Comments from Focus Groups and the ABD Task Force in Response to Medicaid Redesign Options

Please note that this feedback contains opinions of individuals providing input during focus groups, ABD task force meetings, and or directly to DCH for the time period of late 2011 through early 2013. The comments reflected have not been reviewed for accuracy in an individual's interpretation of the Medicaid program. Additionally, this feedback does not represent group consensus or recommendations. Because these are individual opinions, some of the statements noted may be contradictory.

No.	Issues Raised by Stakeholders
Care Management	
1.	Some ABD task force members noted concerns about statements in the Navigant Strategy Report about the ABD population being largely unmanaged. There are individuals who do have care coordination. Other task force members indicated that many are unmanaged.
2.	Lack of focus on prevention/wellness, disease/illness management and coordination of services for ABD population
3.	• CMO case management is weak/care coordination. • Telephonic case management will not work for the ABD population. • The biggest problem is there is no coordination of case management or information. • Quality case management for all population, face-to-face. • MMIS should be strong and user friendly. • Appropriate medication management is lacking.
4.	Select single case management entity.
5.	Have high reliability outcomes, i.e., services ordered are delivered, on time and consistently.
6.	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.
7.	The low-income Aged, Blind and Disabled are more likely to have developed one or more complications related to diabetes. Can a Patient-centered Medical Home model deliver education on diabetes?
8.	Build a flexible and broad benefit design utilizing multiple resources and community-based resources. These services should include community crisis stabilization, community case management, rehabilitation and skill building, family and consumer education, assertive community treatment, peer support, in-home family intervention services, family preservation and reunification work and other recovery-oriented services.
9.	Be accessible 24 hours a day to start care and manage issues that arise.
10.	There could be required communication between a treating specialist and a chosen PCP, but an enrollee with an established need and service provision should not be required to visit a PCP before accessing a specialty provider.
11.	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.
Continuity	
12.	People need continuity of providers especially when enrollees have providers they trust.
Medical Home	
13.	Strongly consider use of medical home that already exists and is in use in other states (like North Carolina).
14.	Recommendation – primary medical home to include behavioral health, medical, dental. Coordinate with physicians and schools.
15.	Keep a medical home, including if moving from private insurance.
Behavioral Health	

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No.	Issues Raised by Stakeholders
16.	There is not enough emphasis on prevention and education for substance abuse – denial often plays a role – people don't want to admit there is an issue.
17.	Carve substance abuse back into behavioral health.
18.	Look to American Society of Addiction Medicine (ASAM) levels of care for substance abuse – are well-defined levels of care prescribing a spectrum of care.
19.	All Crisis Stabilization Units (CSU) staff need contemporary standards training for substance use – have become a catchall and many staff don't have the expertise to manage everything coming in. DBHDD is doing a required training of all CSU providers.
20.	Co-occurring services evaluated on the national standards (this specifically refers to mental health and substance abuse).
HCBS Waiver Programs	
21.	Katie Beckett group definitely needs some coordination and assistance in getting care.
22.	Small percent of population currently managed under waivers.
23.	Barriers to accessing services exist among waivers/services (siloed care) – need to identify patient needs regardless of the service provider and help address those needs.
24.	Waiting lists for waiver programs.
25.	The Katie Beckett program (a program that enables severely disabled children and adults to be cared for at home and be eligible for Medicaid based on the individual's income and assets alone) works well once you are in the program and have your routine. It meets members' medical and prescription needs.
26.	Through the Independent Care Waiver program that provides personal services, a young adult is able to maintain his independence.
27.	Medically fragile children have to apply every year for the waiver, which is burdensome and unnecessary.
28.	Community Care Services (CCSP) enrollment for ABD members is a lengthy process that can take six to eight months until approved for Medicaid. The delay is a result of DFCS having a backlog.
29.	Remove all participant limits/waiting lists, so patients have improved access to these cost effective waiver programs, as opposed to the unlimited access to higher cost inpatient hospital and nursing home services.
SOURCE	
30.	Georgia's current SOURCE (Service Options Utilizing Recourses in a Community Environment) program already includes many components meeting the stated goals of the Department.
31.	Georgia SOURCE appears to be an innovative program with an innovative approach that is offering real, non-institutional service alternatives to its Medicaid clients.
32.	Utilize the proven clinical model of the SOURCE program, which includes primary care physicians and oversight by a Medical Director.
33.	Given the chronic nature of many of the health issues facing the ABD population, they would most likely benefit from true case management and coordination of care, perhaps through PCMHs or the SOURCE program.
34.	We believe the Department of Community Health should embrace the lessons learned from SOURCE, its systems for outcomes measures and the complex network of Georgia based health care partner providers now serving 20,000 people through this program and expand this model to meet the needs of many more Medicaid ABD beneficiaries.
Member Communications and Outreach	
35.	The general feeling is that members do not use the DCH website, so need to identify other ways to reach them.

