



State of Georgia
Department of Community Health

Medicaid and PeachCare for Kids®
Design Strategy Report

EXECUTIVE SUMMARY

January 23, 2012



Executive Summary

Recognizing that this is a critical time for Georgia to carefully consider and plan for the future of its Medicaid program, including PeachCare for Kids®, Georgia’s Department of Community Health (DCH) is conducting a comprehensive assessment of these programs and has engaged Navigant to identify options for innovative redesign of these programs. The first part of this project required developing a Design Strategy Report which identifies and assesses potential redesign options that can be implemented statewide and that will meet DCH’s goals for the Georgia Medicaid and PeachCare for Kids® programs.

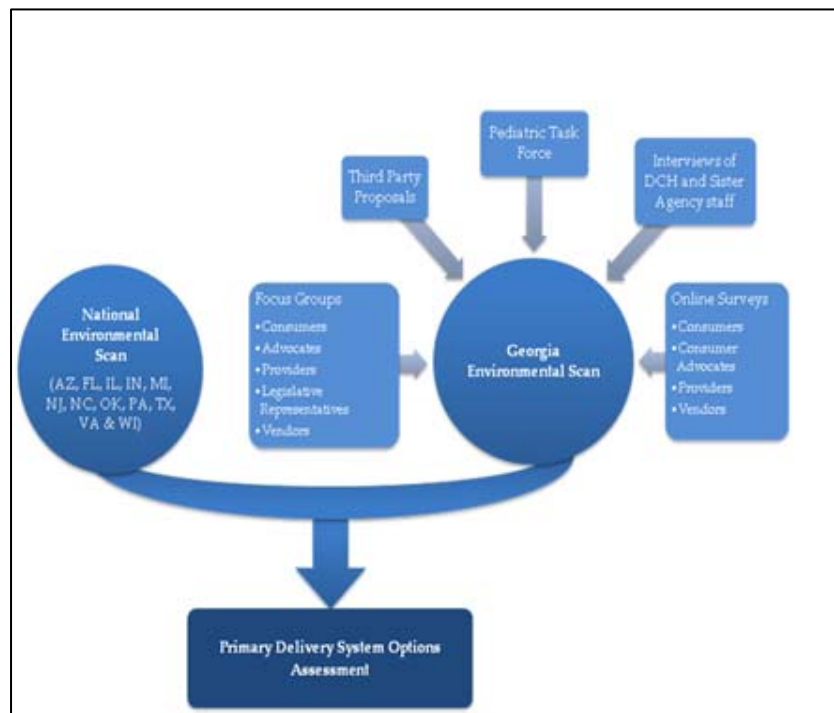
The Design Strategy report is the first in a series of steps DCH will take to select and implement a redesign. After gathering further stakeholder input and further considering the redesign options, DCH will select a future design strategy.

Study Methodology

Navigant conducted a national environmental scan that included research of innovative approaches to and best practices in service delivery within Medicaid and Children’s Health Insurance Programs nationwide, of developments at the federal level and of trends and best practices within commercial health plans. Navigant also conducted an environmental scan specific to the Georgia

Medicaid and PeachCare for Kids programs which sought extensive input from a broad range of stakeholders through the use of focus groups, surveys and interviews. The graphic provides a summary of the inputs for each scan.¹

Information from the environmental scans was used to develop a series of redesign options that were evaluated using a four-phased process. Details about this process and of the options and evaluation are provided in the Evaluation section of this report summary.



Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global expert services firm dedicated to assisting clients in creating and protecting value in the face of critical business risks and opportunities. Our Payer subpractice serves federal, state and commercial healthcare payers with strategic, organizational, tactical and implementation services that design, incent and improve the delivery, measurement and reimbursement of care in both managed care and fee-for-service environments.

¹ Our national scan reviewed all states but examined the listed states in-depth.

National Environmental Scan Findings

The current health care environment is undergoing a period of rapid change as the federal government, states, health plans and consumers deal with the implications of health care reform in an era of budget deficits, high unemployment and grim forecasts for short-term economic

National Environment

- High unemployment
- Rising health care costs
- Increased Medicaid spending
- State budget deficits
- Provider shortages
- Aging population
- Increased demand resulting from health care reform

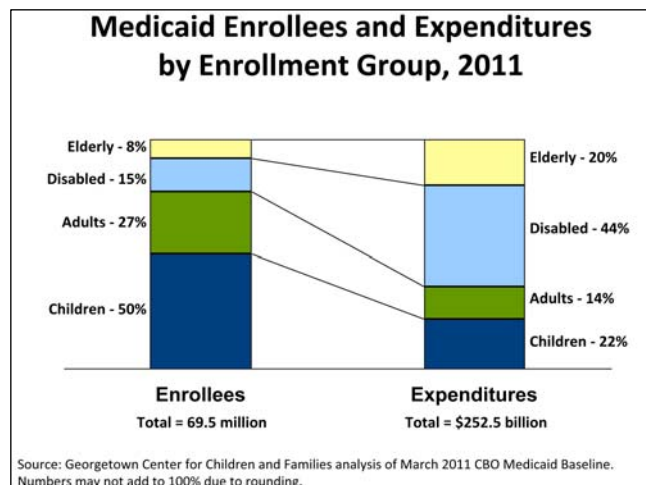
growth. In response, states and commercial payers are pursuing new, innovative program designs.

