includes a summary of provider network design initiatives to consider.

Table 2. Provider Network Design Initiatives, Trends, and Considerations

Provider Network Design	Description	Nationwide Trend	Considerations
Centers of Excellence (COE)	SHBPs incentivize the use of specialized programs within integrated medical systems that have demonstrated their ability through concentrated expertise and resources to deliver better patient outcomes at a lower cost for certain (or specific) groups of conditions such as heart, cancer, spine, and transplants.	23 states have implemented COEs, and two reported cost savings (DE and WA). In Delaware, the state achieved cost savings by engaging in direct contracting for COEs while the state of Washington implemented prospective bundled payment for hips/knees, and spine care.[7]	SHBPs have implemented COEs in varying degrees, either for one procedure or with one (TPA)/insurer. The primary goal is to improve clinical quality and patient outcomes rather than extracting price concessions; the idea is that better quality can yield cost savings through good outcomes and fewer readmissions. However, COEs could create political pressure at the legislature and Governor level in a way that effectively undermines the approach. Specifically, health systems may engage in political lobbying and pressure for their hospitals to be designated as COEs to attract more patients leading to a potential scenario of "everyone gets to be a COE."
Risk Sharing with Providers	Financial arrangements in which providers take on some financial risk through either rewards or penalties associated with lower costs, patient health outcomes, or performance on quality measures. Risk sharing can take various forms like capitation, accountable care organizations (ACOs), or value-based arrangements (VBAs).	9 states have implemented risk sharing agreements with providers and three reported cost savings.[8] In South Carolina, the state established VBAs for oncology and rheumatology. It joined the Oncology Care Model in 2018 and achieved a total shared savings of $862,000 by the end of the second year. And in 2020, it joined the Rheumatology program and saw an 85% pathway compliance rate with savings of $542,000 for the	Many providers are hesitant to engage in risk sharing arrangements, particularly those that have the potential for downside risk. Hospitals and hospital systems are less likely to participate in ACOs because they are disinclined to take on downside risk. As a result, risk sharing arrangements are primarily implemented with physician group practices.

[7] Corlette et al. "Unleashing the giant: Opportunities for state employee health Plans to Drive improvements in affordability"
[8] Ibid.

		following year.[9] Other states like Idaho also engaged in VBAs while Washington achieved cost savings through an Accountable Care Program.[10]	
Provider Networks (Narrow, Tiered, or Both)	**Narrow**: SHBP limits coverage to a select set of hospitals, physicians, and other providers. **Tiered:** SHBP groups or "tiers" providers based on their performance on cost and/or quality metrics. Enrollees are encouraged to seek services from the top performing providers through lower cost-sharing. Additional information on tiered networks follows.	Seven states have narrow provider networks, four states have tiered provider networks, and five have both. Four states reported cost savings – all implemented narrow networks.[11] Tennessee offers four networks (two narrow and two broad). Broad Networks include a significant additional cost to the employee. In a broad network, enrollees may also pay more per claim because the costs for services in these networks are generally higher.[12] Pennsylvania had higher copays (almost double) for its broad network plan (PPO) than its narrow network plan (HMO).[13]	Cost savings can be challenging to achieve through use of narrow or tiered networks because states are obligated (by the legislature, unions, or employees) to offer enrollees a broad network plan option in addition to the narrow or tiered network option.
Direct Contracting with Providers	SHBP negotiates a contract directly with a provider of health care services rather than through a TPA. The goals of such efforts include obtaining lower provider prices than achieved by the TPA, engaging in a risk sharing program, or encouraging value-based care.	14 states have contracted or negotiated directly with providers and four have reported cost savings. Mississippi uses direct contracting across all providers and services. Health benefits are administered by Blue Cross & Blue Shield of Mississippi (BCBSMS) through the state network of physicians, hospitals, and other health care providers. In South Carolina, the state maintains	TPAs can be a significant barrier in direct contracting as one of their core functions is to negotiate broad networks for SHBPs. Some regions of the state can have significant provider consolidation or provider shortages which makes negotiations for discounted prices difficult.

[9] "Meeting Minutes | Health Care Policy Committee," South Carolina Public Employee Benefit Authority, November 30, 2021. https://peba.sc.gov/sites/default/files/hcp_minutes_october2021.pdf
[10] Corlette et al. "Unleashing the giant: Opportunities for state employee health Plans to Drive improvements in affordability"
[11] Ibid.
[12] "Health Insurance Carrier Network Information," Partners for Health, https://www.tn.gov/partnersforhealth/health-options/carrier-network.html
[13] "Summary Plan Description," Pennsylvania Employees Benefit Trust Fund (PEBTF), May 2023. https://www.pebtf.org/PDF/SPD.pdf

		direct contracts with hospitals, physicians, ambulatory surgical centers, and other professionals in the provider networks and generally determines reimbursement rates. The state has set a site-neutral fee schedule using direct contracting to obtain a "preferential government rate" compared to the rest of the commercial market.[14]	

Recommendations:

- Georgia relies on their contracted TPAs to manage provider networks including negotiation of provider contracts. With this broad authority, Georgia should incentivize TPAs to implement cost containment initiatives, specifically related to the network design.
- In the RFP and after a thorough evaluation of the potential benefits and drawbacks of each element articulated above, Georgia should assess potential contractors' demonstrated experience and historical success with each of the following initiatives related to provider network design.
    - **Centers of Excellence:** Designate hospitals which have demonstrated better outcomes and lower costs for complex procedures and types of care, including cardiac surgery, transplants, joint replacements, and oncology care; participants who use these providers would pay reduced out of pocket costs and possibly receive additional perks (e.g., concierge services and reimbursed travel expenses).
    - **Risk-Sharing:** Given the potential drawbacks of implementing down-side risk sharing with large providers in the SHBP, we instead suggest that the state should focus on a payment model focused on rewarding behavior as a first step down the value-based payment paradigm. For example, the state could provide a value-based provider network for providers who manage and care for plan members with certain chronic, complex conditions. The value-based network(s) should include a reimbursement model with incentives for providers paid by the SHBP, who meet specific criteria for high-performance and quality member health outcomes.
    - **Narrow Networks:** The state already has existing narrow networks in their HMO plans. However, improved contractor communications with enrollees about the benefits of a narrow network plan, as well as implementing increases in the differential in premiums between the narrow and broad network options to help facilitate increased selection of these less costly coverage options by members.

Value Based Payment & Quality

[14] Corlette et al. "Unleashing the giant: Opportunities for state employee health Plans to Drive improvements in affordability"

Value-based payments (VBP) are a growing trend to reform the healthcare delivery system toward improved health outcomes by rewarding providers based on the achievement of quality goals, and in some circumstances, cost savings. This payment approach differs from the traditional fee-for-service system that bases payments solely on the volume of services delivered.[15] Value-based payment arrangements are growing in prominence across both the public and private sectors. The unique environment and large market share of SHBPs provides opportunities to negotiate with health plans and provider groups to encourage participation in quality improvement initiatives.[16] Through this influence, SHBPs have the ability to shift the health care system toward value-based payment arrangements that promote high-quality care.

A primary premise of VBP is that through high-quality care delivery and population health improvement strategies, total health care spending will decrease. Value-based programs support the Institute for Healthcare Improvement's (IHI) Triple Aim, which is an approach to enhance health system performance.[17] To promote quality improvement, the framework outlines three factors that must be addressed simultaneously: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care. Achieving the Triple Aim then leads to a less complex and more coordinated system experience for the individual, healthier populations, and stabilized costs.[18]

Georgia's SHBP contract currently requires a quality management program that leverages best practices and quality indicators to evaluate, oversee, and compare outcomes across all medical management functions. The program also specifies contractors will collaborate with DCH to develop benchmarks that measure performance against nationally/locally recognized industry standards.[19] Further, contract requirements around VBP are primarily reflected in the clinical metrics and VBP initiatives defined in the performance guarantees. Those requirements obligate contractors to meet service level targets in specific care areas. These include targets for enrollees identified with chronic disease, asthma, diabetes, coronary artery disease, and heart failure. For example, a performance guarantee may stipulate "85% of targeted claimants will be active participants in any chronic disease management program activated."[20] If this target is not met, a plan is penalized $10,000 for each percentage below the threshold ($150,000 maximum).[21] Using a performance guarantee such as this promotes accountability by placing health plans and providers at risk for losing dollars if there is lack of engagement with participants.

