STATE OF GEORGIA DEPARTMENT OF COMMUNITY HEALTH

REQUEST FOR INFORMATION

INTRODUCTION

The Department of Community Health (DCH) was created in 1999 to serve as the lead agency for health care planning and purchasing issues in the State. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning, and regulating health care in response to growing concerns about fragmentation of health care delivery at the state level and failure to leverage the State's bulk purchasing power.

DCH is designated as the single state agency for Medicaid and also administers the PeachCare for Kids program (PeachCare), Georgia's State Children's Health Insurance Program (SCHIP). ¹ In 2002, the State served roughly 1.2 million Medicaid and PeachCare enrollees and spent \$4.6 billion (total funds) providing a wide range of benefits to those enrollees. The State provides acute health care services to its Medicaid and PeachCare enrollees primarily through its Primary Care Case Management (PCCM) service delivery system known as the Georgia Better Health Care (GBHC) program. The State also offers home and community based services under the authority of Section 1915(c) waivers for the elderly and, the physically disabled, as well as for those individuals with mental retardation and/or developmental disabilities. In addition, the program supports a wide array of mental health benefits to its enrollees.

DCH has four divisions: Health Planning; Public Employee Health Benefits; Medical Assistance; and Managed Care and Quality, as well as the Offices of Women's Health, Minority Health and Rural Health Services. In the first years of DCH's existence, the Commissioner and staff from the Division of Medical Assistance (DMA) engaged in an analysis of the Medicaid program and began to implement strategies to slow the rate of growth in healthcare costs while continuing to work towards expanding access to high quality care for Medicaid and PeachCare enrollees. The State contracted with a Pharmacy Benefits Manager (PBM) to help manage pharmacy access and costs, implemented new Third Party Liability collection strategies, increased its focus on the GBHC program and implemented new prior authorization procedures for certain services. DCH also engaged the services of The MEDSTAT Group (MEDSTAT) to provide a detailed analysis of the Medicaid program, and provide decision support to program management.

Even with many of these short-term strategies in place, Georgia, like many states, has continued to experience a slow-down in its economy, an increase in the number of people eligible for its public health programs, and a growing budget deficit. In order to stay proactive regarding these issues, staff from DCH, the Department of Human Resources (DHR), the Governor's Office and the Office of Planning and Budget (OPB) met extensively throughout 2001and 2002 to thoroughly analyze the Medicaid program,

¹ PeachCare is organized under Title XXI of the Social Security Act but "looks like" Medicaid except for features that will be noted in this document.

its problems, its challenges and its primary cost drivers, as well as opportunities to achieve three key goals:

- Slowing the rate of growth in areas of the program that are within the State's control:
- Creating budget predictability; and
- Increasing the effectiveness and quality of the healthcare being purchased on behalf of the program's enrollees.

The group further identified guiding principles to help them and others assess options for both short and long term programmatic changes. These principles include:

- Keeping people as healthy as possible for as long as possible;
- Providing services in the setting most appropriate to meet an individual's needs in the most cost-effective manner;
- Eliminating health disparities within the population;
- Coordinating the delivery of healthcare;
- Determining desirable outcomes and rewarding providers for meeting or exceeding standards of care; and
- Assuring that short-term options do not negatively impact the State's ability to institute wider-range and long-term options.

As 2002 drew to a close, the group concluded that the time was right to cast a broader net for creative strategies to address the State's concerns and help further its long-range goals. Although the State has invested well in its health care infrastructure and, by managing its resources wisely, has avoided some of the more drastic reductions in provider payments, services, and eligibility that have occurred in other states, it now desires to seek the counsel and creativity of a wide array of individuals and companies engaged in the management of health care in order to develop a more comprehensively coordinated service delivery system.