States are increasingly looking towards new and innovative ways to decrease costs, focusing on providing benefits more effectively with greater administrative efficiencies rather than focusing solely on traditional cost containment strategies. Because state and federal governments are especially interested in innovative strategies, the state and federal Medicaid environment is rapidly changing. States are continuing to focus efforts on Medicaid spending for high-cost populations.

The graphic below shows the Medicaid enrollees and expenditures by enrollee group in 2011. In this example, the elderly and disabled population accounted for 64 percent of spending but only 23 percent of the total Medicaid populations. There is tremendous opportunity for states to control costs and improve outcomes by better managing high-cost populations.

States use various delivery system models to provide services to their Medicaid and Children's Health Insurance Program (CHIP) populations. Traditionally, states have used fee-for-service (FFS), primary care case management (PCCM) or risk-based managed care models, or a combination of those models, to deliver services.

The need to be more cost-effective in the current economic climate, as well as states' goals for improving access, quality and health care outcomes, has led states to consider developing more innovative Medicaid models that incorporate coordinated care, case management and value-based purchasing. Many states are also beginning to focus on their highest risk, highest cost consumers, as traditionally these populations have remained in FFS delivery systems and often have less access to case management services than some healthier populations.



States implement many of these models through contracting with a vendor or directly with providers. Through these contracts, states can mandate that providers and contractors meet certain requirements designed to improve access to care (such as those relating to office hours, credentialing, or case management) or to meet certain quality indicators. Contracts with health plans provide a mechanism for holding contractors or providers accountable for meeting performance standards relating to network adequacy, timely access to care, quality of care consistent with clinical and utilization benchmarks and providing data sufficient to evaluate performance.² They also provide greater budget predictability

There is considerable evidence that supports the ability of risk-based managed care to contain costs. A report by the Lewin Group, which synthesized findings from 24 studies that looked at savings achieved when states have implemented Medicaid managed care, presents evidence that managed care arrangements yield savings. Nearly all studies demonstrated a savings from the managed care setting (percentage of savings varied widely from half of 1 percent to 20 percent). Savings from Medicaid managed care can be significant for traditionally high-cost enrollees. Further, evidence exists that risk-based managed care may improve access and quality of care when appropriately administered.³

Georgia-specific Scan Findings

Although Georgia has achieved much, the State, like most states around the nation, must continually explore opportunities to improve access to and quality of care while also containing costs due to ongoing budget deficits – all while anticipating the potential impacts of federal health care reform.

The Georgia Medicaid program has made significant strides over the last decade. It has:

- Successfully implemented and operated a risk-based managed care program, Georgia Families, for five years
- Developed its quality measurement infrastructure and is working to evolve its quality measurement and performance improvement processes
- Enhanced oversight and monitoring of the care management organizations' (CMOs') performance
- Planned for an eligibility system update which will address many of the current provider and member frustrations related to eligibility determination, program enrollment and service authorizations

² Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: A Summary From a 50 State Survey. September 2011.

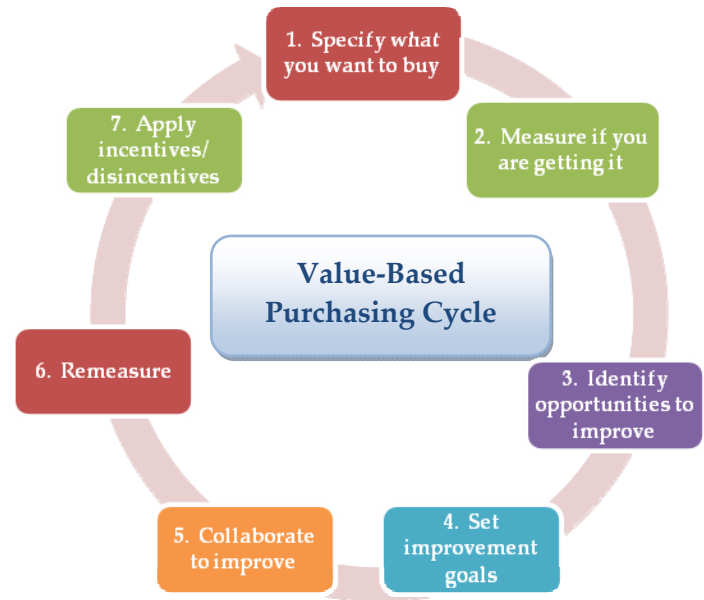
³ The Lewin Group, Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies, 2009. Available online: <http://leg.mt.gov/content/Committees/Interim/2011-2012/Children-Family/Topics/Medicaid%20Monitoring/lewin-synthesis-of-managed-care-studies.pdf>.

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- Progressed in its monitoring of vendors and sister agencies to make improvements in the administration of its home- and community-based services (HCBS) waiver programs

As a purchaser, DCH has progressed by building the infrastructure for quality management and contract monitoring. In other words, it has been establishing the building blocks to become a more sophisticated purchaser. Often, Medicaid agencies evolve in this way. In the early evolutionary phases of managed care program implementation, agencies focus on building infrastructure, bringing up new programs and the like. For example, as most states do when they build a Medicaid managed care program for the first time, Georgia used a somewhat prescriptive approach to health plan contracting and monitoring, focusing primarily on how the CMOs are permitted to operate and not on member outcomes.

