MEDICAID ADVOCACY

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

CARE-M is a coalition of organizations who advocate on behalf of vulnerable populations, patients, and health care consumers in Georgia. The coalition was formed shortly after the Georgia Department of Community Health (DCH) announced plans to explore redesigning Georgia's Medicaid and PeachCare for Kids (CHIP) programs to ensure that the voices of patients and consumers were heard in the process. Many CARE-M partners have been appointed to and serve on task forces and work groups convened by DCH to gain stakeholder input.

The members of CARE-M believe that improved healthcare outcomes for members should be the primary goal that drives changes to Medicaid. We believe improvement in the Medicaid system of services and supports will result in improved healthcare outcomes for the members.

Response Details: State Plan Amendment for ABD Care Coordination, October 2013

We believe there is value in the concept addressed by the 1932 State plan amendment – namely, offering care coordination services to individuals in the Medicaid ABD population. Having a single vendor provide services including data analysis and medical coordination has potential to improve the health of the individuals served as well as reduce care costs. A single vendor could also minimize complications and confusion for doctors and other care providers and make them more willing to accept the program. We want to emphasize that as care coordination moves forward, it is critical to maintain the elements of care management that are working now, such as some of the care management within home and community based waivers, and to consistently implement best practices.

Carve-outs & institution to community: We support the inclusion of all populations, including those in institutional care settings such as nursing facilities, as laid out in the proposal. As care coordination and further discussions about care management evolve in Georgia, we strongly believe that a focus on moving persons from facilities to the community must be part of that conversation. This is in line with the desires of consumers, and it also presents significant opportunities for improved healthcare outcomes as well as reductions in cost of care.

Opt-in and opt-out procedures: We strongly support the need for members to have the choice of opting out of care coordination and appreciate that this is emphasized in the proposal. However, we are concerned that the specific ways members will opt-in and opt-out of care coordination are not clear in the proposal. These mechanisms need to be clearly and explicitly spelled out, as well as clearly communicated to all affected populations and stakeholders in a timely and culturally appropriate manner.

State Oversight and Accountability: In order for the ABD care coordination and indeed any other initiative or redesign to be a success, DCH must build and maintain adequate staff capacity and expertise at the state level to implement, oversee operations, and diligently enforce contract requirements.

Stakeholder Participation: Each population included in ABD care coordination must be fully engaged in designing, implementing, and monitoring the outcomes and effectiveness of that care coordination and be empowered to bring issues occurring in care delivery forward to the attention of the managed care entities and the Department of Community Health. This involvement should not end with the awarding of contracts, but should continue with providing feedback on system performance and recommendations for plan improvement. In order to perform this role effectively, stakeholders need access to performance data and progress on established benchmarks. After care coordination has been implemented, consumer involvement should extend into ongoing monitoring through representation in standing advisory groups at both a state and local plan level. The RFP and anticipated deliverables need to be made available to the public and to stakeholders at the same time they are made available to qualified bidders.

Public Comment: A reasonable time frame for stakeholders to review and provide input on plans and proposals such as this one is an integral ingredient for robust stakeholder participation. In the case of this state plan amendment, exactly two weeks were provided between its release and the day of oral public comment (with four additional days provided to submit written comment). Particularly when plans and proposals deal with such crucial matters as this one does, more time between the release and comment deadline is needed to allow for stakeholder review, discourse and contributions.

Definition of Medical Necessity: The definition of medical necessity for persons under age 21 is statutory and requires that determinations be based on the needs of the individual child. While it may not be addressed in the scope of the current state plan amendment, it is the position of CARE-M that medical necessity standards for persons age 21 and over should be modified to include those home and community-based services that are necessary to support individuals in a stable way in their homes, whether in the community or in a long-term care facility.

Appeals and Independent Problem Resolution: As Georgia continues to investigate the world of managed care for the ABD population, the members of CARE-M emphasize that any managed care system must include an independent ombudsman who has expertise in the delivery of Medicare and Medicaid benefits to seniors and persons with disabilities, including Long-Term Services and Supports and Behavioral Health services. This ombudsman will assist beneficiaries with appeals and will identify systemic problems and be able to bring those concerns to the agency authority.

Provider Network – Choice, Capacity, and Accessibility: Again, as Georgia continues to further investigate the world of managed care for its ABD population, we emphasize that there must be an adequate array of providers to meet the needs of any subgroup of the ABD population that the state determines to include in a managed care program. The network needs to include those who furnish health care, behavioral health, recovery from addiction, and home and community-based long term supports, and should be structured in such a way that it allows individuals to maintain successful relationships with current providers. It is our understanding that this is not an area that will be

addressed by the current state plan amendment, but we feel it is a key issue to keep in mind during any and all further discussions of care coordination and care management for the ABD population.

PCCM Contracts – Assurances of Compliance with Standard Practices: There is no explicit assurance in the State Plan Amendment that the State and its contracted PCCM vendor will lay out procedures for necessary and recommended measures, including Quality Assessment and Performance Improvement, External Quality Review, and Grievance Systems. These procedures should be clarified and opportunity given with adequate notice to obtain input from stakeholders at all levels and advisory groups.

Other issues to be kept in mind during discussions of managed care for the ABD population include:

- **the need to gradually phase-in the ABD population if managed care is adopted;**
- **the need to measure quality of care for each ABD population using home and community based services with the measurement most appropriate for that particular population;**
- **the need to adhere to the infrastructure as well as the intent of the Department of Justice settlement for individuals with behavioral health concerns and/or developmental disabilities;**
- **the potential for improvements to the dental care system. Specifically, CARE-M recommends covering non-emergency dental services for adults, recognizing that oral health contributes to overall health and well-being. CARE-M recommends a carve-out of dental services to one CMO. If that is not a viable option, we recommend that all dental CMO's utilize a single dental subcontractor. We further recommend that DCH require uniform, standardized, quarterly dental utilization reports; and that measures other than HEDIS are used as annual dental utilization reporting measures, as HEDIS for dental is a more of a measure of access points.**

Finally the potential cost of this proposal is quite significant. If you were to assume the vendor was paid $10 per member per month for 450K individuals, this would be $54 million a year in new spending. Successful care coordination should be effective both in terms of health outcomes and financial soundness. In order to ensure this, there is a need for multiple clear and meaningful measurements of both to be established prior to the beginning of care coordination. These measurements should then be reported to both the Board of Directors and the advisory stakeholder committee on a regular, ongoing basis.