GEORGIA ASSOCIATION of Community Service Boards, Inc.

GEORGIA MEDICAID MANAGED CARE RE-PROCUREMENT RECOMMENDATIONS

By:

Georgia's Public Safety Net Providers

Executive Summary

The Georgia Association of Community Service Boards (GACSB) is a trade association providing support to all 22 Community Service Boards (CSBs) operating in Georgia. CSBs provide services for mental illness, intellectual/developmental disabilities, and/or addictive diseases. As part of Georgia's Public Safety Net, CSBs serve eligible persons with serious mental illness, intellectual/developmental disabilities, and/or addictive diseases who have no insurance and limited to no means to pay for treatment. CSBs also serve persons with Medicaid. Individuals with other insurances are served based on the CSB's capacity and local need. As the Department of Community Health (DCH) considers the implementation of a competitive managed care procurement and transitioning Aged, Blind, and Disabled (ABD) population to managed care, GACSB and its members have developed recommendations based on the collective experience with the current managed care system in place since 2006.

Since Georgia implemented managed care, several states have advanced managed care models for the ABD population. Georgia has the opportunity to work with these examples, customize them for Georgia's needs and ultimately improve services and outcomes for Georgia's most needy residents. Best practices studied by GACSB in the development of its comments, include Arizona, New York, Vermont and Pennsylvania. These are available **here**.

- **Arizona** – developed a dedicated, separate model for safety net populations and had a successful transition from carve-out to carve in and shares many features in common with Georgia. Arizona has also designed a specialty health plan for individuals with SMI.
- **New York** – developed a regulated and defined Utilization Management approach for health plans transitioning to behavioral health management.
- **Pennsylvania** – succeeded in developing reinvestment models to support behavioral health services and has developed a shared, interagency oversight model for BH.
- **Vermont** – maintains the highest per capita funding for BH through an integrated statewide Accountable Care model and has very high access to care ratings.

The most significant consideration in the decision to move the ABD population into managed care or have them remain in the current Fee For Service (FFS) system, is the unique needs of the ABD population. The health care needs of the ABD population differ significantly from health care needs of the primary populations currently in managed care, including Temporary Aid to Needy Families (TANF). In addition to acute care needs, the ABD population typically needs home and community-based service structures that support meeting individuals where they are with the services they need. The ABD population is more likely to have complex care needs and requires greater coordination, community support and Social Determinant of Health (SDoH) support.

Recommendation:

1. Given the different health care needs, it is recommended that the state
    a. Conduct an analysis of the needs of the ABD population
    b. Identify the most effective models for meeting those needs.

    This analysis, and the identified models, should be evaluated in terms of the benefits of a managed care FFS structure for members.

2. The State should conduct an analysis to
    a. Identify gaps in access to care
    b. Identify gaps in provider availability
    c. Identify actual outcomes of care and total cost of care.

    Based upon this analysis, there must be a plan to systemically transition the system from its current state to the desired state of a system well structured, equipped, and resourced to meet the often intensive and customized needs of those served.

3. Additionally, the transition to this system must identify a path to sustain services while moving to value-based or risk-sharing models.

    a. This plan, which by necessity will be a multi-year plan
    b. It must address the various topics highlighted by DCH:
        i. Access
        ii. provider network adequacy
        iii. care coordination/management
        iv. information exchange
        v. reimbursement
        vi. mental health equity.

In this white paper, GACSB outlines its feedback, including opportunities and strengths in the current managed care system, and makes recommendations for the bolded topics above the State should consider as it develops its planning for a future procurement and the potential transition to managed care of the ABD populations.