DCH is now primed to transition to the next evolutionary phase: becoming a **value-based purchaser**. Under a value-based purchasing model, the purchaser (i.e., DCH) stipulates what value the contractor would deliver in return for the purchaser's payment, and when used in procurement processes establishes a firm foundation for contract monitoring.



Collection, analysis and comparison of data about CMO performance supports value-based purchasing. Georgia has taken an initial step in implementation of value-based purchasing in Georgia Families by basing auto-assignment of members on the CMOs based on CMOs' performance on selected quality measures. For Georgia to progress to the next stage of evolution, it will need to employ more rigor around contract monitoring, oversight and accountability to achieve successful outcomes and assure value. Monitoring contracts under a value-based purchasing model shifts the focus from monitoring structures and processes to monitoring outcomes – or measuring the value of the services that Georgia has purchased.

DCH is now ready to “take stock” and consider options for redesign. There are opportunities to improve quality of care for members, contain costs, and make budgets more predictable. When designing the new Medicaid programs and services, there are opportunities for Georgia to address some of the current provider and member frustrations. These include:

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- Increasing communication among all stakeholders
- Reducing administrative complexities and burdens for providers and members
- Standardizing, centralizing or streamlining appropriate processes and forms across the CMOs
- Increasing patient compliance through incentives and disincentives
- Increasing focus on health and wellness programs and preventive medicine

Other opportunities for improvement include:

- Tracking progress over time in achieving quality of care improvements using the (Healthcare Effectiveness Data and Information Set) HEDIS® and HEDIS®-like measures, now that the infrastructure for doing so has been established
- Considering an approach to manage care for Georgia's most expensive Medicaid members: those who are dually eligible and those who are aged, blind and disabled
- Considering short- and long-term plans for the use of technology including electronic health records and telemedicine

Factors outside the control of DCH, including health care reform, will also shape the future of Medicaid and PeachCare for Kids. For example, Georgia potentially faces major growth in Medicaid enrollment. These factors may create significant change in the Georgia health care marketplace and in Georgia Medicaid.

The physician shortage must also be considered in any redesign effort. This includes both how the redesign itself can help to assure access for members despite the shortage and how the redesign might help to reduce physician workloads and incent physicians to participate in Medicaid and PeachCare for Kids.

Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids

Georgia faces critical decisions regarding the shape of its planned Medicaid and PeachCare for Kids design strategy. These decisions cannot be made in a vacuum: decisions must account for a variety of factors (such as Georgia's health care market, DCH's experience and the resources it can bring to bear, the experiences of other states in implementing new delivery systems, etc.). Likewise, the decision must be based upon the relative likelihood that the redesign will enable Georgia to achieve its goals. Thus, a design strategy that is preferred by another state might not be the design strategy that is best suited for Georgia.

Also, this Design Strategy Report is part of an extensive public process to evaluate options and select a Medicaid redesign approach. Such a public process requires that the assessment of redesign options be conducted using an explicit approach, where redesign options are clearly described and evaluated and where the basis for the assessment's conclusions are detailed and clear to the reader. Thus, for our evaluation, Navigant has used a modified version of the Kepner-Tregoe tool that is helpful in strategic decision-making.⁴ It assists with unbiased decision-making by ranking all critical decision factors. As such, it limits conscious and unconscious biases that tend to result in decisions that may be out of line with established goals. The success of any assessment based on the Kepner-Tregoe methodology depends, however, upon the identification of the organization's goals.

The goals for the future design strategy serve as the foundation for developing recommended redesign options: each delivery system option is evaluated based on the likelihood with which it would enable Georgia to achieve the goals. In addition to goals, DCH identified strategic requirements that must be employed for achieving the identified goals. DCH vetted its proposed goals and strategic requirements internally and with the DCH Board and with Governor Nathan Deal, followed by a public input process through posting of the goals and strategic requirements on the DCH website and discussion at key provider and stakeholder forums. As presented in Tables 1 and 2, DCH assigned each goal and strategic requirement a relative weight, depending on its relative importance and priority, as determined by DCH. DCH weighted the goals and strategic requirements separately.

Assigning weights is a critical component of our evaluation. Higher priority goals and strategic requirements carry more weight in the overall rating of an option. Re-weighting of the goals and strategic requirements may result in a different set of scores for each option and thus, the selection of different options.

Table 1: DCH Program Goals for the Future Design Strategy

Goal	Weight	Rationale
1. Enhance appropriate use of services by members	33%	Appropriate use of services will decrease inappropriate utilization, improve outcomes and decrease costs.
2. Achieve long-term sustainable savings in services	33%	Medicaid is one of the most expensive public programs in Georgia. Given limited budgets in a challenging economy, the State must have a Design Solution that is cost-efficient and has budget predictability.
3. Improve health care outcomes for members	34%	Improving health care outcomes for members is part of DCH's mission for the Medicaid program. Healthier individuals will have more productive lives and may lead to decreased program costs.