STATEMENT OF PURPOSE

DCH, through this RFI, is seeking ideas and design proposals that will weave the components of its existing programs into a comprehensive, coordinated system of care designed to ensure enrollees have timely access to high quality, medically necessary health care that is cost-effective and efficient. Ideally, this system of care would address the State's goals, be consistent with the guiding principles and include the following features:

- Care management for all enrolled members;
- An easily accessible point of entry for all Medicaid beneficiaries and PeachCare members regardless of the type of eligibility or level of service need;²

² Respondents to the RFI should be aware of responsibilities vested in the Division of Mental Health, Developmental Disabilities and Addictive Diseases, codified in O.C.G.A. 32-1-2 and to the Division of Aging, codified in O.C.G.A. 49-6-60-49-6-64. While these responsibilities do not supersede Medicaid's requirement for a single state agency accountable for Medicaid services, they indicate an intention on the part of the Georgia legislature to hold these two Divisions accountable for the appropriate coordination of state-funded services and the cost-effective delivery of those services.

- A streamlined, more efficient and cost-effective eligibility determination process;
- Better coordination of services across traditionally fragmented systems of care (acute, behavioral health, long term care);
- Incorporation of the best elements of the State's existing infrastructure;
- Incentives throughout the system for the appropriate management of all services;
- Program and provider accountability obtained through a quality improvement program;
- Care delivery in the most appropriate setting; and
- A reduced rate of growth in costs.

This RFI will describe in some detail the various aspects of the programs in place in the State today and will raise a series of questions that DCH would like respondents to address. Once DCH has garnered the best ideas from across the country, it will develop a proposed model for Medicaid reform, which it will then present to a variety of stakeholders throughout the State to build consensus on an approach that best fits Georgia's demographics, program needs, and the members it serves. With that consensus, DCH will acquire the necessary waiver approval and release a Request for Proposals (RFP) to identify the vendor or vendors that can best assist DCH in managing its system of care.

GEORGIA DEMOGRAPHICS

Georgia is the largest state east of the Mississippi River and the 24th largest state in the country. In 2000, there were 8.2 million people living in Georgia, an increase of 26.4% from 1990. This makes Georgia the 10th most populous state in the country and state officials project a population of 9.2 million people by 2010. There are 159 counties in Georgia; of these, 151 experienced population growth during the period 1990-2000.

County population density ranges dramatically from almost a million people living in urban Fulton County, site of Atlanta, to 2,077 in rural Taliaferro County. There are 32 counties with populations under 10,000 and eight counties that have fewer than 5,000 residents. Slightly more than 47% of Georgia's cities had populations under 1,000.

According to the 2000 census, 29.5% of Georgians were age 19 or younger, which is above the national average of 28.6%. Nine point six percent (9.6%) of the state's population was 65 or older compared with 12.4% nationally. The 2000 census also indicated that 65.1% of Georgians were white, 28.7% were black or African-American, and 2.1% were Asian. Hispanics, who may be listed as black or white in the census data, accounted for 5.3% of Georgia's population.

Data from the American Medical Association states that Georgia had 238 physicians per 100,000 population in 1998 compared to the national average of 288 per 100,000. However, like many states that are heavily rural, the distribution of physicians is not consistent throughout the state.

Georgia has a significant economy and in 1999, Georgia's gross state product was approximately \$276 billion, ranking only below Florida in the southeastern region. Much of the economy is fueled by Atlanta's draw as an economic engine and the fourteen Fortune 500 companies and five large non-profit organizations located in Georgia. There are also 10 international banks and 1,600 international firms representing 39 countries operating in Georgia.

In 2000, service sector employment accounted for about 25.6% of the state's jobs followed by retail with about 18.4% and government with about 15.2%. Agriculture also plays a major role in the state's economy and the value of receipts for Georgia commodities total \$5 billion in 2000.

While the state's per capita income is below the national average, it has been increasing. In 1999, the state's per capita income was \$27,324 compared with the national average of \$28,546 and \$25,743 for the southeastern region. Unemployment reached a five year low of 3.7% in 2001. However, in 2002 the unemployment rate jumped to 4.4% and is currently 4.7%.