In the context of VBP arrangements, a value-based downside risk model operates similarly to the performance guarantees currently required. Both define a clinical standard to meet which may result in noncompliance penalties if the contractual obligations are not fulfilled. In more advanced value-based arrangements, there are levels of shared risk and potential for savings if expectations are exceeded. Both

[15] "Value Based Payment," Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/value-based-purchasing/

[16] Savela, Terry et al, "What Public Employee Health Plans Can do to Improve Health Care Quality: Examples from the States," The Commonwealth Fund, Jan 1, 2008, https://www.commonwealthfund.org/publications/fund-reports/2008/jan/what-public-employee-health-plans-can-do-improve-health-care

[17] "Value-Based Purchasing Program," CMS, March 31, 2022, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

[18] "The IHI Triple Aim," Institute for Healthcare Improvement, https://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx

[19] DCH-Kaiser Contract, DCH SharePoint

[20] DCH-Kaiser Contract, DCH SharePoint, p. 236

[21] DCH-Kaiser Contract, DCH SharePoint, p. 236

performance guarantees and value-based models hold health plans accountable for the care delivered to enrollees, but the metrics in value-based models measure the *value* of the care delivered in terms of patient outcomes and total cost of care. The type of metrics used vary, though process and outcome measures are very prominent. The two differ in that process measures provide insight to the provider to maintain or improve health and outcome measures provide data on the impact of a service or intervention on the patient outcomes.[22] For example, identifying members with chronic conditions who participate in a chronic disease management program provides insight to patient engagement in a service, the next step toward advancing quality would measure if there is an impact of the disease management program in those members outcomes (i.e., whether the program improved member health). These measure types can be incorporated into VBP arrangements to better understand how a value-based approach transforms care outcomes and reduces total costs. The various structures of VBP models allow states to identify and implement a model that is suitable for their current delivery system and state priorities. VPM models can also serve as guides paths to more sophisticated arrangements.

In **pay-for-performance models**, payment arrangements align financial incentives or disincentives with improved outcomes.[23] This model is leveraged in Washington, where the state's employee plan is administered by the Public Employees Benefits Board and operated by the Washington State Health Care Authority, which also oversees the state's Medicaid program. The shared organization coordinated 50 measures into the employee plan and Medicaid contract, tying many to payment.[24] **Bundled payments, or episode-based payments**, instead pay a fixed payment to providers for each service they perform for beneficiaries during a single illness or course of treatment.[25] Both Tennessee and Washington implemented this type of arrangement in their SHBPs. In Tennessee, the SHBP episode-based payments are also part of the state's Medicaid managed care program contracts, which promotes greater alignment across the state's health care spend, all of the payers contracted with the state, and the majority of providers, virtually all of whom participate in the Medicaid and state employee health benefit program. In the first year of the Tennessee's coordinated purchasing strategy, the initiative yielded $11.1 million in cost savings.[26] Washington's episode-based payment was not coordinated with their Medicaid program but was instead part of their Center of Excellence strategy.[27] In states such as these where state employees account for a large percentage of the total population, coordinated efforts and value-based care models have the potential to promote multi-payer alignment, shift from fee-for-service, and generate cost savings.

Value-based tiering is another design model that leverages incentivizes to maximize value. Tiering involves organizing providers based on quality or value metrics to encourage enrollees to use higher

[22] "Types of Health Care Quality Measures," Agency for the Healthcare Research and Quality. July 2015, https://www.ahrq.gov/talkingquality/measures/types.html
[23]"What is Pay for Performance in Healthcare?" NEJM Catalyst, March 2, 2018. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
[24] Japinga, Mark et al. "State Employee Health Plans Can Be Leaders and Drivers of Value-Based Initiatives," Duke Margolis Center for Health Policy, Dec 8, 2017., https://healthpolicy.duke.edu/sites/default/files/2020-10/DUKE_SEPH_12.8.17.pdf
[25] "Bundled Payments for Care Improvement Initiative (BPCI)," CMS, April 18, 2016, https://www.cms.gov/newsroom/fact-sheets/bundled-payments-care-improvement-initiative-bpci
[26] Japinga et al., "State Employee Health Plans Can be Leaders and Drivers of Value-Based Initiatives"
[27]Ibid.

performing providers.[28] In Massachusetts, the state's Group Insurance Commission focused on high-volume specialists and organized those providers based on performance on quality measures and cost-efficiency scores, while also incentivizing enrollees to see the highest-value physicians by providing lower co-pays.[29] The state reported enrollees chose providers with higher performance and found it could be an effective cost savings strategy over time. Minnesota also uses this type of tiered network and found it was influential on member and provider behavior.[30] Relatedly, Connecticut uses a tiered network organized by high-value services to reduce wasteful spending on treatments that may be clinically unnecessary or potentially harmful. The state implemented a voluntary program for employees and their dependents that targets preventive care and chronic disease management by requiring age-appropriate preventive screening and care, lower or no co-pays for medication, treatments for individuals with certain chronic diseases and conditions (e.g., asthma and diabetes), and health education. Program results showed improved use of preventive screenings, reduced emergency department use, and a 3.2% reduction in the overall costs of health care. [31]

Because resources are limited, it is equally important to ensure that the focus areas are meaningful. A comprehensive survey of 47 state employee health plan administrators found focusing on primary care produced positive outcomes across reduced emergency room admissions and higher patient satisfaction.[32] Behavioral health has also been found to be a key area to target as it accounts for a large part of health care spending. Focusing on behavioral health has the potential to improve diagnosis and treatment of behavioral health issues, that might otherwise go undiagnosed or undertreated, which reduces long-term costs that may have occurred if conditions worsened and required more care.[33] Each SHBP will need to determine their priorities and implement strategies that fit their delivery system and resources as results will vary in populations, chronic conditions that are prevalent, high cost procedures, regions, and other factors.

Value-based care models and quality improvement strategies can be operationally complex to implement and monitor, which can be further challenged by a plan's experience – or lack thereof. The following are recommendations to be considered for the RFP, that could support the transition to VBP and promote high-quality care.

Recommendations:

- Obtain historical data from DCH on performance in existing measures being collected and Quality Management program requirements to identify underperforming care areas and gaps in performance.

[28] "Value-Based Innovation by State Public Employee Health Benefits Program," State Health & Value Strategies, Nov 2017, https://www.shvs.org/wp-content/uploads/2018/01/SHVS_Value-Based-Innovation_Final.pdf
[29] Japinga et al. "State Employee Health Plans Can be Leaders and Drivers of Value-Based Initiatives"
[30] "Value-Based Innovation by State Public Employee Health Benefits Program"
[31] Ibid.
[32] Corlette et al., "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability,"
[33] Bartlett, Marilyn and Maureen Hensley-Quinn, "State Employee Health Plans Confront COVID-10," National Academy for State Health Policy, https://nashp.org/state-employee-health-plans-confront-covid-19/ https://nashp.org/state-employee-health-plans-confront-covid-19/

- Assess capabilities with respect to data collection, sharing, and analytical capability to ensure selected contractors can effectively assess and implement successful VBP arrangements with appropriate providers. Though the models vary in design and requirements, all value-based payment programs require extensive data to identify priority areas, inform improvement strategies, and measure performance.
- Adopt a standardized VBP model to align approaches and population health goals, such as initiatives in primary care, behavioral health, and/or pervasive chronic conditions in the state.
- Tailor contract incentives to reinforce the state priorities, enhance patient engagement, and improve health outcomes.
- Evaluate experience with performance measures. This includes setting measure baselines, monitoring performance, evaluating performance compared to the baseline, and leveraging performance measures to inform quality improvement strategies.
- Require reporting on organization-developed measures, such as the National Committee for Quality Assurance's Health Effectiveness Data and Information Set (HEDIS) measures and outcome measures that can provide data on the impact of quality improvement strategies. These metrics may measure care areas where there are high-costs and/or high-prevalence, such as previously identified chronic conditions of priority (e.g., asthma, diabetes, coronary artery disease, and heart failure), to evaluate the impact of care interventions.
- Demonstrate use and success with population health management strategies to close care gaps, increase use of preventive services, and promote complex case and chronic condition management.
- Organize providers into tiers based on quality measures, cost-efficiency scores, or other value-based factors that position enrollees to choose higher performance providers in combination with incentives that will save them money (e.g., lower co-pays).
- Explore how partnerships with Georgia Medicaid and other health programs could create opportunities for alignment to drive better health outcomes across the entire portfolio of state health care expenditures, reduce administrative burden for the state's providers participating in all programs, and focus providers on meaningful care areas.

