UHS-PRUITT
CORPORATION
*Committed to Caring*

February 21, 2012

Mr. David Cook
Commissioner Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303

Re: Concept Paper

Dear Commissioner Cook:

Thank you for the opportunity to comment upon the Navigant assessment and recommendations regarding Georgia's Medicaid program. Please find attached a concept paper regarding delivery of services to Georgia's Aged, Blind, and Disabled citizens. The concept paper, developed by UHS-Pruitt with input from a number of other stakeholders, presents a Georgia-centric "home grown" alternative to the approaches recommended in the January 17, 2012 Navigant report. We believe this "Peach 1st" option best meets the Department's stated goals and strategies and best serves the needs of Georgia's ABD population.

Importantly, we believe the changes proposed herein can be financially supported with increased FMAP contributions and program savings derived from the model. Sec. 2703 of PPACA, to which our concepts are attached, also includes federal grants to states for implementation and development costs. UHS-Pruitt has in fact already engaged Accenture Consulting to review the proposed technology solution, which they have validated to be an effective methodology, to share data across multiple service providers.

While it is unique to Georgia, Peach 1st is not dissimilar in many ways to North Carolina's recently approved "duals" demonstration. Both programs envision regional networks, physician driven models, which include the dually eligible chronically ill citizens of their respective states. While we are intrigued by the North Carolina model, we believe the Peach 1st model provides greater "no wrong door" access and is more scalable with respect to innovative reimbursement strategies. Essentially, Peach 1st becomes the umbrella for moving toward provider service organizations or accountable care organizations enabling cost sharing and savings.

Thank you for your consideration of this Georgia-centric Peach 1st model as an alternative to the approaches contained in the January 17th Navigant report. Should you have any questions, please do not hesitate to contact me.

With kindest regards, I am

Sincerely,

Neil L. Pruitt, Jr.
Chairman & C.E.O.
UHS-Pruitt Corporation

NLP/ms

Attachment

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# Patient Centered Health Home Model

# Briefing Points: The SOURCE Patient Centered Health Home Model

## Briefing Points: The SOURCE Patient Centered Health Home Model

- Best meets the Department's stated goals and strategies
- Is consistent with current national trends in health policy
- Relies heavily upon credentialed panels of primary care physicians (PCPs)
- Proposes a Patient Centered, Primary Care Physician (PCP) driven Health Home
- Utilizes well researched and broadly used acuity and resource utilization measures
- Utilizes current outcome measures and is scalable to include additional measures
- Has a history of delivering measurable cost savings
- Emphasizes a patient centered, PCP-driven, "no wrong door" access process
- Eschews a "conflict-free" model in favor of a patient centered, PCP-driven model
- Is scalable with respect to a) covered services, b) number and type of covered recipients, c) reimbursement strategies, shared savings options, and d) patient outcomes
- Can be authorized by an amendment to the State Health Plan (SPA) or by a combined 1915(b) and 1915(c) waiver
- Provides a near term solution to required waiver renewal as well as a longer term solution which could later be incorporated into a SPA
- Utilizes existing information technology
- Access is scalable to include web-based technology
- Has the potential for broad provider and advocacy support

# Patient Centered Health Home Model

# Patient Centered Health Home Model

## ABSTRACT

In 2011 Georgia's Department of Community Health (DCH) conducted a comprehensive assessment of its Medicaid programs]. DCH engaged the consulting firm Navigant to identify options for innovative redesign of these programs. The first phase of the project required development of a Design Strategy Report which identifies and assesses potential Medicaid redesign options that can be implemented statewide while meeting DCH's goals for the Georgia Medicaid program:

- Enhance appropriate use of services by members
- Achieve long-term sustainable savings in services
- Improve health care outcomes for members

To achieve these goals, DCH identified the below strategies that must be employed in the redesign:

- Gain administrative efficiencies to become a more attractive payer for providers
- Ensure timely and appropriate access to care for members within a reasonable geographic area
- Ensure operational feasibility from a fiscal and administrative oversight perspective
- Align reimbursement with patient outcomes and quality versus volume of services delivered
- Encourage members to be accountable for their own health and health care with a focus on prevention and wellness
- Develop a scalable solution to accommodate potential changes in member populations, as well as potential changes in legislative and regulatory policies [1]

The report concluded with the following recommendations:

a) Georgia Families Plus – Expands upon the existing Georgia Families program by enrolling all categories of Medicaid members in Georgia Families Plus health plans:
   - Incorporating value-based purchasing
   - Further encouraging use of medical homes, for example, through Patient Centered Medical Homes (PCMHs)
   - Reducing administrative complexities and burdens for providers and members
   - Increasing patient compliance through incentives and disincentives
   - Increasing focus on health and wellness programs and preventive medicine
   - Continuing to build upon current efforts to focus on quality [2]

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[1] Navigant Report to DCH Jan 17, 2012

[2] Navigant Ibid Page 5 Executive Summary

- "Carving in" more services (e.g., transportation) and populations (e.g., people who are aged, blind and disabled)

b) Georgia Families Plus Transitioning to "Commercial Style" Managed Care Program: The ultimate aim of this option is to enroll many of Georgia's Medicaid members in "commercial style" managed care. The report makes note, however, "... that "Commercial style" managed care is not well suited to all Medicaid populations, so *the following populations would not be targeted for enrollment in the commercial model initially: children in foster care; aged, blind and disabled individuals; and dually eligible individuals* would remain in Georgia Families Plus." [Emphasis added] [3]

c) Georgia Families Plus Transitioning to "Commercial Style" Managed Care Program that Requires Inclusion of Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs): The report indicates "...that under this model participating health plans would be required to include ACOs and PCMHs in their provider networks." [4]

The body of this paper proposes an alternate recommendation for managing Georgia's aged, blind and disabled and dually eligible individuals. The proposed strategy addresses the Department's stated goals and strategies, as well as a number of the concerns Navigant raised regarding Georgia's waivered services. It also proposes a scalable pilot project, within the broad proposal, to deploy and evaluate a new information technology upon which to build the proposed Patient Centered Health Home (PCHH).