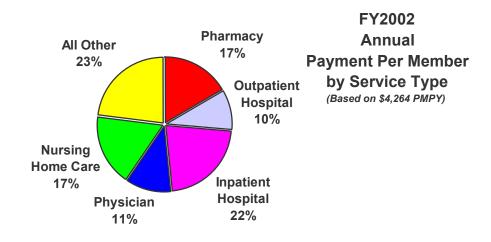
There are eleven urban public transit systems operating throughout the state, in Albany, Athens, Atlanta, Augusta, Cobb County, Columbus, Douglas County, Gwinnett County, Macon, and Savannah. There are 261 airports statewide with 39% of those open to the public. Several of the numbered airports are on one of the twelve military bases that operate in the State.

As evidenced above, the State is diverse. Plans for managing the health care for its Medicaid and PeachCare populations must recognize and be sensitive to this diversity.

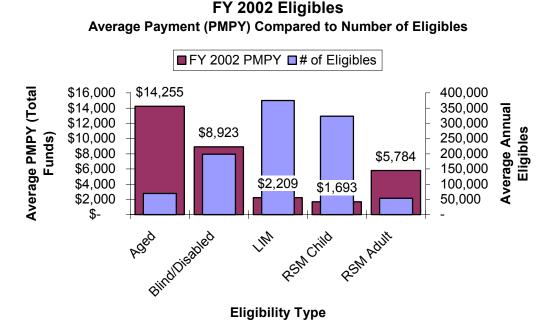
AN OVERVIEW OF THE MEDICAID AND PEACHCARE FOR KIDS PROGRAMS

A Financial Snapshot of the Medicaid Program

The State of Georgia's Medicaid program served over 1.2 million enrollees in 2002 and spent approximately \$4.6 billion providing a wide range of benefits to those enrollees. The distribution of expenditures by service type is presented below.



As shown in the following graph, the average payment per year for the Aged, followed by the Blind/Disabled, is significantly higher than the average payment per year for Low-Income Medicaid (LIM) and Right from the Start (RSM) program enrollees. The Aged, Blind, and Disabled (ABD) account for 21.6% of the recipient population and 61.4% of total program expenditures.



Currently, Medicaid expenditures in Georgia are increasing at a faster rate than State revenues. Despite this, the growth in expenditures is actually better than what other states in the Southern Legislative Conference (SLC)³ of the Council of State Governments have been experiencing. According to the "Comparative Data Report on Medicaid", Federal Fiscal Year 2001 represented the second year of double digit increases in total Medicaid spending for the 16 SLC states. But in Federal Fiscal Year 2001, payments per recipient for Georgia were the second lowest in the SLC and Georgia was one of only six states in the SLC with a decrease in payments per recipient in 2001 relative to 1995, once adjustments for inflation are applied.

In an effort to begin to curb the double-digit increases in Medicaid expenditures, occurring within Georgia, DCH undertook several initiatives in order to identify cost drivers. As a part of this initiative, DCH and MEDSTAT completed an analysis of the major cost drivers in the Medicaid program (See Attachment 1), and found that cost trends for fiscal year 2002 in Georgia exceeded the national average. Depending on which national report one references, the national trend was between 12.8% and 13.3% while Georgia's was 16%. MEDSTAT identified at least three basic reasons for this difference.

³ Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

- Revenue maximization and waiver expansions
 During fiscal year 2001, the State entered into a series of federal revenue
 maximization strategies to draw down federal financial participation for programs
 already operating with state-only dollars. Therefore, while federal expenditures
 increased, they did not require a commensurate increase in state funding to
 support the program.
- Increased provider rates
 In fiscal year 2002, while other states were continuing to freeze or cut provider reimbursement, Georgia continued to provide small reimbursement increases to its providers.
- Slow economic growth
 The economic slowdown, particularly in the information technology, transportation, and service industries, hit Georgia particularly hard since so much of its economy is based on these industries. This slowdown increased the number of individuals eligible for Medicaid, particularly in the LIM category.