Chronic Conditions & Disease Management

Chronic conditions such as heart disease, cancer, diabetes, stroke, and arthritis are a leading cause of disability or death and can limit activities of daily living. Although common and costly, many chronic conditions are linked to lifestyle or risk behaviors such as smoking or poor nutrition. Chronic disease management, or simply disease management, refers to "structured treatment plans that aim to help people better manage their chronic disease and to maintain and improve quality of life."[34] Such programs are targeted at defined chronic conditions, such as asthma, diabetes, or congestive heart failure, and are intended to improve patient health outcomes and decrease costs to the patient's health plan. Disease management programs are one approach to managing chronic conditions and are designed to improve the health of individuals and reduce costs by effectively managing conditions to minimize symptoms, improve quality of life, and avoid hospitalizations or other medical treatment.

Prevalence of chronic disease among the covered population is a significant cost driver for state employee health plans, similar to Medicaid, Medicare, and other common sources of coverage. Drawing on an issue

[34] "What are disease management programs (DMPs)?," National Institutes of Health, 2007. https://www.ncbi.nlm.nih.gov/books/NBK279412/

brief from the Center for Health and Research Transformation at the University of Michigan,[35] the New Jersey State Health Benefits Quality and Value Task Force designed a framework for understanding the relationship between patient mix and spending[36]:

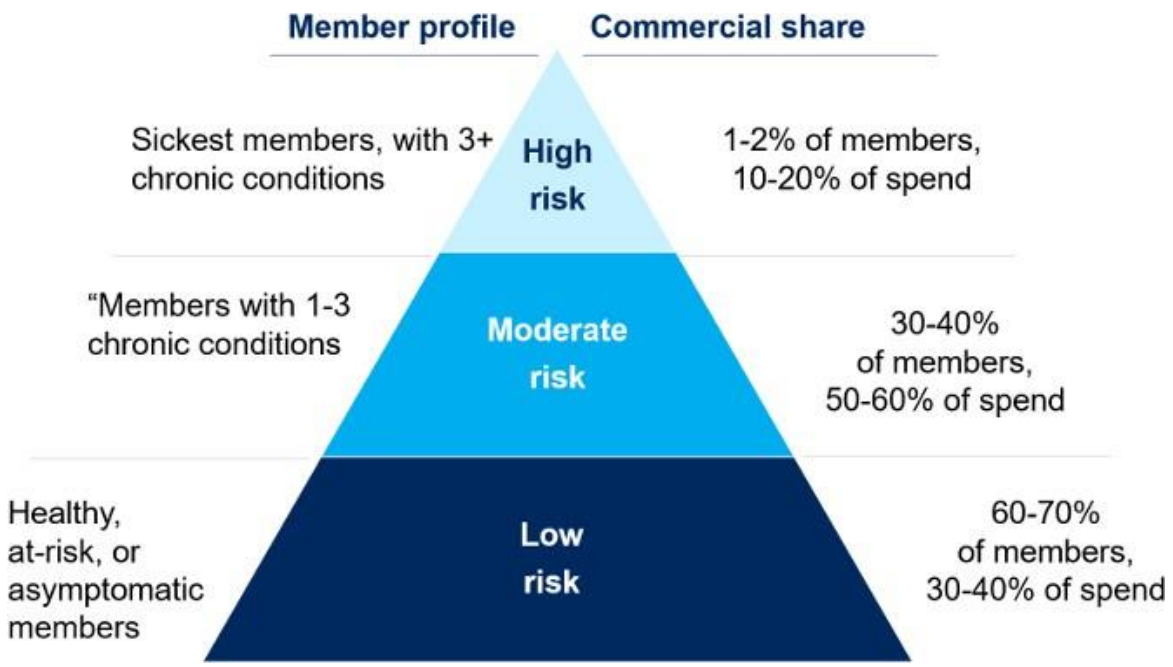


Figure 1: Patient Mix and Total Spend

This framework shows that, while low risk members with no chronic conditions make up 60-70 percent of a typical insurer's membership, they only account for 30-40 percent of total spend. Members with chronic conditions, conversely, make up a smaller proportion of the total membership, but account for 60 to 70 percent of the total spend. In short, patient mix can be a significant cost driver.

A recent study in *Health Affairs* found that price increases, rather than patient mix or service use, were the primary driver of health care spending growth in pharmacy and hospitals.[37] A 2018 *JAMA* article agrees:

> The United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices

[35] Ehrlich, Emily, et al., "Health care cost drivers: Chronic disease, comorbidity, and health risk factors in the U.S. and Michigan," Center for Health and Research Transformation, 2010. https://chrt.sites.uofmhosting.net/wp-content/uploads/2010/08/CHRT-Issue-Brief-August-2010-.pdf?_ga=2.5474871.588142487.1680635501-1405192852.1680121471

[36] "Improving Healthcare Outcomes and Managing Costs: Final Report and Recommendations of the State Health Benefits Quality and Value Task Force," New Jersey Office of the Governor. https://nj.gov/governor/docs/TaskForce_FinalReport.pdf

[37] Bailit, Michael, "What Is Driving Health Care Spending Upward In States With Cost Growth Targets?,"Health Affairs,2022. https://www.healthaffairs.org/content/forefront/driving-health-care-spending-upward-states-cost-growth-targets

of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries.[38]

Thus, while the prevalence of chronic disease among the covered population for a state employee health plan is certainly a cost driver, evidence suggests it is not the most significant factor in cost growth over time. A look at data specific to Georgia shows that diabetes and cardiovascular diseases are among the most common chronic conditions for the state, both in terms of overall prevalence and mortality.

Table 3. Snapshot of Georgia's Chronic Disease Prevalence, Mortality, and Birth Statistics

Georgia Snapshot	Conditions
Chronic Disease Prevalence[39]	• Diabetes – 11.7% (11th highest rate) • Obesity/Overweight – 33.9% (29th highest rate) • Asthma – 9% (36th highest rate) • COPD – 6.2% age adjusted (18th highest rate) • Tobacco use – 16.1% (27th highest rate)
Chronic Disease Mortality[40]	• Heart disease – 183.7/100,000 (15th highest death rate) • Cancer – 147.6/100,000 (24th highest death rate) • Diabetes – 23.9/100,000 (27th highest death rate) • Kidney disease – 18.5/100,000 (6th highest death rate) • Hypertension – 12.2/100,000 (4th highest death rate)
Birth Statistics[41]	• Cesarean delivery – 33.9% (9th highest rate) • Preterm birth – 11.4% (7th highest rate) • Low birthweight – 9.9% (4th highest rate)

Data from Georgia DCH show that the percent of SHBP members reporting at least one common chronic condition has remained steady at between 10 and 12 percent over the last five fiscal years.[42] At the same time, per member per month costs for these members has steadily increased over the same time period:

Figure 2: PMPM Costs for Members with Chronic Conditions

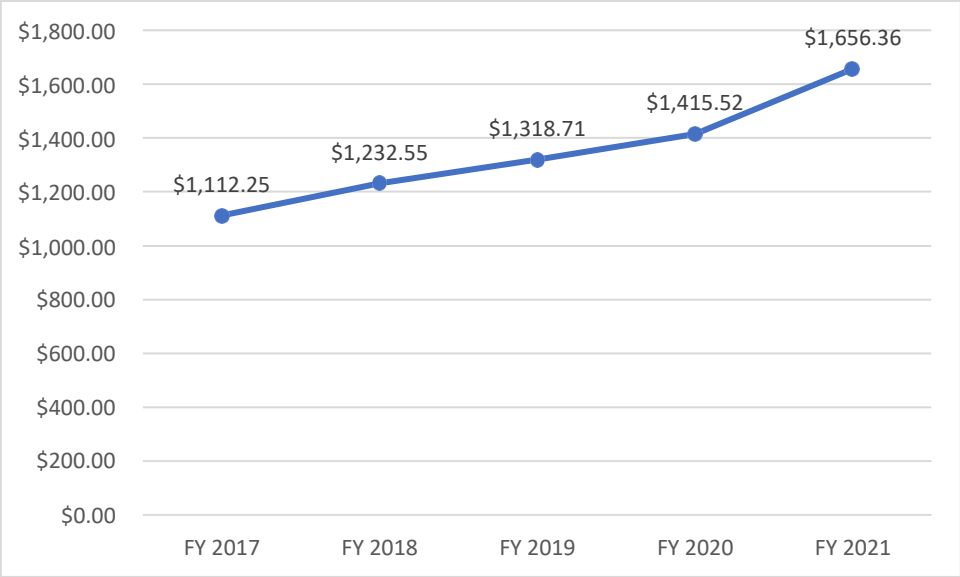
[38] Papanicolas, Irene, et al., "Health Care Spending in the United States and Other High-Income Countries," *JAMA*, 2018. https://jamanetwork.com/journals/jama/article-abstract/2674671

[39] "Stats of the States: Georgia," Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/pressroom/states/georgia/ga.htm

[40] Ibid.