## The SOURCE Patient Centered Health Home Option

Georgia's current SOURCE program includes many of the components of a model from which to meet the stated goals of the Department and dramatically alter an outdated, fragmented, and underfunded post-acute delivery system. Georgia's current SOURCE program:

- Targets the highest cost, chronically ill individuals in the state
- Utilizes a wide array of existing community based services available throughout the state[5]
- Provides face to face care management in every county of the state
- Relies heavily on physician involvement
- Has experienced care managers operating under state established policies and procedures
- Is regulated and monitored by the State Agency (DCH)
- Provides *PCHH-like* services by coordinating an individual's care across multiple providers and suppliers
- Utilizes nationally recognized, validated, and standardized assessment instruments to determine eligibility, acuity levels, and patient outcomes
- Has a base of approximately 20,000 members
- SOURCE programs have a demonstrated track record of reducing costs through:

[3] Navigant pg 6

[4] Navigant pg 6

[5] Each SOURCE program includes a credentialed panel CCSP provider

- Reduced utilization of nursing home services
- Reduced inappropriate hospitalizations
- Reduced inappropriate Emergency Room use
- Reduced poly pharmacy

From this framework, Georgia could quickly build a "health home" demonstration program consistent with the requirements of CMS's "Patient Centered Health Home" initiative. [6] 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 changes include:

- Modify and receive CMS approval of its current 1915(c) waiver
- Establish additional quality standards and data collection tools
- Expand covered SOURCE services to include some or all of the following:
  - Skilled Nursing Facility (SNF)
  - Home Health
  - Hospice
  - Physician
  - Pharmacy
- Design a system for capturing cost savings and improved quality as a result of implementing the new model
- Design a shared savings reimbursement methodology to distribute incentives to providers for meeting quality standards
- Design a variable care management process which reflects the costs of varying intensities of care management required by members as they move through the delivery system
- Support the deployment of new information technology to monitor and evaluate the program

Advantages of the SOURCE Health Home option are:

- The opportunity for the Department to receive up to $500,000 in program design grants from CMS
- An increase in the State's FMAP to 90% for 8 quarters, only if embedded with a SPA
- An opportunity for the State to utilize some of the enhanced FMAP for design and implementation
- Leveraging the experience of one of its own successful HCBS programs
- The existence of "off the shelf" information technology to monitor and evaluate program compliance and success
- Utilizing a proven "home-grown" program to manage the State's aged, blind and disabled and dually eligible individuals
- Efficiently leveraging the statewide coverage of the current program

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[6] Section 2703 of PPACA

# Program Narrative

## Section One: DCH Goals and Strategies

The Georgia Department of Community Health (DCH) states that its goals for Medicaid re-design are to:

- Enhance appropriate use of services by members
- Achieve long-term sustainable savings in services
- Improve health care outcomes for members

It further states that the following strategies must be included in any proposed re-design option:

- Gain administrative efficiencies to become a more attractive payer for providers
- Ensure timely and appropriate access to care for members within a reasonable geographic area
- Ensure operational feasibility from a fiscal and administrative oversight perspective
- Align reimbursement with patient outcomes and quality versus volume of services delivered
- Encourage members to be accountable for their own health and health care with a focus on prevention and wellness
- Develop a "...scalable solution to accommodate potential changes in member populations, as well as potential changes in legislative and regulatory policies" [7]

## Proposed SOURCE Patient Centered Health Home model

The proposed Patient Centered Health Home (PCHH) Care Management Model will build on and expand the successful SOURCE (Service Options Utilizing Recourses in a Community Environment) Care Management program as outlined below. This program is "home grown" and unique to Georgia. Importantly, it has proven to be an effective and relatively low cost Care Management program. It currently operates from 13 sites across the State providing Care Management services to approximately 20,000 individuals.

The proposed PCHH Care Management Model includes six innovative elements to achieve the goals outlined above. These elements are:

a) Care Management which includes those receiving Skilled Nursing Facility services
b) Varying levels of Care Management, based upon Resource Utilization Groups and case mix indices (CMIs) to reduce care gaps that can occur between levels of acuity and different service settings (see Appendix)
c) A "no wrong door" (NWD) network access process [8]

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7 Navigant Report to DCH Jan 17, 2012

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

d) An information technology solution to permit data sharing in real time across the network and more closely link a comprehensive post-acute spectrum of care and services
e) Acute care partners included in the data sharing agreements
f) The utilization of CMS's "Continuity Assessment Record and Evaluation" (CARE) unified patient assessment tool vs. site specific assessment tools

The program design contemplates aggregating data from a broad array of long term care providers (listed in Section 1.1) contractually required by the Care Management entity, to meet specific quality standards. Acute Care, SNF, Home Health Agency, Pharmacy, and Rehabilitation partners will also be required to share assessment data used to establish patient CMIs with the Care Management entity.

