CMO Contract Revision Recommendations: Best Practices

Quality Management

- Allow for auto credit for those NCQA standards that are in line with contractual requirements. If a Plan passes the NCQA standard for appeals, HSAG should accept that standard. DCH could set a minimum threshold for NCQA standard such as 80% or above.
- Alignment of CPG monitoring, PIPs and Focused Performance measure targets in order to focus efforts on improving outcomes. As an example, if ADHD is a focus measure, then it should also be the guideline we are monitoring and the performance improvement project.
- Base performance targets on regional percentiles (NCQA)
- Consider expedited document turnaround time approval in certain instances. (Example: Allow expedited DCH approval for changes to existing communications and collaterals when no material edits have been made).

Compliance

General Contract

- 4.3.2.4 –Consider raising the written materials reading level to 6th grade. Based on the HLI Medicaid survey in 2007, 66% of the Medicaid population reads at this level. The survey also indicates that Georgia's Medicaid population reads is at 6th grade level. The current CMO contract requires adherence to a 5th grade reading level. CMS target readability for appeal decision letters is 6th -9th grade using one of the following: Gunning Fog Index, Fry, SMOG, Flesh-Kincaid or FOG (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf).
- 4.8.16 –Clarify that panel size limitation of 2500 is specific to individual provider capacity and does not apply to group practices (i.e. 10 providers in one group practice can each have 2500 members).
- 5.5 –Include language to specify actions a CMO can take if regulatory response time exceeds the time determined by contract. Previous contracts allowed CMOs to move forward with documents 30 days beyond the time specified for State approval in the contract
- 16.0 – specify that subcontractors are those contractors that have been assigned delegated functions to carry out the contract (i.e. credentialing, quality) and those who have actual interaction with members.
- Include an appendix in the contract that list reporting and due dates for regulatory reports (i.e. tax reports etc.)
- Add language to the provider and member sections of the contract that specifically indicate that benefits and payment changes require 30 day notification to the applicable party (provider/member).
- Review and correct incorrect contract references. As an example in the GF 360 Addendum,
- The contract references that section 4.8.14 references geo access standard where it is actually actually 4.8.13

CMO Contract Revision Recommendations: Best Practices

Provider Relations

- Allow Telemedicine to be included as an access point for behavioral and Physical health services.
- Allow greater distance requirements in certain communities where providers truly do not exist (absence of recruitment opportunity)

Operations

State reimbursement policy changes

- DCH should consider providing 30 day advance notice of any planned changes in provider reimbursement, coding updates, or reimbursement policy changes. This will allow CMOs to develop and rollout a more paralleled approach with DCH in implementing provider reimbursement, coding updates or reimbursement policy changes.

Provider communication

- For state initiated changes in provider reimbursement, coding updates, or reimbursement policy changes, reduce the required provider notification period from 30 calendar days to 15 calendar days. This will allow CMOs to be better aligned with the implementation date established by DCH for a given change or update. CMOs often have to extend implementation dates for state driven provider reimbursement or policy changes in order to allow for the full contractual 30 calendar day notification. Having the same effective date across Fee-For-Service and the CMOs will reduce provider misunderstanding.

HCMS

- Consider removing reports that have not been in effect since 2006 such as the prenatal report for members with a due date of 30 days or less
- Consider contract alignment with all existing reports to make determination if current adhoc reports will become regulatory
- DCH should consider providing assurance that all reporting requirements listed in the contract have complete reporting template(s) prior to go-live implementation.

Regulatory Services

Provider Directories

4.3.5.3 The Contractor shall submit the Provider Directory to DCH for review and prior approval as updated.

- Allow for informational filing (vs. Approval filing) where no material changes are made to a prior approved directory that is simply being updated. This will allow CMOs to more quickly complete and distribute updated provider directories to members following quarterly updates. Some State Medicaid agencies provide common guidance requiring only informational filing and review by the state for provider related collaterals.