

Testimony on Georgia Families to Georgia General Assembly

Presentation to
Joint Appropriations Subcommittee on Health
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DCH Mission

ACCESS



Access
to affordable,
quality health
care in our
communities

RESPONSIBLE



Responsible
health planning
and use of
health care
resources

HEALTHY



Healthy
behaviors and
improved
health
outcomes

DCH Initiatives

FY 2007 and FY 2008

FY 2007

Medicaid Transformation

Integrity of our Programs & Safety Net

Consumerism

Health Improvement & Resolving Disparities

Uninsured: Community Solutions

FY 2008

Medicaid Transformation

Health Care Consumerism

Financial Integrity

Health Improvement

Solutions for the Uninsured

Medicaid Program Integrity

Workforce Development

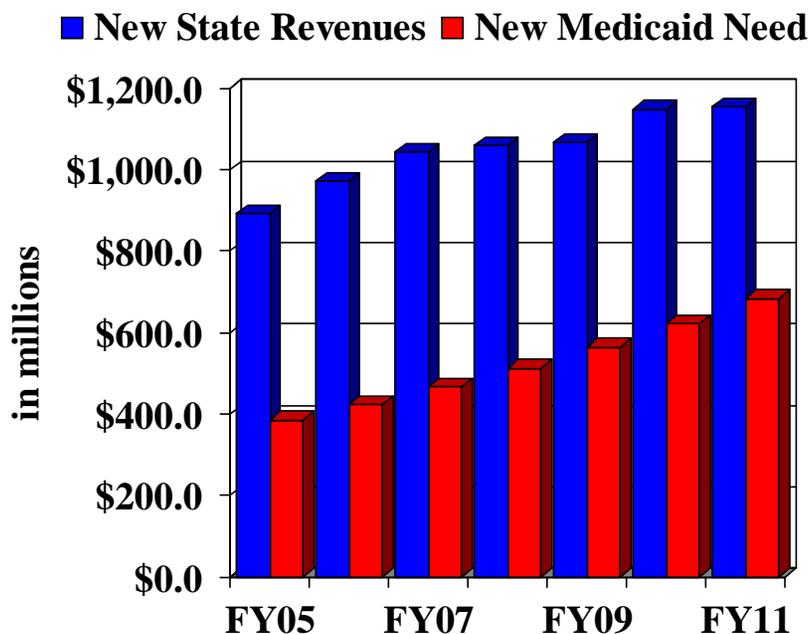
PeachCare for Kids™ Program Stability

SHBP Evolution

Customer Service and Communication



Why Managed Care? Unsustainable Growth



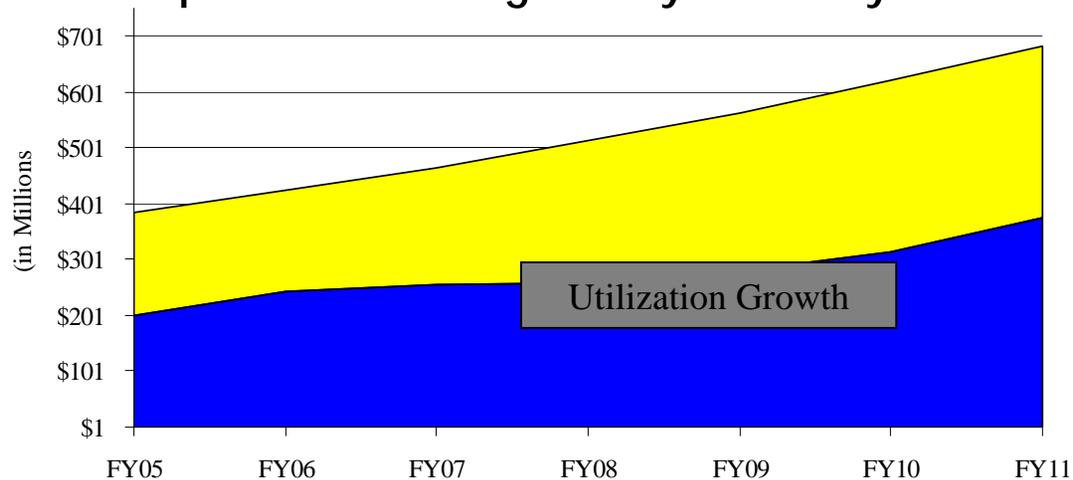
- By FY2008, Medicaid will require over 50 percent of all new state revenue
- By FY2011, Medicaid will require 60 percent of all new state revenue