The features of the new PCHH Care Management Model are compared to the current SOURCE program in the table below.

| Care Management Features | Proposed PCHH Care Management Model | Current SOURCE |
|---|---|---|
| Timeliness | • Proactive | • Retrospective |
| Updates on Patient Status | • Real-time, active surveillance utilizing alerts/triggers | • Monthly – face to face meeting |
| Information Sharing | • Automated to care team | • Monthly meeting |
| Staff Productivity | • Significant time savings<br>• Management by exception | • Time consuming manual process to review all patients |
| Criteria-based LOC | • Automated and tracked | • Manual (IT-driven in the pilot) |
| Longitudinal Patient View | • Automated | • Paper-based |
| Population Served | • Aged, Blind, Disabled receiving or at risk of receiving LTC services and those with dual eligibility | • Individuals at risk of institutionalization, aged => 65 categorically eligible for Medicaid |

The proactive Care Management option will be technologically driven and will include the following processes:

1. **Patient Status Change** – based on patient observations documented in the EMR, the new technology solution will utilize rules-based, real time information to alert professional staff of patient status changes. Alerts generated by the new technology will trigger patient re-assessment and will task Assessment Coordinators to update the patient's assessment. The new data will be available to all entities currently engaged in caring for the patient and, when indicated by a change in acuity, additional providers.

2. **Patient Assessment** – the patient assessment will be performed by SNF staff (MDS), HHA staff (OASIS) or, for HCBS, care managers (MDS-HC). These instruments are

reliable, well-validated, produce quantifiable acuity scores (Case Mix Index CMI) and have applicability across care settings. They are also prescriptive with respect to the services the patient will likely require. The proposed design, supported by its technology solution will utilize a rules-based engine, based upon CMI scores, to develop a prioritized task list for Care Managers. The SOURCE PCHH model proposes to develop levels of Care Management Intervention aligned with the CMI scores. For example, a patient presenting at a SNF with a CMI of 1.0 or greater (indicating relatively higher acuity) would be placed in a limited Care Management cohort. Similarly a patient who presents with a CMI of 0.80 or less (relatively lower acuity) would be placed in a more aggressive Care Management cohort and would be evaluated for HCBS rather than long term institutional care. [9]

3. **Care Management Interventions** – the Care Managers would be alerted of the patient referral, and the patient's name and CMI would be generated to their work list. Care managers would then work with the patient and his/her family, the patient's PCP and facility staff to develop the most appropriate array of HCBS.

The proposed information technology will also alert Care Managers of a patient referral to a component of the network. The proposed design, supported by its IT component, envisions varying levels of Care Management as a function of CMI scores Care managers would then work with the patient and his/her family, the patient's PCP, and facility staff to develop the most appropriate array of HCBS (see Appendix).

In addition to supporting the Care Management process, the technology will provide an aggregated view of all relevant clinical, Activities of Daily Living (ADLs), pharmacologic, and rehabilitation data. This information, available to all stakeholders, will reduce fragmentation of care, both within and across providers, increase the quality of service, decrease redundancy of diagnostics and reduce the overall cost of care.

The model proposes to utilize this aggregated longitudinal patient information on a real-time basis to monitor "significant changes in status" during a patient's course of care. Proposed status changes include but will not be limited to evidenced based physical symptom indicators such as edema, shortness of breath, weight loss, and obesity. The model also proposes to monitor psycho-social indicators such as depression, anxiety and/or care giver support indicators. "Alert reports" will identify individuals whose clinical metrics exceed targeted thresholds. The ability to view this real time information and monitor the patient's acuity score is anticipated to dramatically reduce administrative nursing time, improve the timeliness of clinical interventions, prioritize the allocation of resources, and enhance patient-driven flexible levels of Care Management. Exhibit 1 below displays the operation of the proposed PCHH Model and, within the pilot program(s), its supporting technology.

The current SOURCE program does not have the information technology to aggregate data across the continuum of patient care. In lieu of this technology, Care Managers manually develop service plans using a standard set of outcomes (Care Paths) to address each member's

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[9] Use of the unified CARE tool should be considered as an alternative to the site specific tools mentioned above

course of care. Care Paths identify risk factors associated with chronic illness and functional impairments (SOURCE Manual, page I).

Aggregating patient information across service settings and over time, on a real-time basis, offers the most efficient management of resources to monitor status changes. It also facilitates the effective use of a Disease State Management program which decreases cost and increases patient outcomes. This activity can be employed, albeit less efficiently, by all of the programs in the PCHH SOURCE proposal. The information technology proposed for the pilot sites will automate the stratification of patient outcomes at various levels of acuity and from low to high risk of institutionalization, based upon a number of patient metrics including diagnosis. Resources will be escalated according the severity of need. Targeted diagnoses for all of the PCHH SOURCE sites will include Hypertension, Congestive Heart Failure, Obesity and Diabetes.

**Type:** The proposed model is a proactive, patient centered, post-acute, Care Management Model. It is based upon new information technology capable of producing real-time information and generating surveillance, alert, and work list reports for care givers.