Table 1 summarizes increases in Georgia's Medicaid expenditures for fiscal year 2001 and 2002:

Table 1: Payment per Member Cost Trend

Type of Service	FY01	FY02
Inpatient Hospital	6.8%	5.2%
Prescription Drugs	14.0%	9.1%
Nursing Home	0.0%	(0.7%)
Physician	3.5%	8.4%
Outpatient Hospital	4.7%	10.3%
All Other Services	13.7%	17.9%
Total	7.0%	8.4%

Includes Cross-over claims. PeachCare excluded.

As shown above, in fiscal year 2002, payments per member grew 8.4% over fiscal year 2001. Of all the major categories of service, "other services" and outpatient hospital services showed the largest increases in cost. A more detailed discussion of the cost-drivers can be found in Attachment 1.

As a part of the cost-driver analysis, MEDSTAT also completed a variance analysis to quantify the independent contributions of enrollment and category of service to increases in expenditures.

Enrollment was the Largest Cost Driver
 Average enrollment grew by 7% over fiscal year 2001. Slight declines in the
 ABD category were more than offset by increases in RSM and LIM enrollment.
 MEDSTAT concluded that increases in RSM and LIM enrollment over the course
 of fiscal year 2002 paralleled the rising Georgia unemployment rate. Despite the
 decline in ABD enrollment, the ABD accounted for 60.8% of total Medicaid
 spending in fiscal year 2002.

DHR-Funded Programs account for approximately \$135 million in costs
 The increase in Medicaid services funded by DHR⁴ reflects a shift of services that were previously funded with state-only dollars into Medicaid.

• Cost and Utilization

As shown in Table 2, utilization and cost per service contributions to fiscal year 2002 cost increases were almost equal.

Table 2: Cost and Utilization Trends

Type of Service	Utilization	Cost per Service
Inpatient Hospital	3.3%	2.4%
Prescription Drugs	3.5%	5.5%
Nursing Home	1.7%	6.7%
Physician	8.2%	2.0%
Outpatient Hospital	6.7%	5.7%

Other areas of large cost increases identified by MEDSTAT include emergency room utilization, high-cost recipients and mental health.

• Emergency Room (ER)

ER services per 1,000 enrollees increased by 13% and allowed charges per ER visit rose by 12%. Though ER accounted for 17% of all outpatient hospital charges, three quarters of the Medicaid population did not use the ER at all in 2002, while five percent of ER users accounted for 42% of the visits. More than a quarter of the ER visits occur during physician office hours (defined as 8 a.m. to 5 p.m.).

DCH has noticed an increase in the inappropriate use of ER services as a result of the "prudent layperson" standard incorporated in the Balanced Budget Act of 1997. However, the number of ER visits that occur during regular physician office hours suggests that there are still too many Medicaid enrollees who are either not utilizing their primary care physician or who are not clear about how to secure treatment for acute conditions.

High-Cost Recipients

The top 300 high-cost enrollees cost DCH an average of \$210,000 a year. Sixty-three percent of these cases were neonates. Of the nearly 58,000 other high-cost cases, the average cost is \$31,894 per year. Eighty-four percent of these cases are in the ABD category and the top cost conditions include mental retardation, chronic renal disease and respiratory illnesses. A significant portion of the costs for the ABD group are driven by the costs of residential and long term care services. An additional part of the problem may lie in the lack of case management for high-cost and/or chronic medical conditions.

Prescription Drugs

Prescription drugs are still a major cost driver for the State, despite the significant gains made in conjunction with PBM. There has been a marked decrease in the

⁴ Mental health case management, community mental health services, residential therapy services, child intervention, community care service plan waiver, MR waiver services, among others.

trend rate over the last two years with a 26% decrease in fiscal year 2000, a 22% decrease in fiscal year 2001, and an estimated 17% decrease in 2002. The payment per member compared favorably to the fiscal year 2001 trend of 14.9% while the payment per script grew at the rate of CPI-Rx or 5.4%. Manufacturers' rebates increased to \$155 million up from \$139 million in fiscal year 2001. The MEDSTAT report also quantified the impact of "trendy" drugs on pharmacy cost increases. Ten popular drugs, alone, accounted for 20% of drug expenditures in 2002.