	FY05	FY06	FY07	FY08	FY09	FY10	FY11
New Revenue (Discretionary)	60%	56%	55%	52%	47%	46%	40%
New Revenue (Medicaid)	43%	44%	45%	48%	53%	54%	60%

Why Managed Care?

Change Requires Utilization Management

Medicaid utilization drives more than 35 percent of total growth year over year



Enrollment & Price Growth

Without Change:

- From FY05 to FY10 utilization is expected to increase in the following major categories of service:
 - Inpatient admissions = 23 percent
 - Physician visits = 42 percent
 - Prescriptions = 30 percent
 - Outpatient hospital visits = 34 percent

Why Managed Care in Georgia?

- Georgia needed a model that:
 - Focused on system-wide performance improvements
 - Organized the fragmented system of care
 - Employed a management of care approach
- National research has shown that:
 - Managed care practices can help control costs
 - Managed care can improve member education and knowledge about how to appropriately use health care
- In addition, a recent study by the Center for Health Care Strategies, Inc. indicates that “states are generally happy with and continue to pursue full-risk managed care...”

Goals of Georgia Families

- Improve health care status of member population
- Establish contractual accountability for access to and quality of health care
- Lower cost through more effective utilization management
- Budget predictability and administrative simplicity



Objectives of Georgia Families

- Improve the health care status of the member populations
- Establish a medical home for members through use of selected/assigned Primary Care Providers (PCP)
- Establish contractual accountability between partners
- Slow the rate of financial expenditures in the Medicaid and PeachCare for Kids™ programs while providing quality care to enrolled members
- Expand and strengthen a sense of member responsibility and compliance that leads to more appropriate utilization of the health care system by members

Georgia Families Achievements

- Achievements in member knowledge and responsibility
- Achievements in members clinical care
- Achievements in overall implementation



Achievements in Member Knowledge and Responsibility

- Members are choosing health plans, often based on added benefits, for the first time
 - Plan choice rates exceed 80 percent
- Members are choosing PCP
 - PCP choice rates exceed 40 percent
- CMO member education activities and materials reinforce healthier lifestyles and lead to a “healthier” population

Achievements in Member Knowledge and Responsibility

- CMO community partnerships with local resources
 - Members are engaged at community events, churches, supermarkets, schools, DFCS offices
- CMO member communication is appropriate for members
 - Part of strengthening member responsibility for their own health care is making sure the information they receive is tailored to their needs and abilities (i.e. visual impaired, reading proficiency, etc.)

Achievements in Member Clinical Care

- CMO implementation of case management (CM) and disease management (DM) programs
 - DM for asthma and diabetes
 - CM for prenatal care, complex cases and developmental delay
- Annual CMO Member Satisfaction surveys
 - Required for National Committee for Quality Assurance (NCQA) accreditation
 - Preliminary results show a high level of satisfaction, particularly with children's services



Achievements in Member Clinical Care

- CMOs addressing Emergency Room (ER) utilization
 - Member outreach: High-volume facilities, CMO calls to members after ER visit, educate about appropriate use of the ER, attempt to reconnect with a PCP, assist with transportation to PCP if needed
 - Network development: Urgent care clinics, working with PCPs to expand evening hours, follow up with PCPs who routinely direct patients to the ER
 - Provider outreach: Outreach to high-volume PCPs who have practice patterns outside of norms (high ER usage, high pharmacy costs)



