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David A. Cook
Georgia Department of Community Health
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Dear Commissioner Cook:

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, AARP's mission is to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. Thus, we are writing to express our views regarding the Medicaid and PeachCare for Kids Design and Strategy Report issued January 17, 2012 by Navigant.

AARP, representing almost one million older Americans residing in Georgia, believes the Navigant report highlights significant challenges that must be addressed in any redesign of the Medicaid and PeachCare for Kids programs. These challenges make the aggressive schedule for implementation a serious concern for AARP. In any redesign effort, it is important that the transition to a new program take into account the treatment of the frailest and most vulnerable population served. This means ensuring the network of services and providers is tested, ready, and able to care for the aged, blind and disabled in the new program.

As the Navigant report notes, many states are expanding managed care to "carve-in" long-term care. This is an important issue to AARP and its members. While recognizing that better coordination of care in both acute and long-term settings would help individuals live fuller lives, there is the potential for limits on choice and access to care. In addition, while quality measures exist and are measured for acute care; there is not a consensus around quality measures for long-term care. This presents a challenge throughout the managed care process, from establishing the contract criteria for long-term care plans to assessing and improving quality.

Much of the current national expansion of managed care may be traced to the importance given to "savings" identified by states in managed care models. The Navigant report places an emphasis on these perceived savings in evaluating its models for redesign. This emphasis can lead to a failure in providing care. If the plan is appropriately designed to focus on care and quality, there is a potential for savings in the future as individuals get better care and avoid medical errors and inefficiencies.

Still the track record for such savings is not as clear as the report suggests. A 2005 AARP Public Policy Institute Issue Brief examined a study of the operating Medicaid Managed Long-Term Care programs in Arizona, Florida, Minnesota, Massachusetts, New York, and Wisconsin, as well as PACE programs in 18 states. The report found reduced use of higher cost services and increased access to home and community based long-term services and supports, but found mixed and inconclusive evidence on overall reductions in costs.[1] An October, 2011 Kaiser Family Foundation Issue Brief on Medicaid Managed Long-Term Service and Support (LTSS) programs indicated that they reduce the use of institutional services and increase the use of home and community based services, but found that there is little definitive evidence about whether the model saves money or how it affects outcomes for consumers.[2]

These fundamental concerns about the report's findings reflect AARP's opposition to the aggressive effort to redesign the system without taking into account its impact on aged, blind and disabled populations. The following comments lay out at a very high level the key concerns that must be addressed in any redesign of the Medicaid program.

Enrollment

The enrollment process is extremely important, especially during the transition to Medicaid Managed Care (MMC) from traditional fee-for-service. The enrollee needs to understand how the change will impact them and how to choose a plan. Below is a list of some of the key elements:

1. Education about System Changes: As you move to MMC, consumers need to understand the system changes. All materials should be understandable to all enrollees and readily available to enrollees who need these materials in alternate formats. This includes materials developed for web sites and those that will be delivered electronically.

2. Choice Counseling: There must be a process for individuals to receive individualized counseling about the options they have in choosing a plan. During a counseling session, a counselor can ensure that an enrollee not only makes an educated and informed choice about a plan, but also that the enrollee understands the implications of the choice and the change to MMC. People need continuity of providers especially when they have providers they trust.

3. Initial Screening and Assessment: A number of states have implemented a short health assessment during the enrollment process. The goal is to identify enrollees who may have specific health needs that must be addressed in both the short and longer term. Pennsylvania has its enrollment broker ask specific health status questions, as does Texas and Maryland. New Jersey sends the last 2 years of an enrollee's fee for service claims to the new MMC plan. All of these are good efforts to make sure that enrollees' needs are known to new health plans and providers.