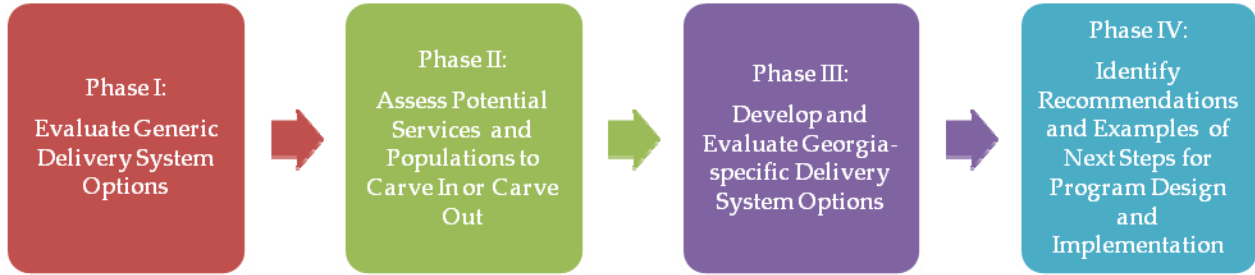
⁴ Kepner-Tregoe Matrix, Decision-making Method Framework Tool. Available at http://www.valuebasedmanagement.net/methods_kepner-tregoe_matrix.html; Kepner-Tregoe Matrix. Available at http://www.12manage.com/methods_kepner-tregoe_matrix.html.

Table 2: DCH Strategic Requirements for the Future Design Strategy

Strategic Requirement	Weight	Rationale
1. Gain administrative efficiencies to become a more attractive payer for providers	20%	Developing a program that decreases administrative burden for providers may help to attract more provider participation and increase access.
2. Ensure timely and appropriate access to care for members within a reasonable geographic area	20%	Access to care for members will help to improve health outcomes.
3. Ensure operational feasibility from a fiscal and administrative oversight perspective	20%	Given limited budgets in a challenging economy, the State must have a design strategy that is cost-efficient and has budget predictability. Additionally, the design strategy must be one for which DCH can appropriately operate and provide a sufficient level of oversight.
4. Align reimbursement with patient outcomes and quality versus volume of services	18%	Given limited budgets in a challenging economy, the State must have a design strategy that incorporates payment reform so as to be cost-efficient and have budget predictability while also improving outcomes and quality.
5. Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%	Implementing a design strategy that incorporates member responsibility may help to decrease inappropriate utilization, improve outcomes and decrease costs.
6. Develop a scalable solution to accommodate potential changes in member populations, as well as potential changes in legislative and regulatory policies	4%	Given potential implementation of the Affordable Care Act (ACA) and the significant number of new lives Georgia would cover due to Medicaid expansion, the design strategy must be able to accommodate new membership.

The assessment of redesign options is complex and must account for many factors, and it must include a wide range of redesign options. As with any Medicaid program, many potential changes could be considered, some of which would have a far-reaching effect, and some of which would be smaller in scale. The options considered in our assessment are focused on the macro level; they do not address every aspect of the Medicaid program. Furthermore, this report is deliberately focused on analysis of delivery system options that have a reasonable likelihood of effecting change given Georgia’s and the nation’s current economic and political environments. Because the scope of the assessment is so broad, Navigant has employed the multi-phased assessment outlined below to evaluate redesign options.

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In Phase I, Navigant identified and evaluated a variety of generic delivery system options that span the spectrum of options, as illustrated in Table 3. We assessed the relative likelihood that each option would enable DCH to achieve its identified goals and strategic requirements for the new design strategy. Scoring is based on our perspective and understanding of each generic delivery system. Each option must be a statewide solution that provides member choice and that DCH can begin to implement in 2014. This assessment is strictly limited to the generic delivery system options assuming they are effectively implemented and operated, and these options are defined at the macro level without consideration of some of the more intricate features of program design.

Table 4 presents an assessment of generic delivery system options using a modified Kepner-Tregoe decision-making method. For ease of use, the assessment relies upon a stoplight model, whereby each option is rated based on the likelihood that it will enable DCH to achieve each of its goals and strategic requirements defined using the following color-coded format:




Key	
	High likelihood that the Option will meet Goals or Strategies (raw score 7-9)
	Moderate likelihood that the Option will meet Goals or Strategies (raw score 4-6)
	Low likelihood that the Option will meet Goals or Strategies (raw score 1-3)