Quality

The CSBs have experienced both strengths and weaknesses with the current managed care program's approach to quality management and improvement. Heavily reliant on the "medical model," the current model incents costly, acute care rather than the more cost efficient "recovery model" that focuses on community-based services and provides better outcomes for individuals with behavioral health conditions. The managed care system could be significantly strengthened by adopting proven approaches utilized by the Community Service Boards (CSBs) in the Fee for Service (FFS) delivery system to effect diversion from more intensive, higher cost levels of care to less intensive community-based services, while simultaneously affording members the opportunity to develop meaningful connections and relationships needed to support recovery. This approach also results in lower readmission rates, which, in turn, improves access for other individuals. The CSBs are operating data-driven clinical programs based on the Service Process Quality Management (SPQM) model, a state of the art analytic and management support tool. Within the overall Quality approach, there are also processes which would benefit from lessons learned across the system, including prior authorization, care management and coordination, and opportunities for innovation.

Authorization

Authorization processes represent both a strength within the FFS system and an opportunity for improvement in the CMO structure. While authorization processes are clearly defined by and through the CMOs, there is no standard or consistent authorization process across the system. Within the FFS system, there is a process for submitting a "batch" authorization request and receiving a "batch authorization" return to the electronic clinical record, reducing the administrative burden on providers. And equally important, the authorization process is standardized and predictable with sufficient amounts of service included in the typical authorization process. The CMO process varies by CMO, with variable results. Typically, CMO authorizations for initial services are for shorter time periods, and reauthorizations are required more frequently. This is not consistent with behavioral health recovery models and creates significant administrative burden for providers. Often, the CMO authorization response time is long, resulting in the appropriate service not being available at the time of need. This results in either a provider not getting paid for services provided or an individual not receiving the services most appropriate to the need.

Recommendation:

1. That authorization be required only for high intensity behavioral health services, such as
    a. Crisis Stabilization Unit
    b. Assertive Community Treatment
2. That authorization NOT be required for services defined within the Child and Adolescent Non-Intensive Outpatient Package and the Adult Non-Intensive Outpatient Package including all Peer Support Services
    a. Per the DBHDD Provider Manual which can be found on page 3 at http://dbhdd.org/files/Provider-Manual-BH.pdf,
    b. Which are all services approved under Georgia's Medicaid Rehabilitation Option State Plan Amendment

Care Management and Coordination

Care management and coordination are essential to improving health outcomes for individuals. Individualized care coordination, resulting from use of a standardized assessment of need that substantiates the level of service needed and includes local representation would significantly improve outcomes. Local care management activities must also be supported financially which requires that providers be reimbursed for these activities. The state's adoption of the CCBHC model as a crucial infrastructure vehicle for advancing quality integrated care, with the CSB safety-net assigned as top tier CCBHCs, would significantly advance the level of local care coordination that occurs with and for individuals with BH and complex needs. Care management activities performed under the auspices of the CCHBCs would be designed to avoid redundancies so that CMO care management and local level care management/coordination would be positioned as an essential component that is coordinated and not duplicative. This should be addressed by procurement and contracting processes. Reimbursement should reflect and accommodate this critical care management role performed by the CSBs. Additionally, a number of CSBs are currently implementing the Certified Community Behavioral Health Clinic (CCBHC) model supported by SAMHSA. This effort is supported by the State. Care coordination is a core component of the CCBHC model. CCBHCs should and will play a critical role in the service delivery system for individuals with complex needs and should be supported by the CCBHC prospective payment system.

Information sharing is critical to effective care coordination and management. The state should explore how to develop, advance, and incentivize streamlined and efficient information sharing through electronic health information exchange. This should include notification to Primary Care Physicians and BH

Providers when individuals are admitted to an Emergency Department or inpatient facility. And finally, service authorizations should be consistent with the care coordination activities, specifically in authorizing a correlated amount of service for the most appropriate level of care.

The state should outline clear goals and intended outcomes for care management, care coordination, and case management including what is expected for identification and service to individuals with complex health needs, yet not be so prescriptive to disallow innovation at the practice level. Equally important to outlining the expectations, the state must take efforts to design these programs to ensure that there is adequate reimbursement to support these efforts at the provider level.