[1] "Medicaid Managed Long-Term Care", AARP Public Policy Issue Brief, Paul Saucier and Wendy Fox-Grage, November 2005. http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf

[2] "Examining Medicaid managed Long-Term Service and Support Programs: Key Issues to Consider", Kaiser Family Foundation Issue Paper, Laura Summer, Georgetown University Health policy Institute, October 2011. http://www.kff.org/medicaid/upload/8243.pdf

4. Specific Provider Transition Issues: Unfortunately not all providers serving individuals with disabilities will be included in the various MMC plans. Hopefully, almost all of these providers will be in some plan accessible to enrollees who have been receiving services from them. There should be an opportunity for an MMC plan to pay for "out-of-network" services until other provider arrangements can be made, so that continuity of care can be maintained, or allow all services authorized under fee-for-service, before the transition to MMC, be continued regardless of who provided the services before the transition.

Provider Network Adequacy/Access to Needed Services

Network adequacy and access to services are vital components that need to reason a great deal of attention during the pre-implementation planning process and required of MMC plans before they are allowed to begin enrollment.

1. Experienced, Trained Providers with Convenient Physically Accessible Locations: Plans must be assessed based on their provider capacity to deliver services for these populations. They should have the needed experience and training in working with the different health needs of these populations. Plans must demonstrate, in a pre-implementation readiness review, that there are sufficient numbers of experienced, trained providers and they have sufficient, conveniently-located physically accessible offices. Many states utilize a time and distance measure to ensure that enrollees can physically access services within a certain time/distance traveled.

2. Direct Access to Specialists: While this issue also needs to be addressed in plan benefits, it is important that enrollees are able to go directly to a specialist to receive services where there has already been an established need and satisfactory services have been delivered. Some enrollees with disabilities may receive a large majority of their existing services from a specialty provider and that should not change with MMC. There could be required communication between a treating specialist and a chosen primary care provider, but an enrollee with an established need and service provision should not be required to visit a primary care provider before accessing a specialty provider.

3. Access to Out-of-Network Providers: This is also another issue that must be addressed under plan benefits. There must be criteria under which an enrollee can access services from providers who are not in a specific plan. This issue could be addressed by allowing enrollees to continue receiving specialty services from providers who delivered services to them prior to MMC enrollment, regardless of whether they are in a specific plan, but requiring "newly identified needs" to be addressed by plan providers. However, there still needs to be a process for enrollees to seek and receive specialty services delivered by out-of-network providers.

4. System Navigators: This term encompasses a number of different functions that could be performed by a number of different entities. The basic function of a systems navigator would be to ensure that enrollees get the services they need when they need them. It would involve enrollee education about the opportunities and restrictions of plan services and provider education on the needs of enrollees. It would involve assisting enrollees with securing needed appointments. It would undoubtedly require system and individual provider advocacy. System navigators could be located inside the plans and be a required administrative service, contracted to an outside organization, like an area agency on aging or center for independent living, located within a governmental entity, or some combination of these. New York, New Jersey and Indiana all have community-based

organizations involved with this process. Oregon requires the MMC plans to have exceptional needs care coordinators; Pennsylvania has special needs units.

Regardless of who performs this function and even if this function eventually becomes part of a plan's care coordination function, it is vital that the navigator understand that access to services outside of plan benefits is part of the work performed. The ABD populations and others must be viewed as a "whole" person, not simply one who is receiving a defined set of covered services. The goals should be wellness and quality of life and this often requires more than what the MMC plan is required to offer. People need expert guidance in accessing whatever services they need and desire.

5. Screening and Assessment : Although states often require a MMC plan to doing some limited screening at the time of enrollment, some states require that a plan perform an assessment shortly after initial enrollment. Arizona requires its plans to do a screening within seven (7) days, an on-site contact within twelve (12) days and require that appropriate services are being delivered within thirty (30) days. This is a good practice and should be completed for at least some percentage of the newly enrolled population, if not all.

Member Communication, Complaints and Appeals

Even with excellent pre-implementation planning, adequate provider capacity and capability, and strong procedures for access to needed services, there will always be issues that need resolution. The best managed care programs work hard to be available to answer questions and resolve complaints and appeals in a timely and fair manner. Below are some of the components to address in your MMC plan design.

6. Advisory Committees: The State should create a consumer advisory committee. This entity can be helpful in raising both systems and individual issues. Meetings should be held at least monthly during implementation. A number of states have also required plans to have advisory committees. Even if there is no state mandate, there is value to advocates having direct contact with MMC plan decision-makers.