Table 3: Summary of Delivery System Options⁵

Design Solution Option	Description
Option 1: Current Delivery Systems: FFS and Georgia Families	<ul style="list-style-type: none"> Maintains the “status quo”: current FFS delivery system for currently-enrolled populations and current mandatory risk-based managed care program, Georgia Families, for currently-enrolled populations For Georgia Families, benefit package remains the same (i.e., transportation is carved out and all other services are carved in)
Option 2: Traditional FFS Delivery System	<ul style="list-style-type: none"> All populations are served in a traditional FFS delivery system, which provides little or no care management Members are not served under a PCCM or similar model. (Such models are considered separately below.)
Option 3: Patient-Centered Medical Home Model (PCMH)	<ul style="list-style-type: none"> Provider groups must be certified and enrolled in Medicaid as PCMHs based on recognition by an accrediting entity such as the National Committee for Quality Assurance (NCQA)⁶ and/or meeting other standards as defined by DCH⁷ Members may choose a PCMH in which to enroll to serve as their medical homes and would be assigned if they don’t select one Providers are paid on a FFS basis with some shared savings requirements PCMHs would provide primary care that is patient-centered and focused on evidence-based medicine, wellness and prevention, care management and care integration so that the “whole person” is managed PCMHs must use information technology to assist in managing care and access (e.g. electronic health records) There is no prime vendor; therefore, State contracts with and pays PCMHs and other providers directly
Option 4: Enhanced Primary Care Case Management (EPCCM) Model	<ul style="list-style-type: none"> All populations are served in an EPCCM model, whereby providers are paid on a FFS basis One contracted vendor statewide administers program Provides case and disease management for members who meet criteria established in the vendor agreement (e.g., diabetes, asthma) Vendor is responsible for member and PCP education and outreach and developing and maintaining a PCP network and specialist referral listing PCPs enroll with Medicaid agency as a Medicaid provider and sign a PCP agreement with the State State pays providers directly Vendor agreement sets forth savings for which the vendor guarantees a portion of the covered population will achieve via more appropriate use of services; if guaranteed savings are not met, vendor pays a penalty to the State Members may choose a PCP in which to enroll to serve as their medical homes and would be assigned if they don’t select one

⁵ Navigant’s detailed report also provides advantages and disadvantages of each generic delivery system option.

⁶ NCQA, Patient-centered Medical Home. <http://www.ncqa.org/tabid/631/Default.aspx>

⁷ DCH may could establish standards that require PCMHs to provide or coordinate a broader range of services than those typically coordinated by PCMHs as defined by NCQA.

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Design Solution Option	Description
<p>Option 5: Accountable Care Organization (ACO) Model</p>	<ul style="list-style-type: none"> • Each participating ACO would develop a network of doctors and hospitals to share responsibility for patient care • An ACO could be a hospital with employed physicians, a health system consisting of several hospitals and employed physicians, physician joint ventures, or multi-provider networks • ACOs would provide primary care, care management and care coordination • DCH would pay ACOs on a capitated basis • Depending upon Georgia insurance laws regarding ACOs, which are yet to be developed, ACOs might need to obtain a license to operate as an insurer
<p>Option 6: Georgia Families Plus</p>	<p>Expands upon the current Georgia Families program by:</p> <ul style="list-style-type: none"> • Incorporating extensive value-based purchasing • Further encouraging use of medical homes, for example, through PCMHs • Reducing administrative complexities and burdens for providers and members • Increasing patient compliance through incentives and disincentives beyond those currently used in Georgia Families • Increasing focus on health and wellness programs and preventive medicine • Continuing to build upon current efforts to focus on quality • Carving in more services (e.g., transportation) and populations (e.g., dual eligibles)
<p>Option 7: Health Savings Accounts (HSAs) with a High Deductible Plan</p>	<ul style="list-style-type: none"> • Contract with health plans to provide Medicaid benefit packages that include a high deductible plan, HSAs and Healthy Rewards Accounts (HRAs) • Some individuals would be subject to deductibles and copayments • On behalf of each member, DCH would: pay health insurance premium for the high deductible plan; deposit funds in an HSA to cover deductibles and copayments; and deposit rewards (e.g., incentive payments) in HRAs of members who meet goals for healthy behaviors • Members could use HRAs funds to purchase certain health care related services or items; remaining balances in HRAs and HSAs could be used in a shared savings model whereby members, upon leaving Medicaid or reaching end of benefit year, have option to spend a portion of remaining funds on pre-approved items such as health club memberships
<p>Option 8: “Commercial Style” Managed Care Program</p>	<ul style="list-style-type: none"> • Expands upon Option 6, Georgia Families Plus program, a full risk-based managed care program with value-based purchasing • Employs all levers and innovations typically used in commercial market, including incentives and, for some members, deductibles and copayments, to encourage members to be active participants in their health care and to comply with treatment plans • Establishes HRAs for members where rewards (e.g., incentive payments) are deposited for members who meet goals for healthy behaviors to purchase preapproved health care-related services or items • Balances in HRAs could be used in a shared savings model whereby members, upon leaving Medicaid or reaching the end of the benefit year, have the option to spend a portion of remaining funds on pre-approved items such as health club memberships
<p>Option 9: Free Market Health Insurance Purchasing</p>	<ul style="list-style-type: none"> • DCH would provide a credit to members for purchase of insurance through the free market • DCH would not contract directly with health plans and would not process claims • DCH would partner with the Department of Insurance to define the standard Medicaid benefit packages participating health plans must offer and certification requirements specific to Medicaid (e.g., covered benefits, provider network composition and reporting) • DCH would contract with or serve as a choice counselor, helping members to select a health plan

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Table 4: Phase I Assessment of Generic Delivery System Options for the Medicaid and PeachCare for Kids® Design Strategy⁸