**Target Population:** The initial target population(s) is Medicaid/Medicare eligible Aged, Blind and Disabled (ABD) recipients, clinically judged to be at risk of requiring institutional services. The target population resides in virtually every county in the State[10] and represents both a Medicaid only and a "dually eligible" cohort. This population has been selected as a result of its disproportionately high presentation of multiple chronic conditions, high utilization of resources, relatively high cost of care and risk of institutionalization. The majority of the targeted cohort are frail elderly and disabled with multiple co-morbidities and significant deficits in the performance of Activities of Daily Living (ADLs).[11] Importantly, the proposed option is scalable to include larger segments of the ABD population. The SOURCE PCHH is suited to the management of these additional recipients. Their needs, though less acute, are similar to the at risk population and could be added to the program as the Department directs.

**Goals:** The PCHH Care Management Model described herein is anticipated to achieve the following goals:

a) Build upon and strengthens an existing, statewide, provider based post-acute and acute network
b) Implement a Patient Centered Health Home Care Management Model
c) Utilizes a new health information technology (IT) platform which supports proactive management across the continuum
d) Enhances Care Management functions within and across a broad acute and post-acute delivery system
e) Improves care for the proposed patient cohort through real-time active surveillance
f) Utilizes quantifiable and standardized clinical alerts and triggers
g) Reduces costs through proactive Care Management

[10] Map available in Appendix on request

[11] Appendix with detailed outline of recipient demographics provided on request

h) Increases the probability of care delivery at the most appropriate, least restrictive care setting
i) Reduces the cohort's incidence of and length of stay (LOS) in institutional settings

**Services to be Delivered**: Care is currently delivered by a complex and diverse network of individual providers and suppliers representing a broad array of institutional and Home and Community Based Services (HCBS). The SOURCE PCHH model proposes to provide a proactive Care Management Model which will provide Care Management functions and services to the target population. Recipients are receiving or are at risk of receiving care in one or more of the care settings identified in the table below. During the implementation period (first three years), the SOURCE-based PCHH model proposes to expand the current SOURCE Enhanced Care Management program to acute and SNF settings. The proposal anticipates that the existing networks of post-acute providers will grow, thereby expanding choice among and access to care settings.

**Proposed SOURCE PCHH provides care management within and across all elements of the post-acute delivery system**

| State Plan and Medicare Services | Home and Community Based Services[12] |
|---|---|
| • Skilled Nursing Facility (SNF)<br>• Skilled Home Health<br>• Hospice (intra-provider Care Management is required)<br>• Rehabilitation<br>• Pharmacy<br>• Orthotic and Prosthetic Supplies and Services | • Home Delivered Services<br>• Adult Day Health<br>• Congregate and "Home Style" Assisted Living<br>• In Home and Out of Home Respite<br>• Emergency Response<br>• Home Delivered Meals<br>• Enhanced Care Management |

**Reimbursement Strategies:** The proposed PCHH strategy is very flexible and lends itself to a number of reimbursement models. However, the proposal assumes a data collection phase that reimburses providers on a traditional FFS with a shared savings element during the first 12 to 18 months. Thereafter, the proposal contemplates a more value based system which utilizes acuity-adjusted resource utilization. While beyond the scope of this paper, the flexibility of the proposed PCHH model offers opportunities to explore increasing levels of provider risk; for example, bundled episodic payments or at risk value based payments.

**Proposed Partners:** Partners in the proposed project include the SOURCE PCHH model's network of SNFs, Home Health agencies, Hospice agencies, Care Management operations, Pharmacies, Rehabilitation agencies, and Durable Medical Equipment suppliers. Additional partners include organizations providing Acute Care Services, Personal Support, Adult Day Health Care, Home Delivered Services, Alternative Living Service (Assisted Living), Respite

[12] Appendix available upon request for a more detailed description of each

Care, Home-delivered Meals, and Emergency Response (Appendix identifies these partners in more detail).

The current delivery system provides Care Management for only HCBS services. Its ability to manage patients across the post-acute continuum at the appropriate LOC is, however, somewhat limited and ineffective for the following reasons:

a) Lack of Care Management across all service types
b) Retrospective reviews of clinical data between providers
c) Lack of standardization of acuity levels across the continuum
d) Transition care gaps between provider types due to a lack of comprehensive real-time information
e) Lack of consistency in care pathways across the continuum
f) Manual processes that are time-consuming and labor intensive to identify patients requiring Care Management Services

The PCHH SOURCE model proposes to use Care Managers to coordinate, monitor, evaluate and refer services across the entire network. Care Managers will coordinate service delivery with the recipient's Primary Care Physician (PCP) and network partners as long as the patient remains in the network. The proposed pilot will use data currently collected, (but not readily available, between providers), from standardized assessment instruments, MDS, OASIS, and MDS-HC to provide evaluation of outcomes in real-time. ,

**Evidenced-based Program:** The model proposes to build upon and enhance the services provided in the successful SOURCE program to support proactive PCHH Care Management. The technology proposed for the pilot is expected to enhance the overall efficiency of the PCHH model. The technology has been shown to improve Care Manger productivity by 40%. One large post-acute provider reported a 70% decrease in nursing time spent looking for data. These efficiencies are anticipated to create savings with respect to care delivery and increase nursing time spent in direct patient care rather than data collection. Importantly, the proposed PCHH model will utilize the widely recognized, validated and quantified metrics drawn from the instruments listed above to:

a) Establish levels of care
b) Monitor fluctuations in patient acuity
c) Develop quantified thresholds to trigger increases or decreases in the intensity of Care Management and service delivery
d) Identify the most appropriate and cost-effective patient care setting
e) Initiate clinical pathways to resolve emergent problems
f) Monitor patient outcomes
g) Monitor resource use and cost

Accomplishing the objectives and goals discussed above will be highly dependent upon successful implementation of the proposed technology solution. The planned technology will permit Care Mangers and providers, including acute care, SNFs, HHAs, and PCPs to access patient data longitudinally, in real time, and across all elements of the continuum. The technology will facilitate proactive decision-making based on established alerts and triggers.