Overall Implementation Achievements

- Large-scale implementation with many complex interfaces achieved successfully with minimum disruption
 - Derived best practices from other state experiences with Medicaid managed care
 - Collaboration among all partners for implementation
- Ability to objectively substantiate statewide provider network adequacy (both urban and rural)
- DCH and CMO open communication with provider professional associations
- Communication and collaboration with Georgia Department of Insurance (DOI) regarding CMO oversight

CMO Monitoring and Oversight Activities

- CMOs have contractual accountability to DCH for access to and quality of health care
- CMO requirements centered around responsibilities for:
 - Member services and activities
 - Provider networks and provider services, including claims payment
 - Clinical and quality programs
 - Financial solvency and IT capabilities

CMO Monitoring and Oversight Activities

- CMO contractual compliance monitored by:
 - Required report submission
 - 58 different reports (weekly, monthly, quarterly and annually)
 - Accuracy of reports formally attested by CEO, COO or CFO of each CMO
- Interaction between DCH and CMO staff
 - Regular meetings at all staff levels
 - Active on-site monitoring by DCH staff of member and provider service activities

CMO Monitoring and Oversight Activities

- Regular DCH communication and collaboration with DOI
- Regular DCH communication with provider professional associations



CMO Monitoring and Oversight Activities

- DCH Managed Care and Quality Division's role is to monitor performance and oversee the activities of the contractors supporting Georgia Families
- Division organized into the following functional units:
 - Member Services Oversight
 - Provider Services Oversight
 - Quality Oversight
 - Contract Oversight



Members Services Oversight

- CMO Call Center calibration
 - Compliance with contract requirements for call center service levels
 - Speed to answer
 - Abandonment rate
 - Watch for trending and monitor service levels; require corrective action plan if necessary
- CMO Web site monitoring
- Report monitoring and validation
- Review and approve Member outreach and education materials
 - Contractual requirements for reading level
 - Multilingual capabilities
 - Hearing and vision impaired versions

Provider Services Oversight

- **Ongoing:**
 - CMO Provider Service Education and Training Meetings
 - CMO Provider Service Office Visit Meetings
 - Direct Provider Service Georgia Families – Provider Visits
 - CMO Provider Service Related Complaints and Issues
- **Monthly Activities:**
 - CMO Provider Service Call Center reports
 - Onsite CMO Monitoring of Provider Service Call Center Incoming Calls
 - CMO Provider Service and Network Development Meetings
- **Quarterly:**
 - CMO Provider Web Site Monitoring for Provider Communications and Provider Handbooks
 - CMO Appointment Wait Time Reports
 - CMO Provider Services Policy and Procedures

Provider Services Oversight

- CMO Provider Network
 - **Ongoing:**
 - CMO Network Access to Care / Provider Availability
 - CMO Provider Recruitment and Network Development
 - **Monthly:**
 - CMO Provider Listings Reports
 - CMO Provider Open/Close Panel Status
 - CMO PCP Assignment Reports
 - CMO Termination Reports
 - Georgia State Exclusion Listing Report
 - Medicaid ID Number, NPI Numbers, and other Provider Credentials
 - **Quarterly:**
 - CMO GeoAccess Network Reports
 - CMO Signification Traditional Provider Reports

Network Numbers

	Fee-For-Service (Statewide plus border providers)	Amerigroup Community Care (Four regions)	Peach State Health Plan (Three regions)	WellCare of Georgia (Statewide)
Primary Care Provider Locations (including Pediatrics)	1,546	2,235	3,840	3,551
Specialists	18,659	15,744	12,881	17,075
Hospitals	265	105	98	157

Quality Oversight

- Review, analysis and trending of quality reports
- Reports
 - Prior Authorization
 - Utilization Management
 - Patient Safety
 - Early Periodic Screening Diagnosis and Treatment (EPSDT)
 - Quality Oversight Committee
 - Performance Improvement Projects
 - Focus Studies