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36.	Medicaid does not provide any information on what is available, how to get services, or about policy and program changes. Some of the information that it does provide is inaccurate. Consequently, families of children with disabilities do not know how to get services.
37.	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.
38.	All performance standards and measures important to consumers must be published at regular times using multiple methods for publicizing the results.
39.	Awareness program for members to allow them to be accountable for their care/health.
Member Compliance	
40.	The ABD population is difficult to serve. This population has a high level of non-compliance, especially among the high-cost segment.
41.	The ABD population is a very non-compliant population.
42.	Provide incentives for healthy behavior.
43.	Incentivize health promoting behavior (e.g., keeping appointments, etc). Missed appointments leads to decreased access because physicians restrict number of slots for Medicaid members.
Provider Access	
44.	Do a phased in approach to build needed capacity. The lack of service capacity will challenge all providers both public and private. We need to identify the services that we need and build that capacity.
45.	Provide a delivery system which incorporates a provider network that focuses on providing a broad continuum of long term care services to the elderly, the physically disabled, individuals with intellectual and developmental disabilities, and children with significant medical needs in the least restrictive and least costly environment, such as the client's home.
46.	Lack of network information on specialists who serve children.
47.	We need to tackle the lack of capacity among providers of substance abuse. We do not have the providers to meet the demand. Criminal justice reform has accountability requirements for treatment – not sure how to meet this given access, as we will have enormous demand.
48.	Lack of HCBS providers/resources in many areas of state (i.e., gerontologists, geriatricians, home care providers, specialty care, transport, etc.).
49.	We need to tackle the lack of capacity among providers of substance abuse. We do not have the providers to meet the demand.
50.	Outside of heavily populated areas, there are no services for individuals with TBI, especially rural transportation.
51.	Access to services in rural areas (timeliness). Access to transportation in rural areas.
52.	Access for specialty care especially in rural areas (including mental health).
53.	While many dentists express a desire to provide dental services to Georgia's needy children, they also indicate that the numerous changes, administrative burdens and lack of program funding make it difficult to continue. Dental providers constantly evaluate how much longer they can "hang on" under the current program and many fear that without significant changes they may have to withdraw as a provider in the program.
54.	The most important way to improve the oral healthcare of children on Medicaid is to provide more access to care.
55.	Transportation – inconsistent network, access.
Reimbursement	
56.	Current payment levels with accompanying administrative hassles for providers serving children and families.

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No.	Issues Raised by Stakeholders
57.	The state must consider the serious negative impact on healthcare providers and on the Medicaid budget itself were risk-based care capitation care management expanded to the ABD population.
58.	Low reimbursement rates drove providers to drop out of the Medicaid system or not accept new Medicaid patients because they cannot afford to have a high percentage of patients under Medicaid.
59.	Low reimbursement rates. The last rate adjustment resulted in cutting the group rate by more than 50 percent. Services were unbundled; the day program for children was cut, and the more intensive services are reimbursed at lower rates.
60.	Adding populations like the aged, blind and disabled, those in long term care, and children in foster care – populations that require more staff, more provider time, and special equipment, and costly care – cannot be supported under current reimbursement rates.
61.	Many situations essentially force providers to provide free care. There are many examples of this phenomenon, but the most egregious is mobile dental operations. This entire delivery system is inherently inadequate because the vans cannot and do not provide the comprehensive care provided in a true dental home.
62.	Reimbursement rates for certified addiction counselors are too low to boost up addiction services.
63.	Appropriately licensed people should be appropriately reimbursed.
Quality and Health Outcomes	
64.	Use quality improvement processes relevant to children and families and use performance management tools to assure outcomes.
65.	We believe the primary goals and priorities should be to achieve better health outcomes for people. An emphasis on preventive care, easy and timely access to health services and continuous coverage, to name a few elements, results in cost savings.
66.	Evaluate DCH success on basis of healthiness of populations, not just on cost savings.
67.	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.
68.	Establish Quality Measures: The design requires sufficient measures of quality outcomes and enforceability.
69.	Better use of health outcome metrics, tie vendor reimbursement compensation to those metrics.
Monitoring and Oversight	
70.	Contractor and subcontractor oversight will be a particular concern for the ABD population.
71.	DCH needs sufficient resources to oversee, manage, and enforce vendors.
72.	Better oversight and regulation of core services (mental health, clinician, nursing).
73.	Community board to oversee all vendors with enforcement capabilities. Need more DCH oversight and enforcement of CMOs.
74.	Advisory council of State agencies and citizen representatives viewing results of implementation.
75.	The Department needs to establish an independent monitoring body.
76.	There must be an outside entity to monitor the quality of service a vendor, while mandating that each health plan have its own methods of ensuring and improving quality.
Data	
77.	No data to support what outcomes are most successful.
78.	Data-driven care to recognize approaches under GA Medicaid state plan not currently available.