**Impact on the Target Population:** The SOURCE PCHH model anticipates that proactive intervention will result in:

a) Improved clinical outcomes
b) Better health through early identification of changes in status
c) Improved management of co-morbidities through active surveillance
d) Timely assessments and variable intensity Care Management interventions
e) Decreased utilization of Emergency Department Services
f) Decreased utilization of acute care
g) Enhanced quality of life resulting from receiving services in the least restrictive care setting
h) Increased patient advocacy facilitated by Care Managers who advocate and provide assistance navigating the continuum as the individual's needs change over time
i) Increased communication and greater integration between PCPs and other providers and suppliers delivering care and services

**Impact on Underserved:** Most elements of the service delivery system described in this proposal are available, on a limited basis (excludes duals and patients in the acute and Skilled Nursing Facility settings) in virtually all of Georgia's 159 counties. Most counties have multiple providers of all service types. The broad distribution of providers, statewide availability of at least some degree of Care Management, and the indigent attributes of the proposed target population will ensure that services are available to each community's most needy. The SOURCE PCHH model's proposed "No wrong door" point of entry process coupled with its existing community relationships, nurse liaisons, and community educators virtually guarantees that anyone can find their way to a Care Manager and seek services. Additional web-based access is proposed to increase patient access.

**Understanding of the Needs of the Communities in which the Target Population Resides:** The SOURCE PCHH model has been serving the much of target population for over 10 years. It is well known in the communities it serves and has built strong relationships with each community's health and social service system. These existing relationships will permit relatively rapid implementation of the enhanced PCHH model tailored to each community's existing delivery system(s).

**Demonstrate the Organizational Capacity across all Proposed Participants to Reach the Three-part Aim:** The SOURCE PCHH model is well positioned to achieve the "three-part aim" outlined by the DCH. The existing SOURCE program and the SOURCE PCHH proposal include:

a) A broad set of provider/supplier partners
b) A broad geographic presence
c) Existing panels of Primary Care Physicians
d) Existing Federal and State licensing, monitoring, and payment structures
e) A model of care that includes a number of elements that have been demonstrated to reduce costs, and promote improved health
f) An existing infrastructure capable of implementing the proposed project within 6 to 12 months

The proposal contemplates a self-evaluation and measurement plan based upon quantifiable metrics drawn from recognized data sets. These metrics will provide measures of the effectiveness of the program in meeting the goals of better care, better health and reduced costs. Through this plan, the SOURCE PCHH model will be able to measure performance across a variety of dimensions, compare results to available benchmarks and take timely and appropriate action to adjust practices.

**Measurement Tools and Process:** Existing measurement tools tailored to each LOC will be used to assess program effectiveness and direct improvements. The following metrics are proposed:

- **Better care and reduced costs**
  - Decreased hospital admissions and readmissions
  - Decreased emergency room visits
  - Earlier identification and management of medical problems including patient incidences, wounds and pressure ulcers
  - Increased utilization of community resources such as Home Health and Day Care verses institutional services/institutional length of stay
  - Improved cost savings within the patient cohort
  - Improved patient function/activities of daily living
  - Improved pain management

- **Better health**
  - Improved weight management
  - Improved medication compliance
  - Improved compliance with doctor visits
  - Increased social support (e.g., chaplaincy and social work services)
  - Improved nutrition

**Process Assessment/Measures**

- **Timeliness of:**
  - Care Manager assessments
  - Transitions between LOC
  - Proactive identification of patient status changes
  - Referrals to Care Managers between care settings

- **Patient/family experience**
  - Independently administered patient/family surveys to assess satisfaction with process and results
  - Improved patient/family satisfaction

- **Provider partner and staff satisfaction surveys to assess satisfaction of PCP and other providers is expected to:**
  - Increase PCP satisfaction
  - Increase provider satisfaction
  - Increase staff satisfaction

