MEDICAID ADVOCACY
Coalition to Assure Redesign Effectiveness for Medicaid (CARE-M)

Memo: December 10, 2012
To: Jerry Dubberly, Blake Fulenwider
Cc:// Terri Branning
Re: Proposed ABD Care Coordination Initiative
From: CARE-M: Coalition to Assure Redesign Effectiveness for Medicaid

Dear Jerry and Blake:

After each series of Task Force meetings, it has been the practice of CARE-M to meet as a coalition and debrief. As the Department gets closer to offering a proposal to bid for a 'care-coordination' management program for the Aged, Blind and Disabled population in Medicaid, we want to take the opportunity to share the conversation the coalition had last week.

We first shared what we know to date on what the Department is thinking, based on the notes from the meeting Linda Lowe and I had with you in November, the powerpoint that was shared at the Task Force Meeting, and other information that emerged with the discussion. Then followed an open discussion on continuing concerns, some suggestions and recommendations, and a few questions, which I summarize below.

Design of Additional Care Management for ABD Populations

First, and this was mentioned during the task force meeting, we agree DCH should consider carefully how this program is named to avoid confusion among all the existing care/support/case management/coordination programs that exist for many of the ABD populations. The program model must be distinctly characterized to avoid confusion, fear of overlapping coordination, etc.

A significant emphasis in the conversation was the interest in determining how DCH and its partners (DBHDD, DHS, SOURCE etc) could proceed with some program improvements that would not be contingent on contracting with an outside management entity. CARE-M recommends also doing an analysis of the agency homes of the existing programs to both identify gaps and strengths, and where program improvements could be made prior to turning that responsibility over to an outside management entity. We ask that you consider where care management is being conducted outside of DCH and Medicaid and identify the scope of that management, provide them with their data and work with them to address their population needs; for example, Hemophilia of Georgia has substantial management mechanisms in place that address the very specialized needs of that population, and imposing another management structure may not be cost effective. Are there other instances of non-profits that may be providing effective case management that is not financially supported by DCH? It is important

not to supplant systems that are effective without government funding. There may be other populations within ABD with similar programmatic elements.

DCH has been sharing a substantial amount of data with the Task Forces, and there is considerable interest in the provider community to have access to the data generated on each population that is already managed and be given the opportunity to identify high cost individuals with ineffective or poor health outcomes and get a first shot to improve health access and care. In order for current providers to make those program improvements, data production and analysis must be timely, responsive and accurate.

This discussion led to a recommendation that DCH consider staging the implementation of the care coordination program, beginning with the currently unmanaged populations first, and leaving the programs with existing management structures for a second or third round, taking into account the following:

- Define "unmanaged." Set clear parameters around the proposed tiers of need for coordination. Begin the program with those individuals with the most critical need for care coordination and opportunity for improvement.

- Consider as part of this first phase an independent study of the reasons people go to the ER. Claims data only reveals the diagnosis for the ER trip, but not why people sought care there as opposed to another more appropriate setting. Such a study may reveal the absence or inaccessibility of primary care doctors, transportation issues, or home support needs that could be addressed more cost effectively.

- Consider coordination of the institutionalized population in the first round. For many individuals in the ABD group, institutionalization is the most costly and most restrictive placement, and analysis of their care and how it might be improved in a community setting would further the rebalancing effort that Georgia has taken significant steps toward accomplishing. Then ensure that the savings are reinvested in the HCBS system.

- Continue to work closely with the DBHDD and the DHS to

    - Analyze the existing coordination mechanisms,
    - Determine which mechanisms could be improved without outside management using existing agency resources, and
    - Establish cooperative agreements that
        - define existing case management or care coordination,
        - specify which entities will have authority to change an individual's care plans, etc, and
        - avoid duplication or excessive layering of management where it will not result in cost savings or better health outcomes.

- As we have stated in many correspondences, ensure individual user rights. How much decision-making autonomy will the consumer have? What are the rights or appeal, or transfer of services, or opt-out? Ensure the Medicaid rights of due process, grievance

filing, etc. In addition, include stakeholders of the various populations under consideration at the table as programs are being rolled out, both to advise the department on the effectiveness of particular approaches, and as a way to communicate to the larger group critical information on program changes. In order for care coordination to result in the desired outcomes, individuals must be engaged with their coordinator, care plan and health. Soliciting their experience and input at the front end may result in programs that are sensitive to the needs of the different populations, and therefore, potentially more effective.

Administrative / Internal Department Considerations

- Analyze the staff capacity of the Department to manage the program. There should be intentional assignment of staff with expertise in these programs who can provide oversight to outside contractors.

- Acknowledge that front end contact/engagement of an outside entity for these programs is expensive, difficult, and requires specific skills. Ensure vendor has specific skills for different ABD populations. As we have communicated from the beginning, the ABD populations have quite diverse needs and characteristics.

- If vendors subcontract to subsidiaries that specialize in sub-populations such as behavioral health, or aging, the subsidiary company should come under the same scrutiny and vetting as the primary company. If a vendor is bought by or sold to another business, there should be consultation with stakeholders and an opportunity for DCH to cancel, review or renegotiate the contract.

RFP Process

- Ensure protections to avoid conflict of interest between the medical home provider and the patient to avoid incentivizing under-treatment.

- Ensure the vendor integrates medical care with social supports that enhance an individual's stable health situation. This is particularly true for individuals with disabilities who may be primarily healthy, but need adequate supports in the community to maintain that stability.

- Continue to share the timeline for RFP release, contracting etc, with the CARE-M coalition and community. How close to the official RFP can the community review and have input?

- Advise CARE-M on the potential to influence the scoring rubric, so that priorities for a contractor are weighted appropriately.

Thank you as always for the opportunity to weigh in on these very important initiatives. As you know, I am leaving for Washington mid-January. Until my replacement gets up to speed, Nancy

Pitra, Elder Law Attorney, and Linda Lowe, will try to keep things moving. I will be at the last Foster care Task force on the 9th, and then I will be turning over the reins!

Have very happy, healthy and safe holidays.

For CARE-M
Patricia Nobbie, PhD