Eligibility for Medicaid and PeachCare

Regardless by which "door" individuals choose to enter to access Medicaid services, eligibility determinations are performed either by workers at the Division of Family and Children's Services (DFCS) or, for those on Social Supplemental Income (SSI), by workers at the Social Security Administration. For those seeking access to one of the State's waiver programs, functional assessments are performed elsewhere (described under each waiver program) but basic financial eligibility is still determined by DFCS.

PeachCare applications are handled through the mail or over the Internet and applicants are not required to have a face-to-face eligibility determination. A contracted vendor determines eligibility for PeachCare. Once determined eligible for PeachCare, an ID card and member handbook are sent to the enrollee.

Like all Medicaid programs, there are special features and nomenclature that are particular to Medicaid eligibility in Georgia.

The following are the basic eligibility groups:

- Presumptive eligibility is offered to pregnant women with incomes up to 235% of the Federal Poverty Level (FPL). The presumptive eligibility determination is made by a qualified Medicaid provider and is available until DFCS renders a decision on ongoing eligibility.
- Pregnant women and their infants up to age one with family incomes below 235% of the FPL are covered as a part of the RSM program. Coverage between 185% and 235% of the FPL is provided as a state option.
- Other infants up to age one with family incomes between 185% and 235% of the FPL are covered under PeachCare.
- Children between the ages of 1 and 5 with family incomes up to 133% of FPL and children between the ages of 6 and 19 with family incomes up to 100% of FPL are covered under Medicaid. Children ages 5 through 18 with family incomes up to 235% of the FPL are covered under PeachCare.
- The Medically Needy category for pregnant women and children up to age 18 is available but in order to qualify for services, the family must spend-down, using incurred medical expenses, to the point where their income does not exceed \$317.00 per month for a family of 2.

- The LIM group is made up of children and parents with monthly income that does not exceed \$500 (\$6,000 yearly).
- Transitional Medical Assistance (TMA) is available for a one-year period for children and parents who lose LIM eligibility due to earnings.
- Women under the age of 65 who have breast or cervical cancer identified through the Center for Disease Control (CDC) screening process and who are uninsured are eligible for services under Medicaid.
- Aged, Blind and Disabled (ABD) individuals who receive SSI and have incomes below the Federal Benefit Rate (FBR), currently \$552 per month. For those ABD individuals who are not eligible for nursing home care, SSI or a waiver, there is a medically needy program under which an individual can become eligible by spending down until they reach the limit of \$317.00 per month.
- In addition, ABD individuals who do meet nursing home eligibility criteria are eligible for services if their income does not exceed the Medicaid Cap (currently \$1656 per month). Individuals may also become nursing home eligible if their income is greater than the Medicaid Cap but less than the nursing home private rate through the application of the spend down process.
- Medicaid coverage is available to individuals with incomes that do not exceed the Medicaid Cap and who meet criteria for services provided under one of the State's home and community service waiver programs include:
 - Community Care Waiver the elderly and functionally impaired, who require a nursing home level of care;
 - Independent Care Waiver the severely physically disabled between ages 21-64 who require a nursing home level of care;
 - MR Waiver those with a diagnosis of mental retardation or developmental disability who meet criteria for Intermediate Care Facility level of care; and
 - Model Waiver children under age 21 who are respirator or oxygendependent and meet nursing home level of care criteria.
- Hospice care is provided for individuals who are terminally ill with incomes up to the Medicaid Cap.
- Georgia covers children who are severely disabled, require a nursing home level of care, and for whom at-home care is more cost-effective than care in a nursing home.
- The Medicare-related categories include: Qualified Medicare Beneficiaries (QMB) with incomes up to 100% of the FPL; Specified Low Income Beneficiaries with incomes up to 120% of the FPL and Medicare beneficiaries who qualify as Q1-1 with incomes up to 135% of the FPL.