[41] Ibid.

[42] Data show FY 2018 is an outlier with, about 16 percent of members reporting a chronic condition. It could be worth investigating if this is a data integrity issue or is attributable to some other factor, such as a change in patient mix or definitions.



Disease Management

Key components of an effective disease management (DM) program include the following:

- Population Identification Processes
- Evidence-Based Practice Guidelines
- Collaborative Practice Models
- Patient Self-Management Education
- Process And Outcomes Measurement
- Routine Reporting and Feedback Between Patients, Providers, and Health Plans[43]

Researchers have studied DM programs extensively, and the consensus is that well-designed programs can improve patient clinical outcomes. A 2018 systematic review in the journal BMC Primary Care found that some DM programs can be associated with clinical improvements.

Research also suggests DM programs can improve member satisfaction rates, which can be a boon to health plans.[44] The evidence is less clear when it comes to cost savings associated with DM programs, as "substantial cost-savings are generally confined to a short duration of time and are typically based on the experiences of a single plan or program." [45]

Thus, while short or long-term cost savings may be achieved through a well-designed DM program, researchers have struggled to quantify those potential savings.

Georgia's current contract requires contractors to operate DM programs under an opt-out model. DM programs include asthma, diabetes for both adult and pediatrics, COPD, congestive heart failure, coronary artery disease, depression, oncology, and co-morbid conditions. For DM programs under the current

[43] "Disease Management Programs: Improving health while reducing costs?," Georgetown University Health Policy Institute. https://hpi.georgetown.edu/management/
[44] Ibid.
[45] Ibid.

contract, contractors must 1) use a proven methodology for calculating and reporting a return on investment (ROI). 2) identify DM program enrollees through information gathered from multiple sources (e.g., UM reports, claims data, predictive modeling, and assessments) 3) have a process for determining risk categories for each member enrolled in the DM programs 4) provide DM participation incentives (e.g., scales, glucose monitors, blood pressure cuffs, etc.) and 5) must also have ability to administer a prescription drug co-pay waiver program for specific medications.

State contracting approaches to chronic disease and DM programs vary. As shown in the Georgetown University SEHP Cost Containment research, most state employee health plans include a DM component, but states vary as to how prescriptive their contracts are when it comes to program design. Moreover, some states include chronic DM as a requirement under their third-party administrator or medical management contract, while others include this component under their wellness program contract.

Table 4. Contract Requirements Across the Nation for Chronic Disease Management Programs

State	Key Contract Requirements
North Carolina	• North Carolina's RFP for TPA services for its state employee health plans includes extensive, prescriptive requirements related to DM and care management. • Contractors must provide comprehensive, holistic, evidence-based medical policies and medical management of members' physical and behavioral health, including SUD. The contractor must partner with the state on initiative design and evaluation, and must provide data to the state on disease trends. • Minimum programs must include: Transition of Care (TOC) programs, including hospital at home programs for inpatient transitions; 2) High utilizer outreach and management programs; and, 3) Complex case management programs. • The contractor must provide DM health coaching services, as well as wellness and prevention services.[46]
South Carolina	• The state's most recent RFP for its SHBP is prescriptive when it comes to chronic disease management program design, but not around the actual conditions to be targeted. • The contractor provides a comprehensive DM program for non-Medicare members and must advise and support the state in its health and disease management efforts. • The contractor must collaborate with the state's behavioral health contractor • The contractor must collaborate with the state to encourage participation in DM programs and develop strategies to promote and encourage these members to enroll and participate in disease management. The contractor must report outcomes of strategies for engagement in and effectiveness of DM. • The contractor must provide the state, in a secure manner, a detailed monthly disease management participation file for those members participating in disease management programming.[47] • Notably, the RFP also requires contractors to use network contracting strategies to address chronic conditions. The contractor must provide a "value-based provider network for providers who manage and care for plan members with certain chronic, complex conditions. The value-based network(s) should include a

[46] North Carolina State Health Plan TPA RFP, State of North Carolina, August 20, 2022. https://www.shpnc.org/tpa-rfp-transparency

[47] "South Carolina Public Employee Benefit Authority," State of South Carolina, Nov 1, 2022. https://procurement.sc.gov/files/2022%20Third%20Party%20Administration%20of%20the%20State%20Health%20Plan%20RFP.pdf

	reimbursement model with incentives for providers paid by the contractor, who meet specific criteria for high-performance and quality member health outcomes. The contractor currently has value-based provider networks for oncology care, renal disease care, and rheumatoid arthritis."[48]
Tennessee	• DM is included under a separate wellness partner contract. The contract specifies a methodology for patient identification through claims analysis and risk stratification as well as targeted chronic conditions for the program including asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease and diabetes. Additionally, the contract includes language requiring outreach and transition of members currently in DM programs. These programs must be evidence based and should apply principles of behavior modification and education aimed at improving self-management. • The contractor must tailor the type, intensity, frequency, and content of a participant's interventions to the participant's needs and the severity and complexity of the participant's condition(s).[49] • The contractor must also provide lifestyle coaching programs for physical activity, nutrition, sleep, stress management, and tobacco cessation, which may be delivered using a variety of modalities, including options for the contractor including via online or video chat, telephonically, or text. These programs must be evidenced based and should apply principles of behavior modification and education aimed at reducing risk factors that, left unmanaged, can lead to chronic conditions.[50]
Texas	• DM requirements applicable to the state employee health plan are outlined in statute. Programs must include: o Patient self-management education o Provider education o Evidence-based models and minimum standards of care o Standardized protocols and participation criteria o Physician-directed or physician-supervised care.[51] • Contractors must implement DM programs for the following conditions: o Heart disease o Diabetes o Respiratory illness o End-stage renal disease o HIV infection or AIDS.[52]

Recommendations:

Our review found that Georgia's current contract already reflects many best practices around chronic conditions and DM from academic research and other SHBPs. Additional considerations to further improve the existing requirements include:

[48] Ibid.
[49] Tennessee Partners for Health Wellness RFP. https://www.tn.gov/partnersforhealth/contracts.html
[50] Ibid.
[51] Texas Insurance Code Section 1551.219. https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1551.htm
[52] Texas Employee Retirement System HMO RFP. https://ers.texas.gov/Doing-Business-with-ERS/Benefits-Program-Administrators-Vendors/Archive/HMO12-rfa-FINAL-010711v2.pdf

- Adopt RFP/contract language to ensure the contractor's chronic conditions strategy is informed by a health risk assessment. For example, the contract could require the contractor to regularly aggregate health risk assessment data to identify prevalence of and trends in chronic disease among the contractor's membership and adopt DM programs identifying the most prevalent and/or the most costly conditions.
- DCH, the Georgia Department of Public Health (DPH), or both should review data to identify the most prevalent chronic conditions, as well as costs associated with members who have those conditions to confirm whether conditions included in the current contract are the right ones. Update conditions in the RFP and/or contract according to the most current and accurate data.
- DCH should review and analyze data to determine if the current disease management programs required in the contract have been successful in containing costs of those members with such conditions. If these programs have not been successful , DCH should then determine what additional oversight mechanisms and/or financial incentives need to be added to the contract to ensure these programs produce actual cost containment for the state in future years.
- Include minimum standards for disease management in the RFP based on an analysis of Georgia data and best practices. Examples include:
    - Minimum set of targeted chronic conditions (already included in the current contract)
    - Program requirements (e.g., number of contacts)
    - Reporting
    - Incentives for participation (drug co-pay waiver already included in current contract)
- Evaluate effectiveness of drug co-pay waiver before determining whether to include or exclude in the RFP and/or contract.
- In adopting reporting requirements, collect data elements that will aid in program evaluation and inform the evolution of disease management approaches.
- An RFP should encourage contractor innovation by requesting approaches and best practices to DM and chronic diseases beyond those identified by the state. Collaborative practice agreements, which is one of the DM best practices described above, are administratively complex and may prove to be too difficult to expect a TPA to implement. However, this should not stop DCH from continuing to advance its DM programs.