Quality Oversight

- Audits: compliance with state and federal regulations
 - Site visits: examination of CMO processes
 - Desk review: review of CMO policies and procedures
- Regular meetings to receive updates, address issues, and/or share information with:
 - CMOs
 - Professional societies
 - Sister agencies
 - National/Federal organizations
 - Other State Medicaid Quality Departments

CMO Contract Management Oversight

- Contract Management is responsible for:
 - Coordinating communication between Georgia Families contractors and other DCH divisions
 - Establishing a consistent process for the distribution and receipt of contract deliverables, such as required reporting
 - Monitoring contractors' compliance with State and Federal law
 - Developing and maintaining a process to assess and track contractor performance against regulatory requirements and contractual performance standards
 - Responding to issues or concerns from DCH and contractors
 - Communicating corrective actions and liquidated damages



Claims and Financial Oversight

- DCH Managed Care Division monitors CMO claims payments to providers, as well as their financial performance and stability through the following:
 - Monthly claims reports to DCH
 - Includes timeliness of payment, claims denial rates, reasons for claims denials and money paid to providers
 - Biweekly conference calls between DCH and each CMO
 - Discussion centers around issues brought by providers, as well as CMO performance in claims timeliness and loading of new providers
 - Monthly CMO performance report card submitted to Board of Community Health's Care Management Committee
 - Includes performance in claims payment, utilization management and customer service
 - Independent claims audit, with input from DOI

Claims and Financial Oversight

- Quarterly claims reports to DOI documenting compliance with Georgia's prompt payment law
- Monthly reports to DCH detailing amount paid by each CMO for medical services by type of service and percentage of revenue
- CMO quarterly and annual financial statements



CMO Claims Summary

- Claims Received by CMOs from Providers 18,608,199
- Claims Paid by CMOs to Providers 16,238,750
- Total \$ Paid by CMOs to providers \$1.7 billion
- Clean claims adjudicated within 15 working days 98.7%
- Average Days to adjudicate a clean claim
 - June - December 2006: 7.3 days
 - January – June 2007: 5.6 days

Managed Care – Clinical & Quality Monitoring



Managed Care Goals

- Improve health care status of member population
- Lower cost through more effective utilization management



Health Care Status

- Georgia currently ranks below mean on many national indicators of health outcome (2004 data – not Medicaid specific)
 - Infant mortality 8.5/1000 44th
 - Low birth weight 9.3% - 44th
 - Pre term births 12.8% - 32nd
 - Pre natal care 84% 26th



Health Care Services

Measure	GA FY06 (prior to managed care)	HEDIS 50 th percentile	HEDIS 75 th percentile	HEDIS 95 th percentile
Well Child Visits	48%	50%	59%	69%
Adult preventive care	79%	79%	84%	87%
Asthma treatment	88%	87%	89%	92%
Diabetes Treatment	65%	77%	85%	89%

Quality of Care Measurement

- Many standard clinical measures are based on 12 months of claim or encounter data
 - Based on statewide CMO implementation of October 2006, and claim lag, expect to see initial data on these measures in early 2008
 - Evaluation of other states implementing managed Medicaid indicates:
 - First year generally viewed baseline
 - Improvement is not usually seen for three to five years



Program Design

- CMOs are required to provide services that are currently covered by Medicaid
- No current benefits have been eliminated
- CMOs are expected to manage utilization and to authorize medically necessary care
- CMOs are expected to promote increased access to and utilization of primary and preventive care
- CMOs will develop case and disease management programs to improve the coordination of care for special populations such as asthma, diabetes, kidney disease, pregnancy



Contractual Requirements Utilization Management

- CMOs shall require prior authorization for non-emergent and non-urgent inpatient admissions except for normal newborn deliveries
- CMOs shall not require prior authorization for emergency services, post-stabilization services, or urgent care services
- CMOs may determine whether or not to require prior authorization for all other services
- For services that require prior authorization CMOs must make determination with 14 calendar days (24 hours for expedited requests)



