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TO: Commissioner David Cook
Georgia Department of Community Health
2 Peachtree Street, NW, 40th floor
Atlanta, GA 30303

FROM: Georgia Council on Aging
Georgia Association of Area Agencies on Aging
Georgia Gerontology Society

DATE: March 6, 2012

RE: Comments on the Navigant Medicaid and CHIP Redesign Final Report

The Georgia Council on Aging, Georgia Association of Area Agencies on Aging (G4A), and the Georgia Gerontology Society welcome the opportunity to comment on the Navigant Medicaid and PeachCare for Kids Design Strategy Report. Our members support efforts to improve outcomes for Medicaid members utilizing resources as effectively as possible. We have worked with the Department of Community Health and the Division of Aging Services and their predecessors for many years to ensure that Medicaid services for older adults meet their needs in the least restrictive environment possible. The Council was instrumental in the passage of legislation and in the design of services which resulted in the Community Care Services waiver program (CCSP), and the Area Agencies on Aging (AAAs) have been instrumental in implementing CCSP and developing the Aging and Disability Resource Centers (ADRC) as a No-Wrong-Door entry point to services for older adults and persons with disabilities.

Continuing to improve the management of care for those currently managed by Care Management Organizations (CMOs) as well as preparing for adding more individuals to the Medicaid rolls in response to the federal mandate in the Affordable Care Act are significant tasks that will require significant adjustment to the current care management structure. In addition, the current CMO contracts will soon expire. Given these coming milestones, it is in Georgia's best interest to consider improvements to current CMO programs to improve outcomes for consumers while creating better efficiencies in health care and financial resources. Navigant's report includes only a high-level overview of Georgia's current program and doesn't adequately analyze them to see what works well and what needs to be improved. A thorough analysis of the weaknesses and strengths of the existing program would help the state chart its course forward.

Georgians who qualify for coverage due to a disability need long-term care services and specialized health care not currently provided by the CMOs. The redesign report recommends moving them into such plans and proposes an aggressive timetable for implementation. This wholesale movement of Georgia's Medicaid program to a managed care model is unprecedented and ignores lessons learned in the national scan Navigant conducted.

Nor does the report provide sufficient detail about how managed care would benefit the ABD participants, especially those residing in Skilled Nursing Facilities (SNFs) or Personal Care Homes (PCHs). While more coordination among acute care providers and long-term care providers such as primary care and specialist physicians, pharmacists, therapists, and direct care workers could help Medicaid members in some instances improve their health or slow the expected decline of their health, there is no indication that this level of coordination has been achieved by other states.

Georgia has made great strides in improving long-term care qualitatively and in a coordinated manner. We feel that a sudden change in long term care service programs could damage the successful structure that is in place while inadvertently creating fragmented access to services and an increased bias toward more expensive institutional care.

The Navigant report states that there is not yet any conclusive evidence that managed care of ABD services results in cost savings over time. At the same time, Georgia in 2008 was 3rd lowest in the nation in per enrollee expenditures for Medicaid-funded health care, making it difficult to foresee further savings. Experience has shown in other states that costs actually rise in the early stages of implementation, and Georgia should plan for this to occur with the ultimate goal of improved access to services and improved quality of health care.

No states have attempted wholesale and rapid carve-in of the ABD population and for good reason. This population has many faces and a diversity of needs not found in other groups more easily served by managed care. Persons who qualify for Medicaid due to age or disability need long-term services and specialized health care not provided in the current CMO programs. For this reason, we urge DCH to proceed carefully, heed the lessons contained in the Navigant's national scan, and take the time necessary for development and implementation of appropriate managed care for ABD.

We believe Georgia should capitalize on the successful programs the Aging Network has already implemented. The AAAs have developed single access points (ADRCs) in each region for services for older Georgians and have expanded the access points to include persons with disabilities. In FY2011, the ADRCs served 264,870 Georgians. They have successfully reduced costs for long term care by helping consumers access community-based services and, through the Money Follows the Person program, navigate the waters of transition from institution to home and community based services.

Through case management and support services the AAAs and their partners in the Aging Network assist older Georgians, their caregivers, and those with disabilities enrolled in Medicaid waiver programs. The Medicaid waiver programs have successfully managed costs while at the same time effectively implementing vital support services and programs for Georgia's vulnerable older adults and those with disabilities, enabling them to live longer in their communities. The statewide Aging Network has crafted innovative tools for intake, screening and service assessment that allow the most fragile in our state to receive necessary support services such as transportation, meals, personal assistance, employment services, and respite care.

While DCH has included in its stated goals for Medicaid redesign the achievement of "long-term sustainable savings in services," we believe that the priority goals should be improvement of health care outcomes for members and effective utilization of resources including the current successful programs already mentioned.

ABD populations are not homogenous. Nor will one solution meet such disparate needs.
States have utilized a variety of approaches to manage, administer, and ensure quality outcomes in its Medicaid managed care programs– from private for-profit companies to NORCs to regional management. After thoroughly examining the alternative, Georgia should develop a management plan which ensures adequate state oversight, local involvement, and quality outcomes. Data must be gathered and analyzed throughout the process regarding outcomes and core measurements for progress toward better health outcomes. The Kaiser Commission on Medicaid and the Uninsured stated that "Regulatory and contractual requirements and standards are only as effective as their oversight and enforcement." We must ensure that DCH has the infrastructure in place to ensure the best possible service delivery within any managed care system established. Kaiser said, "Building and maintaining sufficient state staff capacity to conduct these operations and enforce standards is fundamental."

Georgia has a window of opportunity to thoughtfully contemplate models of care for their most vulnerable populations. Any changes to care in ABD must include a person centered approach recognizing individual needs and must take into account advantages of current structure, existence or lack of providers in all areas of the state, knowledge that significant changes can trigger health declines and raise costs, and differences in the needs of community-dwelling versus institutionalized members. Clear determination of the needs and the solutions for these different populations and the different settings must be identified. Models of integrated health care for the ABD population must bring together care for physical needs as well as behavioral health and support services necessary in order to improve overall health outcomes. To be effective, these models of specialty care must be different and allow Medicaid beneficiaries access to the right comprehensive care while stabilizing system costs if possible.

We recommend:

1. Implement and evaluate changes for the currently managed population and newly eligible members before changing ABD management;
2. Determine cost drivers for the subgroups within ABD to determine what works or needs improvement;
3. Build on current successful models (ex., CCSP and ADRCs);
4. Develop and test evidence-based changes to ABD with pilot programs in urban and rural settings which are tailored to the specific populations to be served;
5. Phase in successful pilots statewide with regular evaluations;
6. Obtain consumer and stakeholder input at every phase;
7. Include Medicare as appropriate.

In the end, Georgia's Medicaid redesign should create a program that better serves the consumers who rely on the program and provide adequate resources to participating providers so that consumers have consistent access to needed services. Hastily developing a redesign proposal will not address the complexities of the program or of the populations within the ABD group. Instead, the state should consider a more deliberate process to develop a plan that meets the needs of the Georgians participating in the program and the health care system that serves them.

Thank you for your attention to our comments. If you have questions or need further information, you may contact the Georgia Council on Aging Executive Director Kathryn D. Fowler at 404-657-5342 or kdfowler@dhr.state.ga.us and/or Nancy Pitra, Senior Citizens' Advocacy Project Coordinator, at 404-401-0055 or nrpitra@elderadvocacy-ga.com.

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