7. Member Surveys: Although consumer satisfaction surveys are often used as part of a quality assurance and improvement process, a number of plans use consumer surveys and focus groups to assess one or more parts of the service delivery process. These methods generally focus on issues in greater depth and are valuable for continuous quality improvement. These should be performed in addition to any more general annual satisfaction survey.

8. Dedicated Unit at the Plan: Each MMC plan should be required to maintain a dedicated unit to answer questions and resolve issues on a 24/7 basis, 365 days a year, with access to appropriate language services and interpreters. Employees in this unit must be trained in working with individuals with disabilities including the use of alternative formats and adaptive equipment. Employees must know and interpret plan policy in a consistent and fair manner. Because there are already many MMC plans that have enrollees who are in this new Georgia ABD population, the plans should train their employees to know that most of the difficult questions will likely be about equipment, pharmacy, specialists, out-of-network services and physical accessibility.

9. Consumer Protections: There should be a right to a second opinion, independent medical reviews of issues including medically necessary services and "experimental"

treatment, timely resolution of complaints including expedited review where necessary, and timely access to all services.

10. Appeals Process : There should be a fair, efficient and timely appeals process with the MMC plan, and the same qualities in a state appeals process. The people reviewing complaints should be specialists in the type of issues presented. There is no excuse for having a provider review an issue when that provider has no expertise in the specialty area being appealed.

Quality Monitoring and Quality Improvement

Quality assurance and monitoring as methods should be used to hold plans and the State accountable for delivering quality services in a timely manner.

1. Public Reports on Performance: All performance standards and measures important to consumers must be published at regular times using multiple methods for publicizing the results. Listing how plans performed on a variety of measures in the same reports allows consumers to compare performance, especially if the information is presented in consumer-friendly fashion. Reports should be available in all formats, be easy-to-read and understood. There should also be regular reports that are presented to the Legislature.

2. Performance Measures: Most states have a focus on national quality performance measures that have been adopted and are being used to compare plan performance both within and across states. While these are valid measures with which to be concerned, they were not developed with a focus on the needs of individuals with disabilities. In addition to the standard national "health" outcomes, there should be other measures such as avoidable hospitalizations, avoidable facility care, depression screenings and cholesterol measures after coronary events. There should also be process measures such as access to specialists, access to equipment, non-emergency transportation, timely access to plan representatives and timely and fair resolution of complaints.

3. Quality Monitoring by Outside Entity: There must be an outside entity to monitor the quality of service provided by a MMC plan, while mandating that each plan have its own methods of ensuring and improving quality. There should also be a mandated process where the plans record member complaints about the system, analyze any patterns of complaints and report how they changed the system to address these issues. There should also be mandated consumer survey done by an outside entity, performed at least annually, and a process to implement quality improvement based on the survey results.

Conclusion

MMC plans are delivering services to the ABD population in many states in the country. The best models have been developed with broad stakeholder participation in a thoughtful and deliberative pre-implementation planning process ensuring sufficient trained and experienced providers with physically accessible offices, a broad set of benefits that meet the health and wellness needs of enrollees, a enrollment assessment and counseling system that helps new MMC enrollees understand the new system and choose the best plan for them, ongoing communication and education and fair and rapid resolution of issues and ongoing work at quality improvement.

Frankly, it is more important to get this redesign done well rather than get it done fast. A too-aggressive implementation schedule has strong potential to compromise the success of the program and jeopardize continuity of care for the population who will need long-term care in the future. Even though the State may feel confident about their managed care program for adults and children, it may be severely underestimating the amount of work it would require to move all the Medicaid aged, blind and disabled (ABD) populations into both primary and acute care Medicaid not to mention thinking about moving these populations into managed long-term care (LTC).

In brief, this is too much change in too short a period of time. If the State feels it must move to managed care, it should start with primary and acute care and build in the type of care coordination with community long-term care providers that would allow them to build the unique provider capacity to deliver home and community-based services.

Thank you for the opportunity to share our concerns and recommendations. We look forward to continuing to be a part of this process.

Sincerely,

Pamela Roshell, PhD, MSW
AARP Georgia Senior State Director