Response to Request for Information: (RFI) #41900-DCH0000127

This document is a response to the referenced Request for Information by the Georgia Department of Community Health (DCH). Set out below are suggestions for DCH to review and, hopefully, implement. Background and supporting information for each of the suggestions is also included.

Suggestions:

1. The RFPs and contracts must have a keen focus on the network adequacy of managed care organizations (CMOs). The focus must not be limited to the number and geographic location of the providers. The RFI and contracts must address (a) CMO practices that unlawfully deny or delay payments to health care professionals in the CMO's network, (b) access and availability (e.g., time to first appointment) of in-network providers, and (c) reimbursement rates that are at parity when comparing rates for medical/surgical providers and rates for behavioral health providers.

2. Require CMOs to provide out-of-network care when it is unable to provide in-network care at no additional out-of-pocket cost to enrollees. The failure by CMOs to have adequate networks should not result in enrollees having either to pay more for services required to be covered by Medicaid and Peach Care or forego needed medical care.

3. Require CMOs to load contracts with providers into their systems within 30 calendar days of the providers been notified of their acceptance into the CMOs' networks. Deny CMOs from rejecting any claim submitted by a provider after that 30-day period on the basis that the claim was not timely submitted (e.g., within X days/months of the contract finally being loaded).

4. Develop and implement a more robust, visible, and transparent compliance function to hold CMOs accountable for their obligations to enrollees, providers, and the state and federal government. This effort can build on the transparency and accountability provisions set out in the Georgia Mental Health Parity Act (HB 1013).

Why are CMO provider networks so skinny?

Medical care providers that are in-network with CMOs are a small subset of the overall number of medical care providers in the state, especially behavioral health care providers. In addition to the payment of below market reimbursement rates, CMOs engage in various shenanigans that appear to violate provisions of law, regulation, and contract and discourage medical professional participation in CMO networks:

- Delaying or denying payments to providers for services that are medically necessary, including services that are specifically included in the monthly capitation payments paid to CMOs by DCH.
- Understaffing provider support functions in violation of the contract and regulations.
- Abusing their market power in provider interactions (e.g., threat of contract termination).

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- Instituting spurious requirements to make the provider appeals and adjustment. processes more difficult and time-consuming
- Failing to undertake root cause analyses for recurring problems and, even when a cause is determined, only correcting payment errors for those providers who complain and not for all affected providers.
- Terminating providers - for no cause - who provide medically necessary and high cost health services to vulnerable populations (e.g., children in foster care or the juvenile justice system), especially when there is no alternative to the terminated provider.

These types of behavior by CMOs make medical health care providers less inclined to be a part of the CMO networks, thereby thwarting one of the primary purposes of Medicaid managed care, which is to increase access to health care for some of our state's most vulnerable citizens

Which behavioral health workforce shortage, the real one or the manufactured one?

Set out below is a visualization of the two primary behavioral health workforce shortage situations in Georgia. One is real, and one is manufactured by CMOs.

While most understand that overall demand for behavioral health care professionals exceeds supply, there is a need to understand that the overall supply of behavioral health care providers in Georgia significantly exceeds the number of in-network behavioral health care providers for CMOs (and private insurers).

The in-network shortage of behavioral health care providers results in Georgians, especially Georgia's youth and adolescents being forced to go out-of-network for care. A 2019 study by the Milliman actuarial firm found that children in Georgia are forced to go out-of-network

Ten times more often for behavioral health care than for general and surgical health care. It is a clear parity violation.

For many Georgians who do not have the financial resources to take their children to out of network providers, especially enrollees in Medicaid and Peach Care programs, they are denied access to necessary and appropriate care. This even though behavioral health access parity is both required and paid for by the premiums and capitations amounts retained by the CMOs.

Why are CMO provider networks so lacking in behavioral health care providers?

Because Georgia insurers, including CMOs, intentionally fail to pay mental health professionals a market-based rate for their services. In 2019, the actuarial firm Milliman found that mental health care professionals in Georgia are being paid 38% less by insurers than health professionals providing comparable services per Medicare codes.

If you are a mental health professional in Georgia and you can get 100% of the market rate for your services paid at the time the services are rendered, why would you agree to get 62% of market rate, paid in arrears by CMOs (in addition to the administrative burdens involved in working with CMOs)? Many of Georgia's mental health care professionals may have been born at night, but it wasn't last night.

Look with skepticism on any claims by CMOs that paying market-based rates for behavioral health providers will result in "skyrocketing" premiums. Such a claim is an admission that CMOs are purposefully failing to comply with their parity requirements.

How is it that CMOs can pay market-based rates for general/surgery providers but not for behavioral health providers?

What MLRs tell us about CMO (ab)use of taxpayer funds

Following unanimous passage by both houses of the General Assembly of HB 1013 and its enactment into law by Governor Kemp's signature, Georgia's CMOs are required to meet a minimum medical loss ratio (MLR) of 85% for each Medicaid and Peach Care program for which it provides coverage.

The latest year for which DCH has audited MLRs of its CMOs is 2019 and the picture is not pretty.