Medicaid and PeachCare Demographics

In fiscal year 2002, the average number of Medicaid recipients was 1,065,798. The ABD made up 25.1% of the population, the LIM was 35.2%, and the RSM women and children made up 35.3%. Of the other groups, 3.7% were QMB's, 0.4% were breast and cervical cancer patients and 0.3% were refugees.

PeachCare was implemented in January 1999 to include children not eligible for Medicaid with incomes below 200% of poverty. In the following year, the program was expanded to include children with incomes below 235% of poverty. Today the program serves approximately 168,000 children.

Covered Services

Georgia's benefit structure is consistent with most state Medicaid programs. For fiscal year 2003, the State share for the cost of these services is 40.51% and the federal government pays the rest. For fiscal year 2004, the State share will be 40.42%.

Medicaid enrollees have access to:

- Inpatient and outpatient hospital care;
- Nursing home care;
- Physician services;
- Home health:
- Dental services for children and emergency dental services for adults;
- Non-emergency transportation;
- Family planning;
- Health Check (Georgia's version of EPSDT);
- Durable medical equipment;
- Lab;
- Pharmacy:
- Mental health (Georgia does not have either the under 21 or over 64 I M D option. Georgia provides mental health benefits under the rehabilitation option.);
- Physician assistants;
- Hospice;
- Emergency ambulance;
- Dialysis:
- Vision care for children;
- Orthotics and prosthetics;
- Services provided by Rural Health Centers and Federally Qualified Health Centers;
- Medicare premium and co-insurance assistance (Based on income and consistent with existing federal law); and
- Home and Community-Based Services under waivers for the elderly, the physically disabled, oxygen-dependent children, and people with mental retardation/developmental delays.

PeachCare benefits mirror Medicaid except that children enrolled in PeachCare do not have access to non-emergency transportation, targeted case management, or home and

community-based waiver services. Additionally, the PeachCare member does not have the same entitlement to services that the Medicaid members has.

Clients being served in the home and community-based waivers have access to a varying benefit package described later in this document.

SERVICE DELIVERY SYSTEMS

Georgia has been innovative in the creation of a variety of delivery systems for the benefits offered. It is important to understand the current structure of the program and to recognize that the State has invested in a fair amount of infrastructure that it desires to build upon. This section describes in some detail these service delivery systems.

A Brief History of Managed Care

Like many states, Georgia's Medicaid program was expanding rapidly in the late 1980s and early 1990s and like many states, Georgia experimented with managed care as a solution to double-digit inflation. However, the environment was not conducive to a successful transition to fully capitated Health Management Organizations (HMOs). Georgia attempted to combat this widespread opposition to a mandatory managed care program by instituting a program that offered enrollees a choice between enrolling in GBHC or voluntarily enrolling in an HMO.

The voluntary HMO program was never successful. The few HMOs that came into the State were only interested in the metro Atlanta area and only wanted to cover women and children. HMOs that participated in the voluntary program believed that the program was not successful because they were never able to obtain sufficient enrollment to adequately spread risk and because the state's capitation structure was inadequate to address their costs. In addition, during the time that the HMOs were operating, DCH had also engaged the services of an enrollment broker whose enrollment practices came into question and created additional negative feelings among the medical community. The voluntary HMO program was ultimately discontinued in favor of expanding the GBHC Program.

Programs Operated by the Department of Community Health

Georgia Better Health Care

GBHC is now a statewide PCCM service delivery system. About 70% of all Medicaid recipients are enrolled in GBHC, the exceptions being those residing in nursing facilities, personal care homes, mental health hospitals or other residential facilities and recipients with short-term Medicaid enrollment such as pregnant women covered under RSM. Those recipients who are covered by both Medicaid and Medicare or other health care coverage are also exempted from GBHC.

About 822,658 Medicaid members are enrolled in GBHC and an additional 168,196 children are enrolled through the PeachCare program. Currently, GBHC Primary Care Physicians (PCPs) are paid a \$2.00 per member per month administrative fee to

compensate them for being available to their patients 24/7 and for authorizing referrals to specialty care.