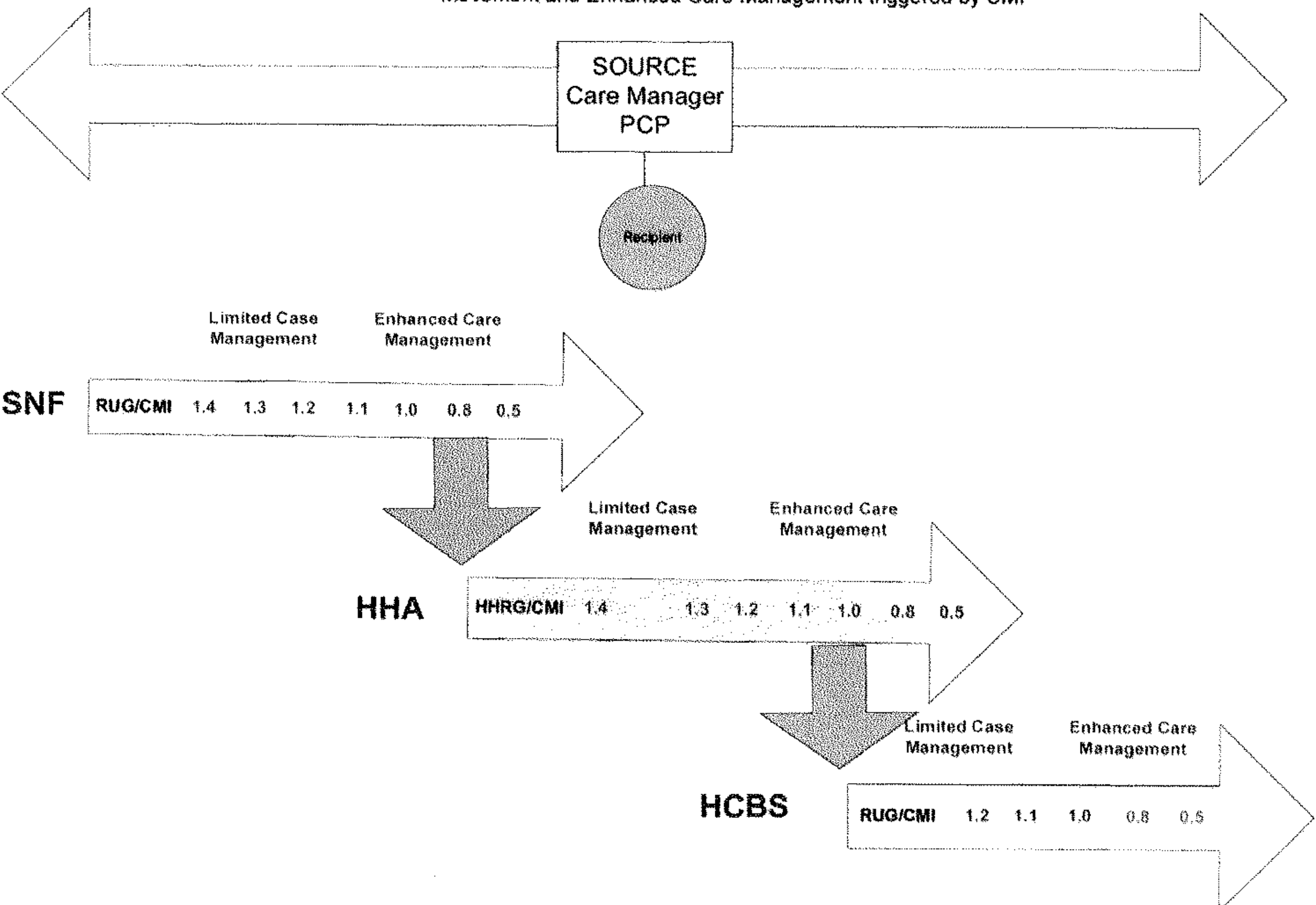
The measurement tools referred to previously are illustrated in the following table:

| Level of Care | Measurement Tool |
|---|---|
| SOURCE (multiple levels of care) | MDS for Home Care (MDS-HC) |
| Home Health Agency | OASIS |
| Nursing Home/Skilled Nursing Facility | MDS |
| Medical Rehabilitation | FIM™ (Functional Independence Measure) |
| Pharmacy | Framework |

Metrics from the measurement tools above will be included in the proposed data aggregation and analysis technology solution. The metrics will be utilized to populate a scorecard (see Appendix X) within the data aggregation and analysis technology. The scorecard will display results, over time, for each measure, and compare to baseline results. The technology has the capability to "drill down" on data from the system level to the individual provider level. Queries also exist for aggregation by geographic region(s), patient, diagnosis, and acuity level (CMI). A variety of visual formats will be utilized for presentation of the results.

# Theoretical Patient movement through the continuum

Movement and Enhanced Care Management triggered by CMI



# Navigant Recommendations Crosswalked to SOURCE
# Patient Centered Health Home Model

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# Patient Centered Health Home Model

| Navigant Recommendations | DCH Goals/Strategic Requirements | SOURCE Alternative |
|---|---|---|
| I Expand Georgia Families Plus | | |
| a) Incorporate Value Based Purchasing | Align reimbursement with patient outcomes and quality | The proposed enhanced SOURCE program envisions a Fee-For-Service (FFS) reimbursement program with a shared savings component. However, the scope of its post acute network (SNF, HHA, HCBS) based on Resource Utilization indices is sufficiently flexible to provide opportunities to bundle payments, structure payments for all service types based upon resource utilization, or in time develop an episodic payment model. |
| b) Encourage the use of Medical Homes | Not a stated goal | Currently operates much like a medical home for members. The proposed enhanced program does, in fact, operate as a member medical home |
| c) Reduce administrative complexities and burdens for providers and members | Developing a program that decreases administrative burden for providers may help to attract more provider anticipation and increase access. | Required routine face to face care management, required involvement of members' PCPs, and care managers acting as system navigators and no wrong door access to SOURCE reduce administrative burdens for members |
| d) Increase patient compliance through incentives and disincentives | Implementing a design strategy that incorporates member responsibility may help to decrease inappropriate utilization, improve outcomes and decrease costs | Required routine face to face care management, required involvement of members' PCPs and proposed CMI triggers all contribute to decreases in inappropriate utilization |
| e) Increase focus on health and wellness programs and preventive medicine | Not a stated goal | Not a stated goal |
| f) Continuing to build upon current efforts to focus on quality | Improving health care outcomes for members is part of DCH's mission for the Medicaid program. Healthier individuals will have more productive lives and may lead to decreased program costs. | SOURCE currently monitors health care outcomes for all members. Disease management for identified chronic conditions, and care pathways are reviewed and modified as required to resolve outliers. The proposed SOURCE program advances this process by linking resource needs, care pathways, Service settings and outcomes to existing quantified assessment instruments (MDS,MDS-HC, OASIS) .This process permits evaluation of outcomes vis a vis nationally recognized outcome measures |