Education, Training, and Technical Assistance:
To improve quality and outcomes, the state could support the development and sustainability of formal convenings that provide training, technical assistance, and consensus-building to design, build, and implement practices that support integrated whole health care and realize positive outcomes for Medicaid members. The state could look to a convening organization to operate this or require that health plans form a statewide convening to support this to provide technical assistance and assure fidelity to minimum standards.

Innovation
Legacy CMO contracts provide "bare-bones" medical coverage with little to no support for innovation. What innovation has taken place is in small pockets, typically short term, at the discretion of the CMO. These original contracts have favored the insurer/payer and this is a great opportunity to flip the perspective 180˚ so that innovation is built with a focus on outcomes for the members, engagement of and compensation to the providers, and then finally for the insurer. Innovative and best practices can be advanced in Georgia by requiring health plans to collaborate and partner with individuals with lived experience, providers, and other stakeholders on designing, implementing, monitoring, and evolving innovations. The state could require that health plans have formal processes to conduct such activities and report on the efforts. In recent years, the DCH has made efforts to publicly share information about CMO quality ratings. This should continue to be strengthened in the breadth of information collected and comparative analytics shared and the active solicitation of direct feedback by DCH from system stakeholders.

Contracting
From an overarching perspective, the GACSB's experience in contracting with the CMOs reflects the Plans' focus on profit margin rather than the opportunity to leverage provider expertise, address population-specific challenges, and improve member outcomes by customizing contractual agreements. If there is to be a real focus on Quality from the state, then the appropriate investment in Quality and structures to support Quality must be built into the procurement framework.

Recommendation:
1. Require CMOs to exceed FFS reimbursement rates for high-cost, complex target populations like members with Behavioral Health needs.
2. Incentivize the CMOs to exceed FFS reimbursement levels even further in certain situations, e.g., to address coverage gaps in rural areas.
3. Require CMOs to obtain from providers and submit to the state with their proposals to the RFP new Letters of Agreement representing their willingness to participate in the network.
4. Require any incumbent CMO to renegotiate their contracts with providers for services to be provided effective under the new contract.
5. Enforce the 85% medical loss ratio (MLR) recently established by law in HB1013.

6. CMOs should be encouraged to set aside 2% of their overall contract dollars as “Reinvestment Funds” used to pilot cost effective alternatives to traditional State Plan Services based on the recovery model.
    a. These services and supports will target unmet or under-met behavioral health needs of its members.

Best Practices: Arizona Targeted Investment Program and Core Values and New York’s Standards for Managed Care Transition

Equity

There are several opportunities to improve equity across the managed care programs.

Pharmaceutical Policy

The most significant opportunity to improve quality, value and access to pharmacy benefits is the development of a common formulary. This formulary, if properly developed, can address accommodations for choice and cultural/personal beliefs (such as non-stimulants for treatment of ADHD), and “fail first” approaches to certain drugs. Secondly, an efficient and predictable authorization process would be beneficial. Finally, regular reporting and monitoring of this is essential to ensuring that it is effectively implemented and that the benefits are realized.

Prior Authorizations for Medications (PAs) are extremely labor intensive, and there is no efficient way to bill for nurses' time to perform this task. Many prescription drugs require PAs, and many CMOs dictate the formularies. The long process of trial and error that physicians are required to go through in order to get the individual on the "best medication" to treat the individual is difficult on the client and their families, particularly children and youth. We recommend all Medicaid Managed Care Companies include pharmagenetic testing as a covered benefit. Sometimes waiting on the insurance company to finally authorize the medication the physician initially intended the individual to have results in the individual having to be hospitalized to stabilize their illness. It is a frustrating, grueling process for the physician, client, and family. This whole process needs to be revamped and reworked, including a more efficient way for organizations to pay for the extensive and needed documentation efforts under the PA process.

There will be obstacles and challenges to implementing such changes. Pharmacy expenditure is a significant cost to Medicaid. As such, CMOs may oppose a standard formulary or changes to “fail first” practices. Also, various stakeholders will have differing opinions and input regarding the development of the formulary and regarding which conditions/medications should not be subject to “fail first” authorizations. These are not insurmountable challenges and the potential impact on quality and consistency justifies the effort.

