Georgia Association of
Area Agencies on Aging

# M E M O

TO: Clyde Reese, Commissioner
Department of Community Health

FROM: Gail Thompson, President
Georgia Association of Area Agencies on Aging

**SUBJECT: PROPOSED AMENDMENT**
**DEPARTMENT OF COMMUNITY HEALTH STATE PLAN**

DATE: October 25, 2013

On behalf of G4A, Georgia's Area Agencies on Aging (AAA), the following comments document remarks made at the public hearing on October 24, 2013 regarding the proposed amendment to the Department of Community Health State Plan.

Creative and appropriately required partnerships can afford Georgia the opportunity to design a service delivery system that will improve quality health outcomes, maximize Medicaid system efficiencies and savings, while simultaneously, building a strong foundation for future managed care.

G4A advises that the selected single vendor must be, or be required to work with, a network of home-and-community based agencies with longstanding experience in the community with both aging and disability service components. Such agencies should be those able to provide appropriate "wrap around" long term services and supports (LTSS) that close the loop with medical care coordination and improve Georgia's Medicaid service system for the Aged, Blind and Disabled (ABD).

> One example of how health outcomes can be improved while lowering health care costs is the recent experience AAAs have had in the delivery of Care Transitions under CMS Medicare program. It clearly demonstrates that when home and community based supports are delivered to patients discharged from hospitals, they are less likely to be readmitted within the following month. Their return home is stabilized by bringing in appropriate supports that allow them to be less fearful, more compliant in medication management and return to the doctor for follow ups with transportation options.

G4A advocates that the single vendor chosen shall have the following capabilities:

<u>Local Presence</u>

- Organization with local presence in each region where services and supports are provided to clients;
- Competence and supporting technology to perform telephonic intakes, screening, and assessments in each locale and ability to interface with appropriate partners;
- Capable of performing follow-up face-to-face assessments and visual assessments of client and the environments where they live;
- Expertise in providing information from a robust database of home and community-based resources when appropriate.

<u>Expansive Network of Approved Providers</u>

- Track record of effective relationships with comprehensive support service providers, including non-medical providers;

- Existing strong alliances between providers and the population; providers who are familiar and trusted by members to strengthen the bridges to care coordination and with the ability to provide adequate and appropriate services that support care and prevent the need for more intensive services.

Comprehensive Services and Supports

- Expertise in providing long-term supports and services;
- Proficiency in providing "wrap-around" services including behavioral health services;
- Ability to provide human service transportation , a critical element for access to a vast array of support services including clients' medical homes;
- Expertise in chronic disease management, medication management, behavioral health, and geographic variations within the state;
- Experience in reducing hospital readmissions and creating smooth transitions out of the hospital either to a community setting, clients' homes, or skilled nursing facility;
- Ability to improve access to behavioral health services.

Quality Delivery

- Expertise in delivering evidence-based programs and utilization of the most recent preventive care recommendations;
- Innovative technological solutions that provide integrated, valid and effective measurement tools that inform quality outcomes and decision making throughout the end-to-end process.

Operational Excellence

- Expertise in implementing proven processes and procedures for quality improvement and cost efficiencies yet nimble enough to respond to dynamic situations;
- Ability to integrate providers to achieve best outcome for the ABD population;
- Capability to identify and resolve the barriers to access of care;
- Ability to improve member understanding and utilization of service coordination across the state;
- Resolution processes for member and provider questions, complaints and appeals.

Transition to Care Coordination

- An adequate period of time is recommended for planning and implementation of this new model to ensure a seamless transition and to identify partners to serve as stakeholders and advocates for ongoing program design, implementation and assessment.

G4A also believes that it is essential for ABD populations to have a clearly defined opt-in and opt-out process that is presented through a robust statewide education campaign.

We look forward to working with you to create new models to serve the Aged, Blind and Disabled Medicaid clients in Georgia.

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