# Navigant Recommendations Crosswalked to SOURCE Patient Centered Health Home Model

| | | |
|---|---|---|
| g) Including more services (such as transportation) and populations (such as people who are aged, blind and disabled) | Given potential implementation of the Affordable Care Act (ACA) and the significant number of new lives Georgia would cover due to Medicaid expansion, the design strategy must be able to accommodate new membership | The current SOURCE program is available statewide. The proposed enhanced SOURCE is scalable to additional population cohorts including "Dually Eligible" Medical Assistance Only, and SNF and HHA populations. In effect the program could manage the entire chronically ill LTC population from SNFs to HCB Services |

| 2 Georgia Families Plus Transitioning to "Commercial Style" Managed Care Program | | |
|---|---|---|
| The ultimate aim under this option is to enroll many of Georgia's Medicaid<br>Members in "commercial style" managed care. | Given potential implementation of the Affordable Care Act (ACA) and the significant number of new lives Georgia would cover due to Medicaid expansion, the design strategy must be able to accommodate new membership | The current SOURCE program is available statewide. The proposed enhanced SOURCE is scalable to additional population cohorts including "Dually Eligible" Medical Assistance Only, and SNF and HHA populations. In effect the program could manage the entire chronically ill LTC population from SNFs to HCB Services.<br>""Commercial style" managed care is not well suited to all Medicaid<br>populations, so the following populations would not be targeted for enrollment in the<br>commercial model initially: children in foster care, aged, blind and disabled individuals;<br>and dually eligible individuals would remain in Georgia Families Plus"[1] |
| Commercial plans may incentivize prospective members with copayments, deductibles, Healthy Rewards Accounts (HRAs), incentive payments and prizes and a myriad of other creative strategies not permitted in traditional Medicaid | Enrollment incentives not a stated goal | The current and proposed SOURCE program operates under the auspices of a 1915(c) waiver. The proposed SOURCE program will require at a minimum an amendment to the current waiver. The State Agency could seek to have the prohibition on incentives waived |

[1] Cautionary statement in the Navigant report contained in their recommendation

# Navigant Recommendations Crosswalked to SOURCE
# Patient Centered Health Home Model

| **3 Georgia Families Plus Transitioning to "Commercial Style" Managed Care Program that Requires Inclusion of Accountable Care Organizations (ACOs) and Patient centered Medical Homes (PCMHs)** | | |
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| "... this [option] is the same as the model described above, except that under this model participating health plans would be required to include ACOs and PCMHs in their provider networks." | Medical homes not a stated goal | The current SOURCE model displays most of the attributes of a medical home. It lacks inclusion of some components of the LCI continuum. The proposed enhanced SOURCE program seeks to include the missing components. If approved the enhanced program exhibits virtually all of the elements of a medical home to include: care coordination of services; physician services; disease management ; and collaboration with HCBS provider networks |

# DCH Goals and Strategies Crosswalked to SOURCE Patient Centered Health Home Model

# DCH Goals and Strategies Crosswalked to SOURCE Patient Centered Health Home Model

| Goals | | | | SEC. 2703. |
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| **Goals** | **Weight** | **Rationale** | **SOURCE Provision(s)** | **State Option To Provide Health Homes For Enrollees With Chronic Conditions** |
| 1. Enhance appropriate use of services by members | 33% | Appropriate use of services will decrease Inappropriate utilization, improve outcomes and decrease costs. | Creates a broad based care managed Post acute net work where services are based upon Resource Utilization Groups, (RUGs) and case mix indices, (CMIs) | Health home services' means comprehensive and timely high-quality services described that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team. report to Congress on the nature, extent, and use of such option, particularly as it pertains to hospital admission rates.<br>(ii) chronic disease management;<br>(iii) coordination of care for individuals with chronic conditions;<br>(iv) assessment of program implementation;<br>(v) processes and lessons learned<br>(vi) assessment of quality improvements and clinical outcomes under such option; and<br>(vii) estimates of cost savings. |
| 2. Achieve long-term sustainable savings in services | 33% | Medicaid is one of the most expensive public Programs in Georgia. Given limited budgets in a challenging economy, the State must have a Design Solution that is cost-efficient and has budget predictability. | SOURCE's enhanced and proactive care management has Demonstrated Reduced costs including<br>• Reduced SNF Medicaid days/Yr [1]<br>• Reduced Emergency Department Use<br>• Fewer inappropriate | The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment for the purpose of determining the effect on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities. |