Value Added Services and Wellness Programs

In addition to standard medical benefits, employers often offer additional benefits to supplement their programs. Common value-added benefits may include preventive dental and vision benefits. However, some employers include other additional benefits like a 24/7 Nurse-line through which members can seek medical advice and nurse insight by phone at any time. Other programs may include telemedicine offerings or Disease Management programs to target specific conditions, like weight loss, smoking cessation, lifestyle coaching or mental health tools for example. Wellness programs are one of the most popular value-added benefits offered to employees and have grown in popularity in recent years with

about 84% of large employers offering some form of a workplace wellness program and often with valuable participant incentives associated. [53]

Wellness Programs

Workplace wellness programs refer to a constellation of strategies employee health plans, including SHBPs, may use to increase employee engagement with their health, improve health outcomes, and reduce costs. A 2013 RAND Corporation study, sponsored by HHS and the Department of Labor, examined workplace wellness programs through literature reviews, surveys, case studies, and statistical analyses of claims and wellness program data. The report includes several data points worth considering. The report finds that participation rates for wellness programs vary considerably by program type. Of note, participation rates are generally low, with fewer than 50 percent of employees participating in a health risk assessment.

The RAND report identifies five factors associated with successful wellness programs. The first factor is effective communication strategies. Employers cited the importance of broad outreach and clear messaging from organizational leaders, especially for those organizations with a large and geographically dispersed workforce. The second factor is creating the opportunity for employees to engage. Making wellness activities convenient and easily accessible for all employees are strategies that employers use to raise the level of employee engagement. The third factor is to ensure that leadership is engaged at all levels. For programs to be a success, senior managers need to consider wellness an organizational priority to shift the company culture. The fourth factor is the effective use of existing resources and relationships. This involves leveraging existing resources and building relationships, often with health plans, to expand offerings at little to no cost. The final factor is continuous evaluation, which requires the health plan to approach wellness with a continuous quality improvement attitude.[54]

Federal regulations governing wellness programs are complex, particularly when programs offer incentives. Under EEOC rules, employers must ensure that all wellness programs are voluntary and cannot penalize employees for not participating. Generally speaking, regulations classify wellness programs as either participatory or health-contingent. Participatory programs reward employees for simply participating, whereas health-contingent programs reward participants for meeting certain milestones or health goals, such as walking 10,000 steps or losing weight. While regulations do not speak to maximum benefit limits for participatory programs, they set a maximum reward/penalty for tobacco-related wellness programs at 50% of the total cost of group health coverage under the employer's health plan, and for all other health-contingent wellness programs at 30% of the total cost of health coverage.

We think there is great value to the state continuing to evolve the effectiveness of its wellness programs. However, we also recognize that the federal statutory and regulatory framework is complicated and the litigation concerning wellness programs based on this framework is also complicated. Therefore, we recommend that the state engage its attorneys in reviewing and opining on how the state can continue

[53] Pollitz, Karen and Matthew Rae, "Trends in Workplace Wellness Programs and Evolving Federal Standards," Kaiser Family Foundation, June 9, 2020, https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/

[54] Soeren Mattke et al., "Workplace Wellness Program Study," RAND Corp. (2013), http://www.rand.org/pubs/research_reports/RR254.html#key-findings.

evolving and promoting its wellness programs while also complying with the myriad of federal legal requirements governing them.

Georgia previously issued a separate RFP and has a separate contract for its wellness vendor. Key contract requirements include that the vendor must:

- Provide online and telephonic health coaching
- Offer a flexible, customizable web portal
- Offer a Health Assessment Tool
- Provide online health trackers
- Have the ability to coordinate biometric screening services at worksites statewide
- Provide educational newsletters and printed materials that are customizable
- Monitor, track, and report member participation data for each Plan Option in a real-time fashion to SHBP
- Demonstrate willingness to interface with SHBP, TPA, PBM, Medical Management, and DSS vendors for data and file sharing as needed

In addition, the state has outlined the following goals for its wellness contract:

- Reduce SHBP members' BMI, with a focus on adults with a BMI greater than 30
- Increase the percentage of eligible members who receive preventive cancer screenings with a focus on colorectal cancer, breast cancer, and cervical cancer
- Reduce the number of subscribers paying tobacco surcharges within the SHBP membership
- Collaborate with SHBP in developing a program to support the state's initiative in reducing childhood obesity
- Increase member engagement and participation in wellness programs offered to Standard and Wellness Option members

Table 6. Contract Requirements Across the Nation for Wellness Contracts

State	Key Contract Requirements
North Carolina	• Minimal requirements. Contractors are merely required to offer wellness programs, but the most recent RFP provides no additional requirements about program features.[55]
South Carolina	• The contractors must implement, communicate and manage population health management programs and collaborate with other contractors when appropriate to develop and promote population health programming. • Programming should be made available using a digital population health engagement platform for members to access and have the ability to track and monitor activities to improve health and wellness (diet, exercise, etc.).[56]
Tennessee	• Operates its wellness program through a separate contract. • Requires its wellness vendor to offer health questionnaire to enrollees, as well as biometric screenings, including workplace screenings, to capture the following: ○ Blood glucose;

[55] North Carolina State Health Plan TPA RFP

[56] South Carolina Public Employee Benefit Authority TPA RFP

	○ Total cholesterol; ○ LDL cholesterol; ○ HDL cholesterol; ○ Triglycerides; ○ Waist circumference; ○ Blood pressure; ○ Weight; ○ Height; and ○ Body Mass Index (BMI). • Prescribes an incentive structure in which the vendor provides incentive (reward) tracking and monitoring on its website for all members eligible to earn an incentive, including those participating in a program provided by an external contractor (weight management and Diabetes Prevention Program, if applicable). Incentives could be in the form of cash added to the member's paycheck or funds added to the member's Health Savings Account. The total incentive amount shall be determined by the state and the value associated with each activity shall be finalized by the state, in consultation with the vendor.[57]
Texas	• Requires the contractor to provide Wellness programs including Health Risk Assessments to all members that will "promote and encourage enrollees to intentionally select a lifestyle characterized by personal responsibility, moderation, and maximum personal enhancement of physical, mental, emotional and spiritual health." • The state defines Wellness Services to be "those services provided by an organization or individual in addition to those for which they are contractually bound that provide good physical and mental health. Wellness programs may include: diet and weight loss, smoking cessation, stress management, and parenting, along with health risk appraisals, high blood pressure screening, and programs to aid in the prevention of certain disease stages."[58]

Recommendations:

- The state should continue its wellness and incentive programs. Given the complex regulatory environment, we recommend the state engage its attorneys to see if there is legal permissibility to evolve the programs beyond just voluntary or opt-out and, as a result, bring more of the covered members into the program. However, if the lawyers believe that going further than a voluntary or opt-out approach is not advisable, then the state should - at a minimum - keep the programs in place as they are currently structured going forward.
- Request the wellness partner provide its methodology for return on investment for wellness programs and other value-added services. There is mixed evidence related to cost saving and improved health outcomes associated with wellness programs, so it is important to understand the methodology used by the contractor. It is equally important to understand the outcomes the vendor has seen in other markets. Requesting examples of cost savings or improved outcomes from initiatives in other states would be useful in assessing contractor performance.

[57] Tennessee Partners for Health Wellness RFP

[58] Texas Employee Retirement System HMO RFP. https://ers.texas.gov/Doing-Business-with-ERS/Benefits-Program-Administrators-Vendors/Archive/HMO12-rfa-FINAL-010711v2.pdf

- Evaluate strategic goals of its existing wellness program-based member satisfaction data, demographic data, data on disease prevalence, and utilization data. Consider making changes to existing goals and program strategies based on what is working well and which programs are being utilized.

Oversight

SHBP administration is largely delegated to multiple health plans. Implementing effective oversight is therefore critical to ensuring that contractors are fulfilling the terms of the SHBP agreements. Oversight activities, such as working with an account management team, reviewing metrics and outcomes, monitoring and enforcing performance guarantees and service level agreements (SLAs), can help reduce the risk of non-performance and avoid unnecessary associated costs. Additionally, vendor management and oversight will support relationship building over time and will enhance contractor performance.

Currently, DCH is considered the administrator of the SHBP and retains sole and absolute authority to design, amend, terminate or modify, in whole or in part, any portion of the SHBP in accordance with applicable law. DCH has a designated Contract Administrator as well as a Program Manager who is responsible for receipt and review of contract deliverables. DCH's Division of State Health Benefit Plan is responsible for vendor management including the responsibility for managing unsatisfactory performance and damages.