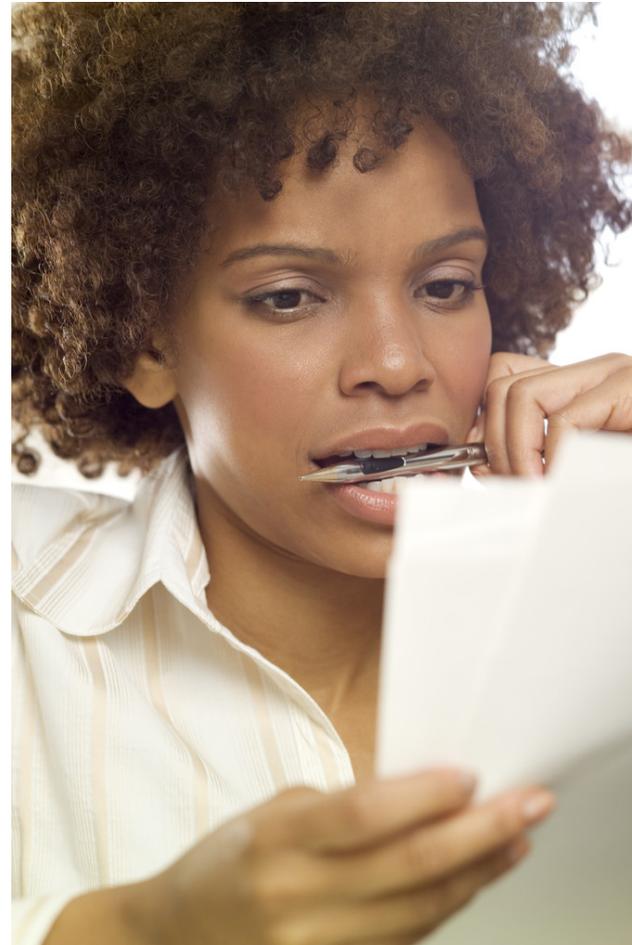
Utilization Management

- Prior authorization process includes review of the medical necessity of care
 - Appropriate and consistent with the diagnosis of the provider and omission could adversely affect health condition
 - Compatible with standards of acceptable medical practice
 - Provide in safe, appropriate, and cost-effective environment
 - Not provided solely for convenience
 - Not primarily custodial, unless custodial care is a covered benefit
- Decisions that care is not medically necessary are made by a physician



Oversight of Utilization Management

- Review of CMO reports on:
 - Prior authorization
 - Utilization trends
- CMO record audits
 - Prior authorization files
 - Denial files
- Member & Provider complaints



Denials & Appeals

- CMOs are required to follow federal guidelines related to a denial of requested services (Proposed Action)
- Member allowed to appeal determination for review by another CMO physician
- If determination is upheld, member can appeal for a hearing with an Administrative Law Judge



Contractual Requirements Disease Management

- Disease Management
 - Asthma
 - Diabetes
 - At least two from the following:
 - Perinatal case management
 - Obesity
 - Hypertension
 - Sickle cell
 - HIV/AIDS



Contractual Requirements Case Management

Targeted Case Management

- CMOs required to provide Targeted Case Management to:
 - Infants and toddlers with established risk for developmental delay
 - Pregnant women under age 21 and other pregnant women at risk for adverse outcomes
 - Children with positive blood lead test equal to or greater than 10 micrograms per deciliter



Disease Management

- **Disease Management**- a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.
Disease Management:
 - Supports the physician or practitioner/patient relationship and plan of care;
 - Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and
 - Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.



Case Management

- Case Management- method to coordinate diverse elements involved in the delivery of healthcare to the individual.
- CMO Case management system to ensure:
 - Timely access and delivery of health care and services required by Members;
 - Continuity of Members' care; and
 - Coordination and integration of Members' care.