Network Adequacy

The current CMOs make Resource Directories and Call Centers available to members and providers, which is a clear strength in promoting equitable access. Another strength that improves access is the fact that one CMO has worked to ease the requirement for authorization for many core services. However, due to the variation in authorization processes (outlined above), there is tremendous inconsistency which creates inequity in access across Medicaid beneficiaries. Access in rural areas is particularly difficult. This is typically due to a lack of providers, whether by CMO or in general. Moving forward, either adequate network adequacy standards, or better enforcement of network adequacy standards, would improve access, particularly in rural areas of the state. More flexible use of telemedicine and telehealth tools should also be strongly considered.

Stigma
Stigma against Medicaid patients, regardless of "diversity", is pervasive among Atlanta area hospitals. Neither state Medicaid enrollment nor CMO contracts with hospitals have been able to successfully address how to keep hospitals from de-prioritizing Medicaid patients. A statewide strategy should be developed for managing stigma, which not only would mitigate the barrier for all Medicaid members, but particularly would enable individuals with mental illness or substance use disorders to be efficiently connected to care. Incentives for hospitals to partner with CSBs to close this gap would be welcome as one approach for addressing gaps in the continuum of care for this population.

Communication
Improved communication between the state, CMOs, and providers will help improve diversity and cultural competency. Prior to the pandemic, CMOs visited communities, meeting with collaboratives and community-based organizations. Understandably, this stopped during the pandemic. Unfortunately, this has resulted in a more disjointed, less connected system. Such visits, or other communication techniques, should be re-established.

Workforce
Workforce challenges are clearly impacting the diversity of the provider networks and the ability to meet the diverse needs of those we serve. Systemic workforce strategies are needed for all areas of healthcare throughout the state.

Training and Education
Another suggestion for improving ability to meet diverse racial, cultural, and linguistic needs is to require CMOs to provide diversity training for providers. Additionally, CMOs should have Cultural and Linguistics Coordinators. CMO provider directories should be required to reflect provider demographics and completion of training.

Recommendation:
1. The State should contractually require CMOs to assess and collect data regarding SDoH needs and incentivize addressing those needs.
2. Compliance with federal parity regulations should also be monitored.
3. CMOs should be required to provide standardized reporting showing progress and what they have done to act on strategic initiatives to address mental health equity.

Best Practices: Arizona Targeted Investment Program

Access and Outcomes
Access to Timely Care
Medicaid members face numerous challenges in accessing health care services and staying engaged with health care activities. Generally, access is one of the biggest challenges Georgia faces and must be a priority. Various challenges that impact access and engagement include, but are not limited to those already discussed, service authorization and network challenges with CMOs. In rural southwest Georgia, access to care is particularly impacted by CMO authorizations and rates. Very few providers will accept at least one of the CMOs Members because of its challenging authorization processes and low reimbursement, resulting in situations requiring families to travel more than an hour to access medical, dental or vision services. Transportation is also an ongoing challenge to accessing and engaging in care. This is especially true in rural areas with no public transportation. Rising gas prices have made this an even greater factor. While many people will drive for a crisis or an initial service, they are far less likely to engage in appropriate ongoing treatment when faced with transportation challenges and costs.

For individuals in treatment who move to a new location, it is typically difficult to obtain a CMO authorization in the new location. This is due to the existence of an “active authorization” in the previous location and provider. Future contracts should address the need for adjusting authorizations to accommodate a change to a new provider with timely authorization and communication. The DCH has created “shared” authorizations for other programs where a PA need not be provider-specific and similar solutions should be considered more broadly.