[1] GHCA Statewide Medicaid Utilization of SNF services over time

# DCH Goals and Strategies Crosswalked to SOURCE
# Patient Centered Health Home Model

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| | | | Hospitalizations [2]<br>• Expansion of lower cost HCBS for the Chronically Ill ABD population eligible for SNF Services will increase the scope of services and add a care management element to the LTC delivery system<br><br>SOURCE also manages the scope and volume of HCBS by authorizing services and payments | |
| 3. Improve health care outcomes for members | 34% | Improving health care outcomes for members is part of DCH's mission for the Medicaid program. Healthier individuals will have more productive lives and may lead to decreased program costs. | SOURCE currently monitors health care outcomes for all members. Disease management for identified chronic conditions care pathways are reviewed and modified as required to resolve outliers. The proposed SOURCE program advances this process by linking resource needs, care pathways, Service settings and outcomes to existing quantified assessment instruments, (MDS,MDS-HC, OASIS). This process permits evaluation of outcomes vis a vis nationally recognized outcome measures | Secretary of Health and Human Services shall survey States that have elected the option and report to Congress on the nature, extent, and use of such option, particularly as it pertains to hospital admission rates;<br>(ii) chronic disease management;<br>(iii) coordination of care for individuals with chronic conditions;<br>(iv) assessment of program implementation;<br>(v) processes and lessons learned (as described in subparagraph<br>(vi) assessment of quality improvements and clinical outcomes under such option; and<br>(vii) estimates of cost savings. |

[2] Ga. Department of Audits Report

# DCH Goals and Strategies Crosswalked to SOURCE
# Patient Centered Health Home Model

| Strategic Requirements | | | | |
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| **Strategic Requirement** | **Weight** | **Rationale** | **SOURCE Provision(s)** | |
| 1. Gain administrative efficiencies to become a more attractive payer for providers | 20% | Developing a program that decreases administrative burden for providers may help to attract more provider anticipation and increase access. | The proposed Enhanced SOURCE program utilizes existing, quantified, and validated assessment tools to identify resource needs. The quantified metrics derived from these instruments permit providers and state agencies to monitor/manage admissions/discharges, level of care, costs, and clinical outcomes vis a vis Resource Utilization Groups | The Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. Use of health information technology in providing health home services and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider |
| 2. Ensure timely and appropriate access to care for members within a reasonable geographic area | 20% | Access to care for members will help to improve health outcomes | The Enhanced SOURCE program proposes a No Wrong Door (NWD) – Unified Entry Point, (SOURCE), to enable consumers access to all long-term services and supports through a care managed network and web based portal. Care Managers will provide information regarding the availability services, how to apply for services, referral for services and supports available in the community, and preliminary determinations of financial and functional eligibility for services and supports.[3] | A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers. |

[3] Section 10202 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), titled the State Balancing Incentive Payments Program (hereafter referred to as the Balancing Incentive Program) provides a cross walk from existing assessment tools, (e.g. MDS, OASIS, MDS-HC to a nationally standardized "screening tool" which can be completed by recipients or care givers. Care Managers may administered by telephone

# DCH Goals and Strategies Crosswalked to SOURCE Patient Centered Health Home Model

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| 3. Ensure operational feasibility from a fiscal and administrative oversight perspective | 20% | Given limited budgets in a challenging economy, the State must have a design strategy that is cost-efficient and has budget predictability. Additionally, the design strategy must be one for which DCH can appropriately operate and provide a sufficient level of over sight. | Over sight of the current SOURCE program, its care management and HCBS networks, is already provided by existing DCH and DHR. The proposed enhanced SOURCE program will offer increased administrative efficiencies which result from the electronic integration of MDS, OASIS, and MCS-HC data. The indices produced by these instruments provide standardized criteria to measure appropriate utilization, quality of care, and cost. Importantly much of this data is already collected by DCH | As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information. |
| 4. Align reimbursement with patient outcomes and quality versus volume of services | 18% | Given limited budgets in a challenging economy, the State must have a design strategy that incorporates payment reform so as to be cost-efficient and have budget predictability while also improving outcomes and quality. | The proposed enhanced SOURCE program envisions a Fee-For-Service, (FFS) reimbursement program with a shared savings component. However, the scope of its post acute network, (SNF, HHA, HCBS), based on Resource Utilization indices is sufficiently flexible to provide opportunities to bundle payments, structure payments for all service types based upon resource utilization, or in time develop an episodic payment model. | The State shall specify the methodology the State will use for determining payment. May be tiered to reflect, each eligible individual with chronic conditions as well as the severity or number of each individual's chronic conditions shall not be limited to a per member Per month basis |
| 5. Encourage members to be accountable for their own health and health care with a focus on prevention and wellness | 18% | Implementing a design strategy that incorporates member responsibility may help to decrease inappropriate utilization, improve outcomes and decrease costs. | | Use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider |

## DCH Goals and Strategies Crosswalked to SOURCE Patient Centered Health Home Model

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| 6. Develop a scalable solution to accommodate potential changes in member populations, as well as potential changes in legislative and regulatory policies | 4% | Given potential implementation of the Affordable Care Act (ACA) and the significant number of new lives Georgia would cover due to Medicaid expansion, the design strategy must be able to accommodate new membership. | The SOURCE program and its HCBS network currently provide services for many of the State's most vulnerable and costly ABD cohort. Most current members have long-term chronic illnesses with multiple co-morbidities. The enhanced program, Its reliance upon quantified Resource Utilization Groups, and scope of services (SNF and HCBS) provides the opportunity to accommodate other long-term care cohorts such as the Intellectually/ Developmentally Disabled cohort. Other populations might also be managed by the SOURCE program. However, the design focuses on the chronically ill and disabled | Not addressed except for monitoring and evaluation by the Secretary |