The section 1915(b) waiver under which GBHC operates expired in December 2002. The program continues to operate today under an extension to the waiver granted by the federal government while DCH and the Centers for Medicare and Medicaid Services (CMS) work towards a goal of using a State Plan Amendment to authorize the continued operation of GBHC. Under the State Plan Amendment, children with special needs will be exempt from the mandatory enrollment requirement.

The GBHC program has been both popular and successful at improving access to care and controlling costs. This success is partly attributable to the Provider Advisory Committee that acts as a peer review group to PCP's in the program so that "best practices" can be discussed physician to physician. The Provider Advisory Committee also worked in collaboration with the State to develop a series of quarterly physician profiles that are sent to the PCP's to advise them of their own performance and their performance in relationship to their peers. The involvement of the Provider Advisory Committee in this process helped to engage GBHC providers and overcome the initial resistance to provider profiling.

Despite its many successes, however, DCH staff responsible for the program have identified a number of issues that must be addressed to maximize the program's potential.

These issues include:

Enrollment and Education: Currently DFCS staff are responsible for determining Medicaid eligibility and providing member information regarding the GBHC program. For a variety of reasons, there is no formal education provided about GBHC, how to choose a PCP, how to access services in the most efficient manner, how the referral system works, how to avoid excessive ER use or any other issues that would help an enrollee fully utilize the benefits of a case manager system at this point. This lack of member education at the point of entry places a burden on PCP's that many simply do not have time to assume. The lack of member education also reduces the potential economic efficiencies of the GBHC Program.

Auto-Assignment: Today, virtually 100% of Medicaid beneficiaries eligible for GBHC are auto-assigned to a PCP. While DCH does look at prior use of physicians by an enrollee and/or family members, the auto-assignment process is not the ideal way to link individuals to a PCP. DCH does not currently have the capacity to do geographic mapping to determine which PCP might be closest to an enrollee's residence. More importantly, letting enrollees choose their PCP is a better way to assure their satisfaction with their care.

Lock-In: Currently, DCH has a one-month PCP lock-in policy. This policy has resulted in some significant switching of physicians and makes it difficult for any particular physician to manage the care of an enrollee. Under the State Plan Amendment for GBHC, DCH is seeking authority for a 90-day period during which an enrollee can change PCPs without cause, followed by a 90-day lock-in period.

Nurse Link/Hotline: DCH had anticipated augmenting the resources of the GBHC by instituting a nurse link triage function but has been unable to secure the necessary funding to do so.

Provider Hotline: The hotline that is used by PCPs to secure pre-authorization for services has been operated by the Georgia Medical Care Foundation (GMCF) and will become part of a new information system contract planned to go "live" in calendar year 2003.

Physician Incentives: The case management fee paid to GBHC PCPs will be a \$2.00 per member per month on average. Payment of the full \$2.00 will be based on the attainment of certain incentives. The incentive pool criteria have not yet been fully developed.

Provider and Consumer Satisfaction: While there is a provider newsletter that is used to convey information to the enrolled PCPs, there is no formal mechanism for assessing provider satisfaction with the program. Nor is there any forum for determining consumer satisfaction with the program. This lack of feed-back hampers DCH's ability to make changes in the program that are directed both by and to provider and consumer concerns.

Emergency Room Use: One of the significant cost-drivers in the Georgia Medicaid system has been identified as non-emergency use of hospital emergency departments by a relatively small number of people. This problem may have been exacerbated by the DCH's determination, in response to the "prudent layperson" definition of emergency in the Balanced Budget Act of 1997, that prior authorization for use of the ER was no longer permissible under federal law. The increase in ER usage may also suggest that the PCPs are either not accessible to their clients after normal office hours or, because much of the ER use is during normal business hours, there is a lack of member education regarding the consequences of inappropriate ER use. In fact, there are no consequences to enrollees but the State is clearly bearing the burden of the increased expenditures resulting from the use of the ER as a primary care setting.