There also remains a large portion of the population that views the Emergency Department as their “go to” health care solution. This results in higher costs for ambulatory care situations and reduces the chance of ongoing care. Future contracts should include requirements for education, connection with PCPs, and incentives to reduce inappropriate ED visits. CSBs have a long history of demonstrating co-consultation with PCPs and setting up infrastructures conducive to integrated care through co-location with primary/physical care clinicians. The State should also adopt a “no wrong door model” which provides treatment access at any point of entry. This popular healthcare delivery model provides access to care when and where there is need, making rapid access to needed services available. This is the most cost-efficient way to create greater access and engage in recovery-based care rather than the costly “medical model” crisis-oriented intervention that is the current standard in Georgia.

In order to improve access in rural areas, the Medicaid managed care program must secure adequate provider networks and provide sufficient reimbursement, as well as work collaboratively to address the workforce shortage issue. For behavioral health, this includes contracting with the CSBs in a manner similar to the FQHCs for physical health with a payment model that supports the costs of care management. The State should lead and contractually require, movement to value-based payment methodologies. Also, telehealth/telemedicine services, as implemented during the public health emergency, should be maintained and enhanced. This must include support for technology and equipment needed for telehealth/telemedicine. This will greatly improve access to needed services.

Social Determinants of Health (SDoH)
Unmet SDoH needs, such as housing instability, food insecurity, lack of transportation, and education and employment barriers, can impact access to health care services, adherence to plans of care, and health outcomes. Providers, Care Management Organizations, and local entities, such as school systems and social service organizations, are positioned to help address these needs with support and direction from DCH. Across the country, Medicaid programs are embracing the importance of addressing SDoH needs with members and their families. There are several opportunities to incorporate SDoH interventions in the upcoming procurement.

- Health Care Providers: Providers, particularly PCPs and BH providers, are well positioned to identify unmet SDOH needs among their patients. To help equip providers to consistently screen patients for SDoH needs and refer them to appropriate services in their community, DCH can work with CMOs and other stakeholders to deliver provider education and training on SDoH needs, health disparities, tools for assessing needs, and available resources within the community. DCH should continue to encourage the use of z codes to help capture standardized information about SDoH needs on provider claims.
- Care Management Organizations (CMOs): Health plans participating in Medicaid programs across the country are increasingly using screening tools to assess the unmet SDoH needs of their members and resource referral platforms to help connect their members to local community-based organizations and resources to help address these needs. Closed loop referrals are

particularly helpful as they can indicate whether a member received the service to which they were referred.
- Local Organizations: DCH can encourage CMOs and providers to work closely with local community-based organizations that deliver services, such as job training, access to nutritious foods, housing supports, and transportation. CMOs and providers may also work with local school systems and social service agencies to help ensure children can access the SDoH resources they need to be healthy.

Recommendation: Multiple state Medicaid programs are beginning to incorporate meeting SDoH needs into their Medicaid managed care programs.

1. Among the various approaches, DCH could consider an approach similar to that developed by North Carolina's Healthy Opportunities Pilots, which incorporate backbone organizations that coordinate a network of human services providers to deliver services to eligible members. This pilot is authorized through an 1115 waiver.
2. DCH should also consider leveraging managed care flexibilities such as "in lieu of" services to align the efforts across CMOs in addressing certain high priority SDoH needs facing Georgia Medicaid members.

Common SDoH barriers include housing instability, food insecurity, lack of transportation, and education and employment barriers. Interventions that are tailored to address these needs can help address existing gaps in the program. Examples include:

- Home modifications to help address asthma: Housing modifications to help purify the air or remove mold is an intervention that can help improve outcomes for children with asthma.
- Access to nutritious foods: There are a number of interventions that state Medicaid programs are deploying, including referrals to local food banks or organizations that can help members experiencing food insecurity, home delivered meals following discharge from the hospital, and nutrition classes.
- Lack of transportation: DCH and the CMOs could help improve awareness of the NEMT benefit for members.
- Education and employment: Interventions such as GED support and job training can help members become more economically self-sufficient. At least one of the current CMOs has demonstrated significant long-term outcomes with their related interventions.