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No.	Issues Raised by Stakeholders
79.	Real data, real time not available.
80.	Lack of data on utilization and outcomes across all populations.
81.	Lack of data available to providers, advocacy groups, etc. on utilization, outcomes, eligibility, trends, network data, etc. across all populations; want data real time.
82.	Data-driven care to recognize approaches under GA Medicaid state plan not currently available.
83.	Information sharing among state agencies with attention to HIPAA.
84.	Member and provider access to Medicaid data.
85.	Health scorecard with ongoing review of encounter, service, performance data.
86.	Data sharing across state agencies, vendors and providers (like CCNC's analytics capabilities).
87.	Information sharing and data access.
88.	Improve information systems and data collection tools to provide transparency into enrollee outcomes including enrollee utilization of hospital and nursing facility inpatient days. The current CCSP information system platform is a statewide preferred solution.
Medicaid and PeachCare for Kids Eligibility	
89.	Eligible individuals are not applying; application process = barrier.
90.	Too many eligible people are not enrolled; need aggressive outreach and enrollment and marketing.
91.	Awareness of eligibility (248,000 kids are eligible but not enrolled).
92.	Most uninsured Georgia children are eligible for but are not enrolled in Medicaid or PeachCare
93.	Skilled personnel to enroll members armed with information to educate on options
94.	Aspects that need fixing, such as maintaining continuous eligibility for children.
95.	The six-month eligibility redetermination requirement is a barrier for children to get services.
96.	The shortness of the eligibility determination period is not reasonable for families with children with disabilities or for individuals with chronic conditions.
97.	Continuous 12 month eligibility, expand express lane eligibility.
98.	Need easy enrollment process. Need online enrollment.
99.	Expand eligibility to include aged, blind and disabled at high risk for hospital and nursing facility inpatient care, emergency care and high pharmacy cost. The objective is lower total cost of healthcare.
Medicaid Coverage and Benefits	
100.	Need to be able to assess kids 0 – 6 years for social, emotional, mental health, and be able to pay providers for specialty therapy (not available today).
101.	Lack of dental care, mental health, vision, preventive care for adults and kids.
102.	Social, emotional, behavioral health – age appropriate, comprehensive array of services that involves family and community.
103.	Lack of equipment for kids with special needs. Wheelchairs are needed.
104.	Need child/family-centered, comprehensive, community-based services including transportation, specialty care.
105.	Provide family support/respite beyond medical services to maximize impact of medical services.
106.	Lack of support for informal caregivers – more people working, transit, etc.

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No.	Issues Raised by Stakeholders
107.	Many times consumers are denied needed services and are offered alternatives that do not fit what the consumer needs as they often only approve services where consumers are required to travel in to clinic. This is especially troublesome in the rural, economically deprived areas.
108.	No coverage for dental, vision and hearing.
109.	Limiting access to services results in long waiting lists. For example, 6,000 ABD beneficiaries are on the waiting lists.
110.	Medicaid covers a lot of children throughout the State of Georgia who would otherwise not have access to medical care.
111.	Single benefit package not available for all or specialty programs.
112.	Increase Medicaid eligibility for substance use – should be a covered benefit for everyone.
113.	Have statewide geographic coverage – to include remote areas in rural Georgia and the mountain region.
Prior Authorization	
114.	Waiting for pre-authorization may cause harm to a patient.
115.	Pre-authorization is not saving the hospitals any money. For example, a hospital had to get pre-authorization for a medical device so that the hospital could send a child home instead of keeping the child in the hospital.
116.	Be able to begin services quickly following referral.
117.	Many times the authorization rules are changed constantly without notification on what is required on authorization summaries and that is the reason why services are denied.
Contracting	
118.	These are challenging populations (ABD) that require active care coordination and substantial face-to-face interactions with care management staff to be successful.
119.	We want the best quality, fully-integrated, community-based care for people with disabilities. I believe it would be difficult to achieve true integration of clinical services simply by contracting with a managed care entity. True clinical integration requires access to appropriate supports, services and qualified personnel.
120.	Revise the payment model to provide for shared savings based on outcomes and process quality. A focus on the reduction of unnecessary hospital and nursing facility inpatient days would be a critical driver of any shared savings mechanism.
Miscellaneous	
121.	Recognize that one size does not fit all. It is not plausible that one system can meet the needs of multiple special populations. Individuals with disabilities have co-occurring diseases and multiple chronic conditions that are unique in nature. These groups cannot be lumped together. The needs of children with mental illness are very different from those of adults or older adults.
122.	Be capable of serving all special populations – the elderly, the physically disabled, individuals with developmental disabilities, and children with medical needs.
123.	The Department must adopt a values foundation that establishes the principles on which the expansion of managed care for ABD populations is achieved.
124.	ABD should not be blended into Medicaid program; set specific target plan for ABD due to complexity.
125.	Should the state decide to expand the Medicaid managed care program to the ABD population, a waiver should be sought to protect the UPL funds for that population.
126.	Survey of best practice waivers in other states that support commercial based care versus institutional care, seek CMS approval.
127.	Be capable of delivering both in-home and residential services to accommodate the needs of individuals whose conditions continue to worsen as they age.

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No.	Issues Raised by Stakeholders
128.	Georgia can be proud of its accomplishments as it relates to Real Choice System Change grants, utilization of evidenced based practices, innovative program development (i.e. Peer Support, Aging and Disability Resource Centers, the Gateway management information system, chronic disease self management initiatives etc.).