SHBP contracts typically set forth the governance and oversight structure, which may vary in different states. In Tennessee, for example, the SHBP is governed by the State Insurance Committee and is a financially separate and self-funded program.[59] South Carolina's Public Employee Benefit Authority is the state agency responsible for administration and management of the SHBP. However, South Carolina uniquely emphasizes the inclusion of the contractor as a partner in SHBP management and administration with specific responsibility for taking a proactive approach in identifying problems and solutions.[60]

Georgia SHBP's primary contract oversight tools are required reporting, established through the RFP process, and performance guarantees, which are outlined in the contract. Performance guarantees with associated liquidated damages are a common SHBP oversight and enforcement tool which most states incorporate into SHBP RFPs and contracts. The Georgia SHBP team responsible for contract oversight and compliance includes internal staff from the SHBP and the DCH Procurement Division. The team receives and reviews monthly, quarterly, and annual reports from contractors and discusses outcomes and performance with contractors through a regular cadence of meetings and communications.

Use of data and analytics is key to performance oversight in order to identify trends and patterns which could point to risks or opportunities. There are several contract management software solutions and tools available for purchase to assist in contract oversight. For example, South Carolina's SHBP RFP indicates the intent to use a performance oversight instrument during the term of the contract.[61] Such tools can

[59] "Request for Proposals for Third Party Administrator Services for the State's Public Sector Health Plans," State of Tennessee Department of Finance and Administration, Feb 20, 2020. https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/contracts/health_rfp_31786_00148.pdf

[60] "South Carolina Public Employee Benefit Authority"

support collection of reports and data from multiple sources and even consolidation of data to assist the SHBP with analysis and identification of trends or issues.

An assessment of historical performance is critical to ensuring appropriate resources and structures are in place to support contractor oversight and contract compliance. Reviewing historical liquidated damages will help identify performance guarantees, which may have been problematic over the term of the current contract and will help the DCH's SHBP determine which should be maintained or adjusted forthe upcoming procurement. Historical underperformance within cost containment strategies like utilization, chronic conditions, disease management, or wellness may also reveal gaps to include in the upcoming procurement.

Recommendations:

- Maintain consistent oversight channels, like reporting, performance guarantees, and meeting structure, across contractors to the extent possible to minimize administrative burden of monitoring unique metrics for individual contractors. Standardizing reported metrics, specifications, and information reported during contractor meetings will align overall SHBP performance and aid the SHBP contract management team in easily comparing performance across contractors.
- Include required reporting metrics to support oversight of contract performance and contractor operations. Though performance guarantees are the main source of contract oversight, consider including additional monitoring tools outside of liquidated damages to ensure ongoing visibility into performance across certain key functional areas. Over time, reported metrics could be amended for elimination or replacement if the contractor is performing consistently well throughout the term of the contract. Alternatively, reported metrics showing poor performance by the contractor should become areas for which the state develops and implements new performance guarantees and attaches sanctions or liquidated damages in the contractor for failure to improve performance.
- Leverage automation where possible to streamline processes and ease administrative burden for the state in assessing the contractor's performance. This could include consideration of available contract reporting and evaluating tools, like third party software.
- Understand current pain points and historical performance and operational challenges. Review any formal deficiency notices issued over the life of the current contract including any liquidated damages triggered due to performance guarantee failures as well as remediation conducted to assess its effectiveness.

Performance Guarantees

One tool to help states align financial incentives between the state and the contractors and TPAs administering the SHBP is to include performance guarantees in the contract. Performance guarantees, as the term implies, assign financial risk to the contractor if the contractor fails to meet the required performance levels set out in the guarantees. While these guarantees rarely assign financial risk at the same level as that of a fully capitated arrangement, their presence helps focus the behavior and efforts of the contractor and gives the contractor ownership and accountability outside of just earning the administrative fees for performing the contracted work.

Performance guarantees often focus on a wide variety of areas, including:

- Timely or successful completion of readiness reviews and go-live requirements of the contract.
- Timely payment of claims and resolution of provider grievances
- Proper implementation of utilization management
- Effective reduction of medical claims costs related to a properly functioning disease management program (or set of programs)

The table below provides examples in which other SHBPs focus contractor efforts through performance guarantees.

Table 5. Performance Guarantees in other State Contracts

State	Key Areas of Focus for Performance Guarantees in Other State Contracts
North Carolina[62]	• Standards for amount of claims paid within (or sooner than) 30 days • Standards for amount of inquiries responded to within 24 business hours • Requirements that all daily enrollment files received by 5:00 p.m. processed and loaded in contractor's system by 9:00 am the following day
South Carolina[63]	• Standards relating to appropriateness of services subjected to prior authorization decisions • Standards relating to accuracy of all prior authorization decisions • Standards relating to accuracy of claims payments • Standards for average speed-to-answer member calls • Standards relating to accuracy of provider information listed for members • Standards relating to accuracy of provider fee schedule information listed for members
Tennessee[64]	• Access standards for providers (primary care and specialists) with respect to both number of and geographic proximity to members • NCQA Health Plan Accreditation requirements for contractor • HIPAA privacy and security compliance standards • Standards relating to utilization management processes • Standards relating to prior authorization processes

When comparing the current performance guarantees of Georgia's contract to those other states, we note that Georgia has a robust number of performance guarantees that cover a wide variety of focus areasfor the contractor. In addition, Georgia's contract includes what appears to be a novel weighting factor system that minimizes or magnifies the financial risk associated with each unmet performance guarantee based upon the size of the covered population for each contractor. For example, those contractors with the smallest number of covered lives have a factor of 0.75 multiplied to any financial risk associated for failing to meet the performance guarantee whereas the contractors with the largest populations have a factor of 1.25 multiplied to any financial risk associated with failing to meet the performance guarantee. Given the state's broad scope and well-established set of current performance guarantees, substantial changes are not needed. Rather, the recommendations included below are focused on evolving the state'salready mature performance guarantee approach.

[62] North Carolina State Health Plan TPA RFP
[63] South Carolina Public Employee Benefit Authority TPA RFP
[64] Tennessee Partners for Health Wellness RFP

Recommendations:

- Assess the historical performance of the current contractors in meeting the performance guarantees in order to ascertain whether any modifications to the performance guarantee standards need to be made. For example, those performance guarantees that have been consistently met or un-met by the contractors, could be candidates for the state to modify in the next RFP and/or contract.
- The state should revise its currently required performance guarantees, that have been consistently achieved, to focus the next contractors' efforts on areas which have the greatest opportunity to increase the health of members covered by the contractor as well as areas which have the greatest opportunity for financial and operational improvement for the contractors.
- The state should increase the financial risk associated with those performance guarantees that have consistently remained unmet by the current contractor during the contract term.
- The state should develop new performance guarantees relating to the successful implementation of any new program that the state adds to this contract based upon the recommendations included in this report. Examples would include: adding performance guarantees focusing the new contractors' efforts in implementing any new value-based payment initiatives, health care cost/price transparency requirements, new disease management programs, etc.
- The state should include broad language in the contract to allow it to:
    - Add new performance guarantees during term of the new contract based upon recognized under-performance by the contractors or based on new health care priorities set by the Governor during the term of the contract.
    - Shift financial risk from performance guarantees the contractor consistently meets to those which the contractor consistently fails to meet.
- The state should expand its usage of weight factors from just being dependent upon the size of the covered population of each contract, to also being dependent upon annual performance of each contractor in meeting the performance guarantees. For example, in addition to the 0.75 to 1.25 multiple applied to the financial risk associated with each guarantee based upon the size of each contractor's population, the state should apply the same factor to each contractor in a given contract year based upon each contractors' performance in meeting a predetermined percentage of the performance guarantees in the prior year. Doing so would assure the state of its continued leadership position in leveraging performance guarantees in a way that maximally incentives high levels of consistent performance for each contractor selected to administer the SHBP.

Medicare and Medicare Advantage

State and other public health benefit plans commonly offer Medicare plan options to Medicare eligible employees and retirees. Georgia currently offers four Medicare Advantage (MA) plan options through two different vendors with approximately 130,000 members enrolled across its plans.[65] The plans offered include coverage for Medicare Parts A, B, and D. These plans are:

- United Healthcare Medicare Advantage Standard

[65] Georgia Department of Community Health – State Health Benefit Plan Member Report, August 2022

- UnitedHealthcare Medicare Advantage Premium
- Anthem Medicare Advantage Standard
- Anthem Medicare Advantage Premium

While benefits are similar across the four plans, the premium plans offer lower out of pocket costs through reduced deductibles and co-pays at a higher premium cost to enrollees.