Another opportunity to make a positive impact in this regard would be through improved communication and education for the provider networks regarding SDoH and Disparity. Providers, especially PCPs and BH providers, as the first line of contact with individuals, are best positioned to understand members' needs and to assist them in accessing help. This requires that providers be educated as to the importance of SDoH, the reality of racial and cultural disparity, tools for assessing needs, and available resources within the community. Once data regarding need are collected, effective HIE is needed to share pertinent information with the appropriate parties. CMOs gathering this information are well positioned to have access to a broad array of organizations to assist individuals throughout their region.

Dedicated funding for pilot programs and/or expectations for CMO community benefit investments at certain levels to address SDoH will help identify programs that are effective in assisting individuals. Pilots may address food and nutrition, housing, transportation, employment, and more. As noted above, Medicaid programs across the country are implementing various programs to address SDoH needs. A large percentage of those with housing insecurity, food insecurity, transportation and employment needs, are currently Medicaid beneficiaries or are eligible to be Medicaid beneficiaries. This means that Medicaid CMOs and providers have both the opportunity and the incentive to address these needs. To capitalize

on this opportunity, the State must support such efforts through program design and funding, understanding that stabilization of SDoH is key to improved health outcomes and reduced total cost of care.

Engaging other sectors and community-based organizations is critical to sustained efforts to address SDoH needs. As noted, Medicaid CMOs, PCPs and BH providers are well positioned to support this effort. Georgia's Community Service Boards provide a regionally based network of safety net BH providers that are well integrated to their communities and have the local presence and knowledge to support this engagement with other sectors. Other safety net programs offer this same potential.

In addition to drawing on the safety net system, communication, education and planning are essential to addressing SDoH needs. This requires planning and funding.

Recommendation:

1. The State should move to contractually incentivize CMOs and providers to improve how they address SDoH through improving communication with other entities, providing education to members, patients and partners, and to measure and report outcomes.
2. This can, and should, be included in any procurement process.

Best Practices: Arizona Rural Health Policy, Arizona Differential Adjusted Payment Program, and Vermont Rural Regional Networks

Value

The biggest challenge to improving health outcomes and managing the cost of care is consistent access to a consistent healthcare benefit across CMOs and FFS systems and across the state. There are multiple facets to the access challenge. Reimbursement rates must support the cost of providing care. This is a growing challenge as inflation is impacting all sectors of the economy. Certain sectors of the provider system have not seen rate increases in many years. Additionally, the CMOs do not always provide reimbursement that is adequate to cover cost. This is compounded when authorization cannot be obtained in a timely manner and there is no reimbursement for a service.

The Medicaid benefit, i.e., the services available and the criteria for authorization, should be consistent across the state. In practice, this is not consistent. Whether due to availability of providers, authorization processes and criteria, or varying drug formularies, the actual benefit available varies considerably from CMO to CMO and from region to region.

Recommendation: that the State address this through the procurement process, future contracts, and through future reporting requirement. Ensuring a consistent benefit also requires maintaining well trained staff at the CMO and provider levels.

1. The State must invest in efforts to develop and maintain a well-trained workforce, in particular behavioral health workforce challenges.
2. The State should consider exploring options to relax certain standards of practice and licensure requirements to leverage paraprofessionals to expand the number of qualified professionals who can serve as direct service providers, including other state-level certifications and training to assure competency.

This reduces turnover and cost as well as improving the care delivery system which shortens the cycle time to strong outcomes and reduced cost of care.

Best Practice: Vermont ACO Program and Pennsylvania Health Choices Program

Coverage and Services

In addition to the recommendations included in previous sections, the state can and should address barriers to coverage and services in both the procurement process and in the contract. Potential contractors should be required to demonstrate an adequate provider network, in terms of capacity, location and accessibility. Potential contractors should be able to demonstrate consistent authorization processes that are compliant with federal parity rules, and timely claims processing. These items, with appropriate metrics, should be included in the contract for all contractors as well.