Likelihood that the Option will...	Wt.	Option 1: Current Delivery System	Option 2: FFS	Option 3: PCMH	Option 4: EPCCM	Option 5: ACO Model	Option 6: Georgia Families Plus	Option 7: HSA with High Deductible Plan	Option 8: "Commercial Style" Managed Care	Option 9: Free Market Purchasing
Goals										
Enhance appropriate use of services by members	33%	●	●	●	●	●	●	●	●	●
Achieve long-term sustainable savings in services for members	33%	●	●	●	●	●	●	●	●	●
Improve health care outcomes for members	34%	●	●	●	●	●	●	●	●	●
Strategies for Medicaid and PeachCare for Kids® Redesign										
Gain administrative efficiencies to become a more attractive payer for providers	20%	●	●	●	●	●	●	●	●	●
Ensure timely and appropriate access to care for members within a reasonable geographic area	20%	●	●	●	●	●	●	●	●	●
Ensure operational feasibility from a fiscal oversight and administrative perspective	20%	●	●	●	●	●	●	●	●	●
Align reimbursement with patient outcomes and quality versus volume of services delivered	18%	●	●	●	●	●	●	●	●	●
Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%	●	●	●	●	●	●	●	●	●
Develop a scalable solution to accommodate potential changes in member populations as well as potential changes in legislative and regulatory policies	4%	●	●	●	●	●	●	●	●	●
Weighted Average Score		3.8	2.0	4.8	4.7	4.8	7.2	4.6	8.2	6.0

⁸ As DCH refines the design strategy through ongoing planning, it may wish to revisit the individual scores. This initial scoring of options is a tool to help inform DCH's decision-making and provides a framework for conducting a rational decision-making process.

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Based on our assessment, the generic delivery system options that received the highest weighted evaluation scores and are most likely to enable DCH to achieve its goals and strategic requirements are: *Option 6: Georgia Families Plus; Option 8: “Commercial Style” Managed Care; and Option 9: Free Market Health Insurance Purchasing.*

In Phase II of our analysis, we evaluated the populations and services identified in Table 5 and which DCH should consider including in its selected delivery system. States have employed a wide variety of approaches to handle special populations and services in Medicaid managed care and other Medicaid care management systems. Recent developments seem to indicate a national trend toward including historically carved out populations and services in Medicaid managed care. This trend might be explained by increasing budgetary pressures and by states’ collective wealth of experience designing and operating Medicaid managed care programs. For example, in a recent Kaiser study, 27 states reported plans to implement Medicaid managed care programs “to a greater extent.”⁹ Based on our findings compared to the goals and strategies that DCH identified for its design strategy, Navigant recommends that DCH consider carving in to the selected delivery system all populations and services identified in Table 5.¹⁰ The best opportunity for improving quality of care for members is by caring for the whole person.

Table 5. Special Populations and Services

Populations	Services
<ul style="list-style-type: none">• People using behavioral health services• People using LTC services• People using home- and community-based waiver services• People who are dually eligible for Medicaid and Medicare• Children who are in foster care	<ul style="list-style-type: none">• Behavioral health services• LTC services• Home- and community-based waiver services• Dental services• Transportation services• Pharmacy services

In Phase III, we use the results of Phase I to identify delivery system options best suited to Georgia. Then, we develop permutations of those delivery system options tailored to Georgia, i.e., Georgia-specific delivery system options. These Georgia-specific options present a variety of combinations of the generic delivery systems determined in Phase I as having the greatest likelihood of enabling DCH to meet its goals and strategic requirements. They reflect not only our consideration of combinations specific to meeting needs of particular populations, but also our consideration of the need for a model that can be implemented statewide, provides

⁹ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

¹⁰ Overarching themes that impact our recommendation to carve in all of the identified populations and services to the delivery system selected along with additional opportunities specific to each population and service are provided in Navigant’s final report. Also, potential cost savings are also provided.

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solutions for all populations and is administratively simple for providers who participate in the program and for DCH to manage.

- Option 1: Georgia Families Plus
- Option 2: Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program
- Option 3: Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program that Requires Use of ACOs and PCMHs
- Option 4: Georgia Families Plus and Free Market Health Insurance Purchasing

These options assume that the delivery system can be implemented statewide, the delivery system can apply to all populations and that DCH can use a phased approach to including some populations. Additionally, each of these options provides budget predictability based on the payment structures recommended.

Table 6 provides a high-level overview of key design features and potential risks for each of the delivery system options. It is not an exhaustive listing, since the delivery systems we are evaluating are defined at a high-level. Also, these discussions do not address how some special populations (e.g., Medicaid spend-down members, prisoners, people receiving emergency assistance for aliens) might or might not be included in or excluded in the delivery system. DCH should consider the options available for these individuals during the planning process.

As in Phase I, we once again evaluate the options using a modified version of the Kepner-Tregoe decision-making method, and the scoring of each option is based upon the relative likelihood that the option will enable Georgia to achieve its goals. Table 7 presents an assessment of the Georgia-specific delivery system options. Scoring is based on our perspective and understanding of each option and how it will apply to Georgia. As DCH refines the design strategy through ongoing planning, it may wish to revisit the individual scores. This initial scoring of options is a tool to help inform DCH’s decision-making and provides a framework for conducting a rational decision-making process.

