Georgia Health Care Association

Serving Georgia's Elderly Since 1953

GHCA Option for Care Management of Aged, Blind and Disabled Citizens

The following is a recommendation for managing Georgia's aged, blind and disabled Medicaid beneficiaries, including those dually eligible for Medicare.. The proposed strategy addresses the Department of Community Health's stated Goals and Strategies (referenced later in this document), as well as a number of concerns Navigant raised regarding Georgia's waivered services. It also proposes a scalable project, within the broad proposal, to deploy and evaluate a new information technology upon which to build the proposed Patient Centered Health Home (PCHH).

This proposed option will transform Georgia's current multiple long term care systems into an integrated service delivery model that accomplishes goals of the State identified in the Navigant report on Medicaid, and will also:

- Utilize existing local and regional provider infrastructure (keeping resources and data in the state).
- Build on the success of a "home-grown" program with a proven track record.
- Garner the State a 90% federal match for eight quarters for new costs associated with innovative strategies, as well as a $500,000 planning grant available to DCH.

The proposed PCHH Care Management model includes five innovative elements to achieve Navigant goals. These elements are:

a) Incorporates case management of all Medicaid services including nursing homes and home and community-based long LTC, as well as for hospital care and other state plan services. It serves conventional recipients of nursing home care and waiver programs geared to the elderly, but have the flexibility to include other special needs ABD populations.
b) Varying levels of Care Management, based upon Resource Utilization Groups and case mix indices to reduce care gaps that can occur between levels of acuity and different service settings.
c) A "No Wrong Door" network access process. [1]
d) A new Information Technology solution to permit data sharing across the network and more closely link a comprehensive post-acute spectrum of care and services in real time.
e) Acute care hospital partners included in the data sharing agreements.

[1] That is, access will be supported though PCP, acute care providers, post-acute providers, direct patient inquiry, or public/private social service organization.

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The SOURCE Patient Centered Health Home Option

Georgia's current SOURCE (Service Options Utilizing Recourses in a Community Environment) program already includes many components meeting the stated goals of the Department. This home-grown program unique to Georgia has proven to be an effective and relatively low cost Care Management program. It currently operates from 13 SOURCE companies across the State and provides Care Management services to approximately 20,000 individuals and:

- Serves some of the highest cost chronically ill and most functionally impaired Medicaid patients in the state. They are characterized by high utilization of resources due to their multiple chronic conditions.
- Has demonstrated savings through preventing or delaying admissions to nursing homes and by reducing inappropriate hospitalizations and ER visits.
- Provides face to face care management in every county using a carepath planning approach that targets and addresses risk factors for this population and incorporates all key players (including informal caregivers, PCPs and support service providers). This approach has received national recognition and has been adopted by other programs over the years.
- Relies on a significant physician role through regional panels of primary care physicians and an active team approach to case management, led by an engaged medical director
- Provides *PCHH-like* services with experienced care managers coordinating an individual's care across multiple providers and suppliers throughout the state [2]
- Utilizes nationally recognized, validated, and standardized assessment instruments to determine eligibility, acuity levels, and patient outcomes.

From the existing SOURCE framework, Georgia could quickly build a "health home" demonstration program consistent with the requirements of CMS's "Patient Centered Health Home" initiative[3]. To implement a health home compliant SOURCE program and maximize the federal funding opportunities available under the initiative, Georgia will need to strengthen and expand the scope of its SOURCE program. These steps include:

- Preparing and receiving CMS approval of a combined 1915 (b) 1915 (c) waiver or an appropriate State Plan Amendment
- Formalizing and expanding provider networks and covered services to encompass additional services such as physician care, nursing home services, home health, hospice, pharmacy, etc. and ensure increased access to needed care
- Upgrading and expanding information technology systems for network providers to allow real time data sharing and to ensure patients receive appropriate care for optimal outcomes as well as providing tools with which to monitor and evaluate the program
- Establishing additional quality standards and data collection tools to will measure outcomes and identify cost savings
- Designing a shared savings reimbursement methodology with incentives for meeting quality standards

[2] Each SOURCE program includes a credentialed panel CCSP providers
[3] Section 2703 of PPACA

- Adapting care management practices to include other LTC populations and to reflect the changing needs of members as they move within the system

Integration of the PCHH SOURCE Proposed Model with DCH Goals and Strategies

The recommendation of the Navigant report is **Georgia Families Plus – which expands upon the existing Georgia Families program by enrolling all categories of Medicaid members in Georgia Families Plus health plans** by encouraging use of medical homes, e.g., through Patient Centered Medical Homes (PCMHs), reducing administrative complexities and burdens for providers and members, increasing focus on health and wellness programs and preventive medicine, continuing to build upon current efforts to focus on quality, and carving in more services (such as transportation) and populations (such as people who are aged, blind and disabled).[4]

GHCA sees the SOURCE Option for Care Management of the ABD Population as enfolding Navigant's recommendations, as well of the Georgia's Department of Community Health (DCH) goals for the Georgia Medicaid program. They are addressed by the following:

- **Enhance appropriate use of services by members** - the patient assessment instruments have applicability across service types. They are also prescriptive with respect to the services the patient will likely require. SOURCE protocols also currently emphasize supporting rather than supplanting informal caregivers.
- **Achieve long-term sustainable savings in services** - SOURCE programs have a demonstrated track record of reducing costs through reduced utilization of nursing home services, reduced inappropriate hospitalizations, reduced inappropriate Emergency Room use, and reduced poly pharmacy. Proactive care management will enhance these results and expand them to additional beneficiaries.
- **Improve health care outcomes for members** – previous bullet speaks to this, as well.

To achieve these goals, DCH identified the below strategies that must be employed through the redesign. Included are the PCHH SOURCE strategies that are appropriately aligned:

- **Gain administrative efficiencies to become a more attractive payer for providers** – more effective information technology should improve payment, information gathering, and reporting.
- **Ensure timely and appropriate access to care for members within a reasonable geographic area** – SOURCE currently utilizes a wide array of existing community based services available throughout the state. Enhanced information technology will improve communication throughout that network.
- **Ensure operational feasibility from a fiscal and administrative oversight perspective** – already in place are *PCHH-like* services coordinating an individual's care across multiple providers and suppliers.

[4] Navigant Ib.id Page 5 Executive Summary

- **Align reimbursement with patient outcomes and quality versus volume of services delivered** - the proposed PCHH strategy is very flexible and lends itself to a number of reimbursement models. It features fee for service reimbursement with enhanced information technology capabilities to track encounters, cost data and outcomes measures, with the intent to transition to a gain share approach to reimbursement and funding that will save the state money and reward providers for improved care.
- **Encourage members to be accountable for their own health and health care with a focus on prevention and wellness** – use of the SOURCE carepath formally incorporates self-care and informal giving (take out dash and make caregiving all one word) capacity whenever possible, for all members.
- **Develop a scalable solution to accommodate potential changes in member populations, as well as potential changes in legislative and regulatory policies** – the flexibility of the proposed model encourages extension to other provider groups with or without an increased level of risk.

The SOURCE Patient Centered Health Home Option provides a unique opportunity for DCH and providers to develop a modern payment system for the most expensive ABD beneficiaries in the Medicaid program. This proposal is for the collection and analysis of utilization and claims data for a 24-month period for those ABD beneficiaries assigned by DCH to this project. In partnership with DCH project providers will establish a payment system and rates that meet DCH's goals of budget predictability and allow for a gain share arrangement between Georgia providers and DCH.