MA has grown substantially in popularity over the past decade and has become an attractive option for employers due to the potential for cost savings opportunities.[66] Within employer-sponsored MA plans, enrollment has grown from 1.6 million in 2008 to more than 5 million in 2021. [67] In some cases, public employers, like SHBPs in Illinois and Pennsylvania and recently Vermont, or city employee plans in New York, have mandated enrollment in their MA offerings to maximize cost savings. However, some instances of mandated MA enrollment have led to lawsuits from organized employees due to concerns over MA managed care practices and perceptions of limited networks and service denials. [68] [69]

Recommendations:

- Ensure plan reporting and performance guarantees are specific to the Medicare program. Medicare members represent a substantial portion of the SHBP and have healthcare needs and priorities that may be distinct from the non-Medicare population. Health plans typically operate commercial and Medicare Plans separately, so bifurcated reporting and analysisis necessary to understand any issues or trends specific to this subpopulation of members and performance of associated plan offerings. Also, MA specific Performance Guarantees currently focus on member transition into the MA Plan as well as establishing appropriate member risk scores. Review MA Performance Guarantees to ensure these remain the most appropriate standards and priorities for the upcoming procurement.
- Evaluate utilization management (UM) practices. Since authorization requirements and service denials can be a source of member dissatisfaction, especially in an MA plan, request UM related metrics like overall denial rates, top denied services, rate of denial, and top reasons for denial.[70] Consider also requesting denial rates for specific key services which may be important to the Georgia SHBP population. For services with high denial rates, include performance guarantees specific to managing the denial rate. Consider also eliminating authorizations with high approvals

[66] Freed, Meredith et al. "Medicare Advantage in 2022: Enrollment Update and Key Trends," Kaiser Family Foundation, Aug 25, 2022, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

[67] Jaffe, Susan, "Employers are saving money by moving retirees to Medicare Advantage – but the switch may disrupt care," Fortune, March 2, 2022. https://fortune.com/2022/03/02/employers-medicare-advantage-health-insurance-retirees/

[68] Miller, Mark, "More Retiree Health Plans Move Away from Traditional Medicare," The New York Times, March 10, 2023, https://www.nytimes.com/2023/03/10/business/medicare-advantage-retirement-nyc.html

[69] Duffort, Lora, "State employees gear up for fight over cost-cutting Medicare Advantage Plans," VTDigger, Sept 23, 2022. https://vtdigger.org/2022/09/23/state-employees-gear-up-for-fight-over-cost-cutting-medicare-advantage-plans/

[70] Sommerfeldt, Chris, "Mayor Adams Kills Medicare Advantage Option That'd Let NYC Retirees Stay on Traditional Coverage: 'We do not intend to offer this,' New York Daily News, March 22, 2023, https://www.nydailynews.com/news/politics/new-york-elections-government/ny-mayor-adams-kills-medicare-advantage-option-for-traditional-coverage-20230322-lxknbwykqvh4bmmxo3e6ok3adi-story.html

or overturn rates to ease administrative burden and member dissatisfaction. Plans commonly delegate portions of UM to third parties, so request information and metrics for any UM programs managed by third parties.

- As a best practice, consider offering a PPO plan with broad national coverage which also accepts any Medicare provider to avoid disruption to members. The PPO plan should have the same in-network and out-of-network cost sharing for members. This will mitigate member concerns with quality and access within the MA plans.

Pharmacy Benefits

Georgia's DCH SHBP Division has delegated full responsibility for administering prescription drug (Rx) benefits to a contracted state employee pharmacy benefits manager (SEPBM) – CVS Caremark. Under the current arrangement between DCH, SEPBM, and SHBPs, SHBPs are required to coordinate with the SEPBM on the following activities:

- SHBPs must receive access to pharmacy claims data for real-time viewing by case managers and disease managers as well as claims data feeds for use with predictive modeling and for purposes directly related to the health plans.
- SHBPs must provide the SEPBM with data on health plan participation to determine eligibility for special member cost sharing, copayment waiver programs, or any other benefits.
- SHBPs must share data in its systems with the SEPBM to the extent necessary for the SEPBM to perform its services on behalf of DCH.

In the past few years, Georgia has passed multiple laws that govern Rx pricing, primarily focused on price transparency and PBM operations and reporting. However, beyond these regulations, the state has not implemented additional cost containment innovations. Below are two different design initiatives the state can consider to improve pharmaceutical benefit access and contain Rx costs.

Reverse Auctions

Traditional PBM procurement processes involve complex proposals containing pricing and terms that can make it difficult for a state to compare bids. The reverse auction procurement model requires all participating PBMs to offer the same contract terms and to compete on price only. PBMs' participation in the auction is contingent on them agreeing to the terms of the proposed state drug benefit plan which includes formulary control, plan design, and member cost sharing. The winning bid is based solely on the least expensive offer.

In implementing a reverse auction PBM procurement model, the state initially contracts with a vendor to conduct the reverse auction. PBM bids are managed through a technology platform that allows the State to share bid information among competing PBMs to see how each one compares with the others. This transparency of disclosing bid information in an anonymous fashion encourages lower offers by PBMs in subsequent rounds of bidding without reducing drug benefits. States achieve savings by forcing PBMs to offer the same contract terms but at a lower price than in preliminary rounds of bidding.

Many states need legislative changes to procurement rules to allow for reverse auctions. The earliest state to implement reverse auctions in PBM procurement for their state employee health benefits program was

New Jersey in 2017. At that time, the state was expected to spend $8.3 billion on Rx over three years by staying with its PBM under the original contract. However, when the state implemented the reverse auction procurement model in its 2017 RFP, it went through two rounds of bidding which led to it choosing a new PBM with a three-year contract totaling $6.7 billion – a projected $1.6 billion savings in Rx costs for its SHBPs. In its 2019 RFP, the state went through three rounds of bidding that yielded a $5.7 billion contract – an additional $1 billion in savings. In the first nine months of the contract, Rx costs for New Jersey and its local governments declined by up to 25% and premiums for plan year 2019 decreased by 1.1%. Furthermore, the state contracted with a single vendor to conduct both the reverse auction as well as manage the PBM contract to ensure compliance which led to additional savings of $45.9 million in claim processing issues over an 18-month period. By 2022, New Jersey was projected to save $3.1 billion in Rx spending in their SHBP program.[71]

New Jersey contracted with its reverse auction vendor through a Request for Quotation (RFQ) process. The state issued an RFQ to solicit quotes for technical and professional services in procuring a SEPBM and performing a PBM invoice review. The state was explicitly requesting a vendor with an online automated reverse auction technology platform that can project SHBP costs based on different potential contractor's proposed pricing terms. Additionally, the state also wanted the vendor to have an automated claims adjudication platform that allows the state to conduct line-by-line review of PBM invoices.[72] Through this process, New Jersey contracted with Truveris, a digital health company, for $9.5 million.[73]

Given New Jersey's success with the reverse auction PBM procurement model, other states are in the process or considering implementing this design in their SEPBM procurement. The following are projected savings from other states' reverse auction PBM procurement models:

- Connecticut: The state's recent SEPBM reverse auction included pricing as well as technical responses and helped the state achieve cost savings of approximately 10% and increased transparency within Connecticut's SEPBM contract.[74]
- Colorado: Currently in the process of procurement; estimates that the reverse auction could save $6 million to $10 million per year.[75]

[71] "States Save on Rx Spending by Using Reverse Auctions for Pharmacy Benefit Manager Service Procurement," National Academy for State Health Policy, https://nashp.org/states-save-on-rx-spending-by-using-reverse-auctions-for-pharmacy-benefit-manager-service-procurement/#:~:text=A%202016%20New%20Jersey%20law,known%20as%20a%20reverse%20auction

[72] "New Jersey Technical and Professional Services for Pharmacy Benefits Manager (PBM) RFQ," State of New Jersey, Sept 28, 2018. https://www.nashp.org/wp-content/uploads/2020/08/NJ-RFQ-for-Technical-and-Professional-Services-for-Pharmacy-Benefits-Manager-.pdf

[73] "Master Blanket Purchase Order 19-TELE-00621,"NJ START. https://www.njstart.gov/bso/external/purchaseorder/poSummary.sdo?docId=19-TELE-00621&releaseNbr=0&parentUrl=contract

[74] Kaminski, Janet, PBM Reverse Auction Legislation," Office of Legislative Research, June 3, 2020. https://www.cga.ct.gov/2020/rpt/pdf/2020-R-0158.pdf

[75] Winegerter, Meg, "Colorado hopes to save millions by changing how state's employee health plan pays for prescription drugs," The Denver Post, December 12, 2022. https://www.denverpost.com/2022/12/12/colorado-employee-health-plan-drug-prices-pharmacy-benefit-managers/.