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Table 6: Design Features of Models within Georgia-specific Delivery Systems¹¹

	Georgia Families Plus (Pertains to Options 1, 2, 3 and 4)	“Commercial Style” Managed Care (Pertains to Options 2 and 3)	Free Market (Pertains to Option 4)
Enrollment	<ul style="list-style-type: none"> All populations, including: <ul style="list-style-type: none"> Georgia Families enrollees Children in foster care Dual eligibles Individuals who are aged, blind and disabled 	<ul style="list-style-type: none"> Low-income Medically Needy adults Potential Medicaid expansion population <p>Note: DCH could consider phasing other populations into “commercial style” managed care at a later date, if desired.</p>	<ul style="list-style-type: none"> Low-income Medically Needy adults Potential Medicaid expansion population
Services	<ul style="list-style-type: none"> All State Plan services, including behavioral health, transportation, dental, LTC and HCBS waiver services 	<ul style="list-style-type: none"> State Plan services, including behavioral health, dental and non-emergency medical transportation, care management services Excludes LTC and HCBS waiver services 	<ul style="list-style-type: none"> Benchmark benefit packages¹² that include all the full scope of Medicaid services, including EPSDT services
Program enhancements	<ul style="list-style-type: none"> Value-based purchasing Encouraged use of medical homes Reduced administrative complexities and burdens for providers and members Use of incentives and disincentives to improve patient compliance Increased focus on health and wellness programs and preventive medicine Continued efforts to build upon current focus on quality 	<ul style="list-style-type: none"> All enhancements listed for Georgia Families Plus Use of copayments, deductibles, HRAs, incentive payments and prizes and a myriad of other creative strategies to encourage healthy behaviors <p>Note: For Option 3, health plans would be required to contract with PCMHs and ACOs.</p>	<ul style="list-style-type: none"> Most members would be subject to copayments Insurers would offer Medicaid benchmark benefit packages and HRAs to every member; funds from that account would not transfer if the member changed plans DCH would provide choice counselors to aid members in selecting a health insurer DCH would not contract directly with health plans Medicaid would no longer pay claims or operate a FFS program or other infrastructure for members who participate in this free market programs Gives members increased choice of health plans which may increase their access to providers and would give members the responsibility for managing their own care DCH would limit participation to less than six health plans, and interested insurers would seek certification from the State. DCH could also elect to be open to any willing qualified insurer.
Payment	<ul style="list-style-type: none"> Full-risk based managed care 	<ul style="list-style-type: none"> Payment structure listed for Georgia 	Members provided a credit with which to purchase a

¹¹ To avoid duplication, we have consolidated information in Table 6. For example, Georgia Families Plus is a component of each delivery system option.

¹² As allowed by the Deficit Reduction Act of 2005.

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	Georgia Families Plus (Pertains to Options 1, 2, 3 and 4)	“Commercial Style” Managed Care (Pertains to Options 2 and 3)	Free Market (Pertains to Option 4)
Structures	<p>program using risk-adjustment</p> <ul style="list-style-type: none"> Value-based purchasing 	<p>Families Plus</p> <ul style="list-style-type: none"> HRAs for enrollees to use in purchasing certain health care-related services or items 	<p>standard Medicaid benefit insurance product from a certified insurer</p>
Program Implementation	<ul style="list-style-type: none"> Initially enroll current Georgia Families enrollees Use phased approach for implementation of additional populations and services 	<ul style="list-style-type: none"> Implement Georgia Families Plus first Use phased approach to roll Georgia Families Plus enrollees into the “commercial style” managed care program 	<ul style="list-style-type: none"> Implement Georgia Families Plus first Implement Free Market model after receiving federal approval
Examples of Risks and Potential Challenges	<ul style="list-style-type: none"> Significant discontent among some providers with Georgia Families will require DCH to be diligent in educating stakeholders about the significant differences between Georgia Families Plus and Georgia Families. Enrollment of the additional populations would require submission of a waiver application to CMS for approval, which could delay timelines. 	<ul style="list-style-type: none"> Risks and challenges listed for Georgia Families Plus Additional hurdles in gaining CMS approval, depending on the types of tools DCH decides to include. While some of the tools can be used in a limited fashion in traditional Medicaid managed care programs, the vast majority– most notably copayments and deductibles – are not permitted in Medicaid for certain populations and services without seeking federal waiver authority.^{13,14} Specific to Option 3, DCH can include requirements for use of ACOs and PCMHs in CMO contracts; however, contract requirement will not assure that CMOs will be successful in enrolling them. 	<ul style="list-style-type: none"> Additional hurdles in gaining CMS approval, as it is a model that does not exist and places significant responsibility with the member which may not be appropriate for all Medicaid members. DCH would have little to no oversight of health plans, which may create concerns with whether members have access to care and care management, whether members use services appropriately and are encouraged to do so and whether health plans’ provider network composition is sufficient to meet Medicaid members’ needs. The Supreme Court’s ruling on constitutionality of the Affordable Care Act and any decisions required on Georgia’s part based on that ruling may impact implementation timeline Approach to operationalizing this model is most simple in a Health Insurance Exchange infrastructure and will be more administratively burdensome if there is no Exchange

¹³ The Deficit Reduction Act of 2005 allows states to implement cost-sharing requirements for Medicaid members without waiver approval, but exempts some populations. States may impose cost-sharing requirements on members who are above 100 percent federal poverty level (FPL), but the requirement may not exceed five percent of their income.