Care Coordination

- **Discharge Planning**- begins at the time of admission, with input from all stakeholders (e.g., patient, family, physician, primary care nurse). A discharge plan should include information relating to:
 - Care coordination among the various case managers
 - Involvement of ancillary services (e.g., physical therapy) after discharge and home healthcare /therapy plan or follow-up counseling
 - Expected discharge date
 - Goals to be met before discharge
 - Specific instructions (e.g., equipment use, preventive measures)
 - Specifics regarding follow-up plans with the primary care provider



Emergency Room Utilization

- All three CMOs have programs in place to reduce the non-emergent utilization of emergency room and promote medical home
- DCH has required that all CMOs conduct a performance improvement project addressing unnecessary use of emergency rooms



Emergency Room Utilization

- Interventions include:
 - Identification of high utilizers for on-going case management
 - Member outreach & case management
 - Identification of barriers
 - Member education
 - Nurse lines
 - Pharmacy lock-in program
 - Network development
 - Work with PCPs that have panels with high utilization
 - Expand access to urgent care



Preventable Hospitalizations

- Focus on conditions such as:
 - Asthma
 - Diabetes
 - Low birth weights
 - Re-admissions
- Interventions include:
 - Disease Management programs for asthma and diabetes
 - Perinatal case management programs
 - Discharge planning and case management



Asthma Initiatives

The overall goals of the CMO Asthma Disease Management Programs incorporate the goals of Healthy People 2010 and include:

- Enhance member knowledge about their asthma and medications thereby improving quality of life for the member
- Increase preventive service utilization
- Decrease asthma-related ER visits
- Decrease asthma-related hospital stays



CMO Asthma Disease Management Programs

Interventions/Activities

- telephonic contact to assess severity of asthma
- mailed newsletters and educational material that encompasses asthma information
- access to 24 hour nurse-call for general questions and assistance with identifying when to go to ER/urgent care



Contractual Requirements Quality Improvement

- Quality Assessment Performance Improvement Program
 - Monitor, analyze, and improve the delivery of health care to all members
 - Interdisciplinary oversight committee
 - Input from network providers and members
- Attain accreditation by NCQA or URAC within three years

Contractual Requirements Quality Improvement

- CMOs have internal quality improvement programs that monitor both clinical care and service
- Each CMO is required to conduct annual performance improvement projects
 - five clinical
 - three non-clinical



Contractual Requirements Performance Improvement Projects

Clinical Performance Improvement Projects include:

Required (all of the following):

- Health Check screens
- Immunizations
- Blood level screens
- Detection of chronic kidney disease

Optional – one of the following:

- Coordination/continuity of care
- Chronic care management
- High volume conditions
- High risk conditions



Contractual Requirements Performance Improvement Projects

- Non – Clinical Performance Improvement Projects
 - Required (all of the following):
 - Member satisfaction
 - Provider satisfaction
 - Optional (one of the following):
 - Cultural competence
 - Appeals/Grievances/Provider complaints
 - Access/service capacity
 - Appointment availability



Measurement

- DCH will utilize data provided by CMOs, as well as analysis of encounter data to monitor clinical services and quality of care
- Standard measures will be utilized to the extent possible to allow for comparisons with national or regional data
 - CMS required data
 - HEDIS data

Measurement

DCH will also rely on utilization data as proxy for clinical outcome measures



- Utilization Measures
 - ER admissions/1000
 - Asthma ER admissions/1000
 - Hospital admissions/1000
 - Mental health admissions/1000
 - Readmissions within seven and 30 days
 - NICU admits/1000
 - NICU days/1000

Measurement

- Preventive Health Indicators
 - Health Check/ Well child visits (15 months)
 - Well care visits children & adolescents
 - Access to preventive & ambulatory care children & adults
 - Childhood immunization status
 - Blood lead screening
 - Timeliness of pre natal and post natal care



Measurement

- Provision of Clinical Care
 - Use of appropriate medications for asthma patients
 - Appropriate clinical screening for diabetic patients
 - HbA1c
 - Serum cholesterol levels
 - Retinal eye exams
 - Follow-up after hospitalization of mental health patients