- Minnesota: Recently finished its SEPBM procurement using reverse auction; projected to save more than $130 million in Rx costs for public sector employees in 2023 and 2024.[76]
- New Hampshire: Currently in the process of procurement; estimated to save between $42.5 million and $53.1 million over the life of a three-year SEPBM contract, compared to the state's current $212.5 million PBM contract.[77]

Single-State, Multi-Agency Rx Purchasing Pools

State governments are one of the largest employers in the state and have considerable bargaining power to negotiate favorable Rx prices with manufacturers, wholesalers, and PBMs. Therefore, purchasing Rx in bulk, known as volume purchasing, or creating/joining a purchasing pool composed of multiple state agencies (and other non-state participants) can significantly increase negotiating power to receive lower Rx prices for all parties.

Pharmacy benefit plans negotiate drug price discounts and rebates based on the number of lives covered. And the larger the number of covered lives, the greater the discounts. Therefore, to increase the number of covered lives, many states are starting to pool the procurement of pharmaceuticals, pharmaceutical benefits, and pharmacy services among state agencies/programs (Medicaid, SHBPs, corrections, public schools and state universities, Veteran homes, etc.) to negotiate deeper discounts on behalf of state and local agencies. Additionally, allowing non-state public employers (e.g., municipalities, counties, etc.), private employers, insurers, or individuals to participate in a common purchasing pool with the SHBP allows more members to benefit from greater economies of scale and purchasing power.

There are multiple benefits to having a large purchasing pool. Expanding the purchasing power of SHBP to non-state employers and insurers can streamline administration of Rx benefits by using a common formulary or preferred drug list and favorable contractual terms with a single PBM. Furthermore, unlike medical coverage, prescription drug plans do not pool risk since the focus is more on the number of covered lives. Therefore, there is less concern about adverse selection causing the costs of coverage for state employees to increase by adding new populations or members to a state purchasing pool for prescription drugs. Finally, State Rx Purchasing Pools can increase competition as they compete with existing Rx plan products, encouraging carriers and PBMs to offer competitive benefits and prices in these markets.

One state that has implemented a multi-agency Rx purchasing pool is Washington. The Washington State Health Care Authority (HCA) is the largest purchaser of health care in the state as it manages both the state's Medicaid program and its state employee health benefits plans. The HCA maintains independent administration of the public employee plan and Medicaid but engages in collaborative planning like utilizing evidence from health technology reviews to guide conditions of coverage and covered services in both plans and sharing pharmacy reviews and expertise across both programs. HCA also administers the Washington Prescription Drug Program (WPDP). The WPDP coordinates the pharmacy benefit for

[76] "MN Modernizes Pharmacy Benefit Manager Marketplace, Achieves Historic Savings on Prescription Drugs," PBM Accountability Project of Minnesota, Oct 11, 2022. https://www.pbmaccountabilitymn.org/post/mn-modernizes-pharmacy-benefit-manager-marketplace-achieves-historic-savings-on-prescription-drugs

[77] Winegarden, Wayne, "The Reverse Auction Opportunity: How New Hampshire can save tens of millions of dollars a year on prescription drugs for state employees," Josiah Bartlett Center for Public Policy, https://jbartlett.org/wp-content/uploads/JBC-Reverse-Auction-For-PBM-services-Study-Winegarden.pdf

Medicaid, state employees/retirees, school employees, and the workers compensation program. Under the WPDP, all programs use a unified preferred drug list. The WPDP manages costs through negotiating manufacturer, wholesaler, or pharmacy discounts and further reduces Rx spending by developing treatment and prescribing protocols to optimize care and treatment.[78]

Other states are following suit and considering establishing multi-agency purchasing pools. Delaware established the Interagency Pharmaceuticals Purchasing Study Group that provides recommendations to leverage bulk purchasing of Rx by effectively negotiating lower prices using interagency contracts and other approaches to maximize savings for Medicaid, SEHB, Corrections, Veteran Homes, and other agencies.[79] And in New Mexico, the state established the Interagency Pharmacy Purchasing Council that reviews and coordinates cost-containment strategies for the procurement of Rx among state agencies (human services (Medicaid), corrections, public schools, and state universities, etc.). New Mexico's initiative goes further and is considering private sector partnerships to maximize the purchasing power of New Mexico residents purchasing Rx in the private sector.[80]

Recommendations:

- Consider implementing a reverse auction procurement model to achieve cost savings for the SHBP Rx program. Under this model, the state could contract with a single vendor, via an RFQ process, that will manage the reverse auction process as well as conduct oversight of the SEPBM contract.
- Consider establishing a multi-agency Rx purchasing pool combining Rx procurement across multiple state agencies and programs including SHBPs, Medicaid, corrections, as well as local county and city agencies to expand its purchasing power. Medicaid, specifically, is also a large state funded and run program that could be considered a part of the intra-state purchasing pool initiative. The state can further consider including private sector employers in its purchasing pool. The state should select an administrative body or create a new one that will establish and administer a State Rx Purchasing Pool. To avoid any regulatory issues, the State Rx Purchasing Pool should be established as a separate entity from the SEPBM, which would offer Rx coverage to both the SEPBM and other State Rx Purchasing Pool participants, such as self-funded employers and insurance carriers offering Rx coverage to individuals and small groups.
- It is important to note that both above recommendations require significant legislative backing to create regulatory authority as well as establish rules and procedures to manage these initiatives.

Cost Containment

States incorporate a host of measures into their state employee health benefit contracts that require the contractors to constrain the growth of underlying medical costs from year-to-year. Similar to

[78] "Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power,"National Academy for State Health Policy, April 2019. https://www.nashp.org/wp-content/uploads/2019/04/States-Leverage-Purchasing-Power.pdf

[79] "Delaware Takes on High Prescription Drug Costs by Leveraging Public Purchasers," National Academy for State Health Policy, May 6, 2019. https://nashp.org/delaware-takes-on-high-prescription-drug-costs-by-leveraging-public-purchasers/

[80] "New Law Enables New Mexico to Leverage State Purchasing Power to Lower Rx Spending," National Academy for State Health Policy, April 22, 2019.. https://nashp.org/new-law-enables-new-mexico-to-leverage-state-purchasing-power-to-lower-rx-spending/

performance guarantees, the reason for cost containment requirements, is to ensure that the contractors' interests in administering the SHBP are aligned with the state's goal of enhancing the quality of care and improved health status for the covered population. Additionally, states seek to appropriately reduce the costs of medical claims provided to the population each year and want to reduce as much unnecessary medical claim expense as possible.

Examples of the wide variety of cost containment strategies and measures employed by states in these contracts include robust utilization management programs, requirements to proactively engage the population in preventative care, chronic condition and disease management programs, case management for complex and costly members of the covered population, wellness initiatives and programs, price transparency efforts to better educate the population served, recruiting covered members into high deductible health plans, and reference-based pricing initiatives.

In addition to including the elements mentioned above, Georgia's current SHBP contract also includes quality assurance programs, meaning that the utilization management procedures as well as other coverage and payment policies for services function as designed. Georgia's contract also includes robust language requiring the contractors to implement policies that strongly encourage in-network providers to refer specialists and other providers who are also in network. Failure to do so allows for the contractor to terminate a provider from their network. Lastly, the Georgia contract requires that the contractor provide robust cost avoidance, third party liability, and coordination of benefits processes for every person enrolled into their programs. Collectively, the current contract has a robust approach to containing costs and broad scope of initiatives, so the recommendations below are meant to be complimentary rather than substitutionary.

Recommendations:

- Request and assess performance data for current contractors based on its self-evaluation report regarding its quality assurance program and utilization management program. Based on review of these results, the state should refine and address any areas that are perceived to lack effective oversight and, therefore, may be contributing to the contractors' poor performance (if any).
- The state should, consistent with its overall health care policy goals of expanding health care transparency, align and evolve the current health care transparency and health information exchange requirements in the contract. Examples could include requiring the contractors to contribute data to the state's all payer claims database (APCD), host or link the APCD on its member portal, and provide proactive outreach to members to educate them on how to use the APCD to make better informed health care decisions.
- The state should consider legally permissible ways to incentivize members to opt into its high deductible health plan coverage options to ensure broader financial alignment between the state and the covered members and increase the efficacy of the member education efforts of the contractor on matters like price transparency and become more mindful consumers of health care.

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