¹⁴ U.S. Department of Health and Human Services. Medicaid Cost-Savings Opportunities. February 3, 2011. Available online: <http://www.hhs.gov/news/press/2011pres/02/20110203tech.html>.

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Table 7: Assessment of Delivery System Permutations for the Medicaid and PeachCare for Kids® Design Strategy¹⁵

Likelihood that the Option will...	Wt.	Option 1: Georgia Families Plus	Option 2: Georgia Families Plus Transitioning to "Commercial Style" Managed Care	Option 3: Georgia Families Plus Transitioning to "Commercial Style" Managed Care Req. PCMH and ACO	Option 4: Georgia Families Plus and Free Market Purchasing
Goals:					
Enhance appropriate use of services by members	33%				
Achieve long-term sustainable savings in services for members	33%				
Improve health care outcomes for members	34%				
Strategies for Medicaid and PeachCare for Kids® Redesign					
Gain administrative efficiencies to become a more attractive payer for providers	20%				
Ensure timely and appropriate access to care for members within a reasonable geographic areas	20%				
Ensure operational feasibility from a fiscal oversight and administrative perspective	20%				
Align reimbursement with patient outcomes and quality versus volume of services delivered	18%				
Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%				
Develop a scalable solution to accommodate potential changes in member populations as well as potential changes in legislative and regulatory policies	4%				
Weighted Average Score					

¹⁵ As DCH refines the design strategy through ongoing planning, it may wish to revisit the individual scores. This initial scoring of options is a tool to help inform DCH's decision-making and provides a framework for conducting a rational decision-making process.

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In Phase IV, we present our recommendations for the delivery system for the future design strategy of the Medicaid and PeachCare for Kids programs, as well as recommended next steps in the planning process for the overall program redesign. Based on our assessment, we recommend DCH consider implementation of one of the following three delivery systems:



As shown in the graphic, each of these delivery systems builds upon the prior one. They each incorporate a managed care model, and while some challenges have been identified with Georgia Families, overall it is working for a large number of members. However, care is currently managed for the majority of Medicaid members but not those members who have the highest risks and use the costliest care. As with most newly implemented delivery systems, Georgia Families has been focused on development of infrastructure and operations. DCH has over the past couple of years begun to move to a program that is based on quality and outcomes, and has built an infrastructure for operating a risk-based managed care program. DCH is implementing contract changes and monitoring and performance improvement initiatives to address areas identified for improvement. Making significant changes to Georgia Families to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to care for the “whole person” through one well-managed delivery system.

Georgia Families Plus expands upon the current Georgia Families by incorporating value-based purchasing, further encouraging implementation of medical homes, reducing administrative complexities and burdens for providers and members, increasing patient compliance through incentives and disincentives, increasing focus on health and wellness programs and preventive medicine and continuing to build upon current efforts to focus on quality.

The “commercial style” managed care program is also a full risk-based managed care program with value-based purchasing. However, it includes all levers used by commercial health plans to encourage patient compliance and participation in their health care and to encourage providers to participate in initiatives to promote quality and improved health outcomes. For example, it would include incentives, such as HRAs and penalties, such as cost-sharing, to encourage appropriate member behavior and participation in their health care. Members

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would receive HRAs for use in purchasing certain health care related services or items not covered by Medicaid or for copayments. Requiring inclusion of ACOs and PCMHs in provider networks may help to move the Medicaid program to a more patient-centered program that involves teams of providers sharing responsibility for care of the whole person.

The recommended delivery systems can help DCH to further evolve its managed care delivery system. To realize these opportunities, DCH must allow for significant thought and time for program planning and implementation. The exact questions DCH must consider will depend upon the selected delivery system, but below is a sampling of important questions to consider:

- What delivery system levers will DCH include in the design?
- How prescriptive will DCH be with regard to care management, disease management and medication therapy management?
- What types of vendors will DCH contract to help administer the delivery system and what payment strategies will DCH employ?
- When carving in each special population, how will the needs of these populations differ from populations traditionally covered in Medicaid managed care programs?

DCH should discuss and plan for internal operational changes to address programmatic concerns identified by stakeholders and improve administrative efficiencies and contractor oversight. Since the beginning of the redesign effort, DCH has been committed to gaining stakeholder input, and we encourage DCH to continue involving the community throughout the planning process. DCH should also spend significant time considering implementation needs, for example:

- What federal approvals are required for the program, and how do the required approvals impact the implementation timeline?
- Will DCH use a phased approach to implementation? If so, on what basis will it phase in – by population, by geographic location, by program requirement, other?
- What information systems and other operational changes are necessary?

Navigant's report is the first in a series of steps DCH is taking to fully develop a new design strategy. While risk-based managed care with all services and populations offers potential for Georgia to achieve its Medicaid redesign goals, achieving these goals by implementing a comprehensive managed care model is not a given. The decision to implement such a comprehensive program should not be taken lightly: the intricate decisions made during the program design and planning process will influence the degree to which the program is able to achieve its potential.