There are myriad opportunities to better serve specific Medicaid and CHIP populations, particularly those with need for assessment and treatment of behavioral health conditions. Primarily, if Georgia chooses to continue to carve-in mental health and substance use disorder services into managed care, the state must:

1. Adopt and comport with a recovery and resiliency approach for treatment coverage which includes mirroring current FFS prior authorization episodes of care with equivalent frequency, duration, and number of units and ability to retroactively approve a prior authorization;
2. Establish consistent utilization management and prior authorization processes;
3. Require associated information systems to accept batch prior authorization requests;
4. Consistently and routinely recalibrate reimbursement rates as Georgia shifts to a risk-sharing model vs. a FFS model, recognizing that current rates are outdated and inadequate. New rates and funding mechanisms must encourage incentivizing quality and reliability of CSB Tier One BH providers and covering the cost of care.
5. Relax the requirements for prior authorization of services by only requiring PAs for high intensity services. Core, community-based, recovery-focused services should not require prior authorization or frequent re-authorization.
6. Reduce the administrative burden for prior authorization, including for providers that routinely (at least 90% of the time) meet medical necessity criteria and receive approval for services
7. Consistent with the CCBHC model, allow delegation of and reimburse for care management and care coordination integral to successful, quality integrated care;
8. Coordinate and consolidate program integrity, certification, credentialing/revalidation audits;
9. Address and hold CMOs accountable for nonpayment;
10. Require CMOs to coordinate with DCH and DBHDD and/or its agents in the treatment of individuals with SMI, SPMI, and SED to leverage and coordinate the state resources and expertise for this subpopulation;
11. Make mandatory and hold CMOs accountable at risk of penalty for ensuring Mental Health Parity and addressing SDOH indictors; and
12. Require CMOs to contribute to a community benefit which supports the service delivery system infrastructure for addressing SDOH and gaps in the continuum of care for individuals with complex, including BH needs, with value-add and in-lieu of services.

As discussed previously, care coordination is essential to improved outcomes and requires several key elements. This is particularly true for those with behavioral health needs. Persons with BH needs and co-morbid physical health needs are generally among the highest cost Medicaid beneficiaries. Coordinating care for all needs is essential to improved outcomes and to reducing the total cost of care.

Recommendation:
As the State proceeds with managed care structure redesign and procurement, it is important that the CCBHC model be incorporated into the procurement and contracting processes. CMOs that contract with Federally Qualified Health Centers are familiar with the prospective payment system and should be well equipped to contract with CCBHCs.

1. The state should consider requiring that CMOs contract with CCBHCs in each area and support the establishment of new CCBHCs or CCBHC-like entities in underserved areas.
2. The State should consider how to formalize the CCBHC structure across Georgia in collaboration with the Department of Behavioral Health and Developmental Disabilities.
3. CMOs should be charged with promoting the CCBHC model.

Contracting for the provision and oversight of crisis services and a crisis *system* must take on a unique thoughtful approach to maintain and continue to advance the exceptional crisis services and system approaches that already exist in Georgia. As such, the state should consider some of the strategies used in Arizona including:

- Contract with one health plan (or other entity like an integrated network or administrative services organization) per region to oversee and manage crisis services and the crisis system.
- Include both the Medicaid and non-Medicaid funding for *crisis services* per health plan
    - Provide a PMPM to the health plan for all Medicaid eligibles that is sufficient to fund crisis services
    - Include federal block grant dollars, state allocated dollars, and other funding
- Address what is included in the crisis benefit as the responsibility of the health plan (e.g., crisis call line that includes answering 988 call, text and chat, mobile response, crisis stabilization, and other crisis services) and delineate the CMO responsibility for post crisis care
- Outline the required technology to be used within the delivery of crisis care and for managing the performance of the crisis system
- Include requirements to foster and enhance local crisis system collaboratives that include, lived experience, 911, law enforcement, emergency medical services, protective service, and other stakeholders

Best Practice: Arizona 1115 Waiver