- Peach State Medical Plan's MLR for PeachCare for Kids is 80.4% and its MLR for Planning for Healthy Babies (P4HB) is 58.9%.
- Amerigroup's MLR for P4HB is 58.1% and its MLR for Georgia Family 360 (serving children in foster care and juvenile justice) is 81.8%.
- CareSource's MLR for P4HB is 32.5%

Hundreds of millions of dollars have been paid to Georgia's CMOs to provide health care, including behavioral health care, to some of Georgia's most vulnerable children. The number

don't lie; CMOs have abjectly failed to provide the services for which they have been paid by Georgia's taxpayers.

Might there be an increase in costs to providing market-based reimbursement rates? To the CMOs, of course. To the state, not so much. As set out above, many of Georgia CMOs' MLR rates are below 85%, especially Medicaid and PeachCare programs for children. The difference between actual MLRs and the 85% minimum means that there is taxpayer money that has been allocated and should be spent on care for Georgia's citizens, rather than rolling to the bottom lines of the CMOs.

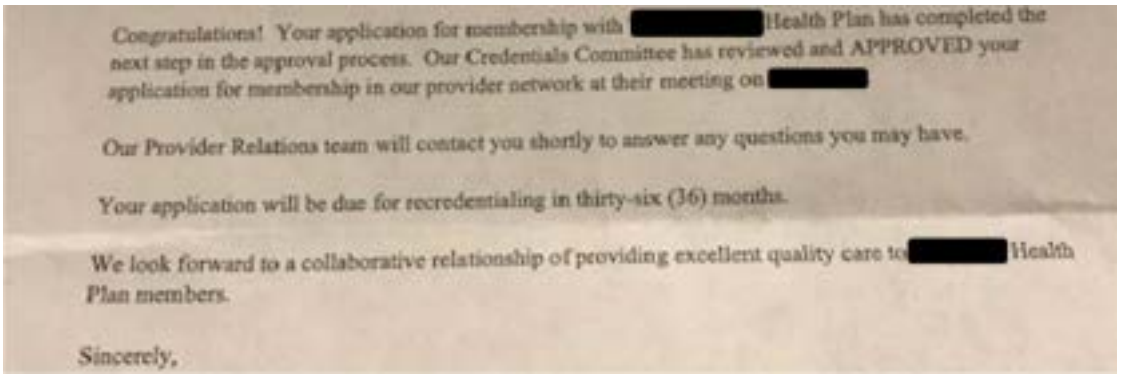
It is worth noting that overall behavioral health care costs account for less than 5% of overall CMO expenditures. Even if expenditures for behavioral health care are doubled, that still amounts to less than 10% of overall Medicaid spend.

Why the long delay in "loading" provider contracts?

Given their "skinny" networks, one might think CMOs would move with some speed to bring additional providers into their networks. One would be wrong.

Certain CMOs take 6-12 months to "load" the CMO's contract with the provider into the CMO's systems. For others, the process usually takes approximately one month. Until the contract is loaded, the CMO will not reimburse the provider.

Some providers have gone ahead and provided care for CMO enrollees after receiving a letter like the following from a CMO, and then submitted reimbursement requests.



Congratulations! Your application for membership with [redacted] Health Plan has completed the next step in the approval process. Our Credentials Committee has reviewed and APPROVED your application for membership in our provider network at their meeting on [redacted]

Our Provider Relations team will contact you shortly to answer any questions you may have.

Your application will be due for recredentialing in thirty-six (36) months.

We look forward to a collaborative relationship of providing excellent quality care to [redacted] Health Plan members.

Sincerely,

While reasonable given the words and tenor of the letter, the provider contracts require providers to submit bills within six months of the services being rendered. If a provider provides services in month 2 and their contract isn't loaded until month 9, their claims for month 2 reimbursement will be denied for failure to submit within the six-month time period. Such a situation is the "best of both worlds" for a CMO: their enrollees receive medical care and the CMO doesn't have to reimburse the provider for that care.

This allows the CMO to retain the portion of the month 2 capitation payment for the enrollee that should have gone to the provider. While this may be "good" for the CMO and its shareholders in the short-term, such actions are the reason why the CMOs have inadequate networks of providers, leading to a lack of medical care, and a less healthy state population. Exactly the opposite of what Medicaid and parity are designed to achieve.

The need for greater oversight, transparency, and accountability

While there is a necessary and appropriate focus by DCH (and the Georgia Attorney General's office) on potential fraud, waste, and abuse by Medicaid providers and enrollees, a similar focus on potential fraud, waste, and abuse by CMOs is also necessary.

Health care funding is the second largest expenditure in Georgia's budget, behind only education funding (primary, secondary, and higher education). Medicaid is the largest component of state health care funding. Georgia's three CMOs currently receive more than $9 billion from the state and oversight of Georgia CMOs is feeble.

For example, Ohio and Mississippi investigated pharmacy benefit overpayments by their states' Medicaid agencies to Centene Corporation (parent company of Peach State Medical Plan). This led Centene to announce a year ago, that it was reserving and/or paying out $1.25 billion to affected states, including Georgia. Had the Medicaid agencies and auditors in Ohio and Mississippi not undertaken their investigations, Georgia would be none the wiser.

While there have been approximately ten states with whom Centene has settled over the past twelve months, there has been no settlement for Georgia. Tens of millions of dollars should be returned to the state sooner rather than later.

Since its enactment more than 40 years ago, the Medicaid program has been required to "[p]rovide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined and such care and services will be provided in a manner consistent with the simplicity of administration and the best interests of the recipients." 42 U.S.C. §1396a(a)(19) (emphasis added).

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