Case Management: Perhaps one of the most significant issues for the GBHC program is the lack of case management to augment that of the PCP in order to coordinate services across systems of care, particularly for the chronically ill or for those at high-risk of debilitating illness. This is an issue that must be addressed if the system is ever going to realize its goal of maximizing prevention while assisting clients in managing their chronic health conditions.

The SOURCE Program Demonstration or Pilot Program

The SOURCE (Service Options Using Resources in Community Environments) program is a small, innovative integration of social and medical services designed to delay institutionalization of the elderly over the age of 65 and/or the disabled of any age. The concept combines the access to traditional home and community-based services for the elderly/disabled with the assignment of a PCP who provides 24/7 access to physician services. The project was established in the mid-1990s and today operates in 10 urban and rural sites around the State.

Each SOURCE site has a team of professional case management staff with varied backgrounds to encourage a mix of disciplines and ideas. Each site also has a medical director who meets weekly with the team for ongoing concurrent review of all enrollees. The team also meets quarterly with the enrollee's PCP to review each enrollee's progress, medical issues, social needs and agree to all services provided to support the enrollee. In addition, there are monthly meetings between the site team and other providers to whom the enrollee is referred (e.g., personal support services, adult day health services, respite care).

The SOURCE sites are paid a \$150.00 pmpm fee that is used to pay for the case management services. In part, the sites use this funding to pay PCPs and a medical director for participating in case reviews. Other covered services are reimbursed on a fee-for-service basis.

Each SOURCE site maintains a list of preferred providers who are authorized to provide home and community-based services, and have demonstrated improved outcomes when compared to peers. By including these providers in a monthly meeting, the site obtains information needed to revise the enrollee's care plan. In addition, the site and provides an oversight function by ensuring that preferred providers are continuing to see enrollees in accordance with their care plan.

Today over 2,000 elderly and disabled Medicaid recipients are enrolled in the SOURCE program. The program has received national attention for the integration of health and social services to support individuals desiring to live at home and/or in their communities. Recent reviews have demonstrated that the SOURCE program manages acute care, treatment sensitive conditions, significantly better than other long-term care programs in the State.

<u>Pharmacy</u>

In October 2000, DCH contracted with a PBM, Express Scripts, Inc. Prior to the implementation of the contract, there was a \$0.50 co-pay on all medications in the Medicaid program, no preferred drug list, a maximum allowable cost (MAC) list of 186 drugs, limited drug utilization review and paper claim submissions.

In conjunction with the PBM, DCH has taken major steps to control the costs and utilization in the pharmacy program while continuing to develop ways to ensure that clients are being well served by this program.

Under the new program design, DCH and the PBM have developed an extensive Preferred Drug List (PDL), created incentives for providers to dispense generics, expanded the Drug Utilization Review (DUR) process, implemented an on-line Third Party Liability and Medicare Part B cost avoidance program, enforced most favored nation pricing where appropriate, improved the prior authorization program, and expanded the MAC list. DCH has also undertaken a study of drugs in the long-term care setting by reviewing the prescriptions for residents in the top prescription-utilizing nursing homes—those that averaged 9 or more scripts per patient per month. The results of this study are currently being evaluated and should lead to policies designed to ensure the safety and cost-effectiveness of drug treatment for those residing in the State's nursing homes. DCH instituted a tiered co-pay structure for Medicaid with co-

payments ranging from \$0.50 for generic and preferred brand drugs to between \$0.50 and \$3.00 for non-preferred brand drugs, depending on the cost of the medication.

Home and Community-Based Waiver Programs

While all of the waiver programs operated by DCH and DHR have demonstrated an ability to offer home and community-based services in a cost-effective manner, DCH staff has general concerns about the waivers related to accountability measures, plan coordination on the part of case managers, and the lack of appropriate documentation of services provided relative to approved plans of care, as related to waiver review. DCH and DHR are open to creative ways to increase the accountability within the waiver programs.

Independent Care Waiver Program (ICWP): This program provides home and community-based services for severely physically disabled individuals between the ages of 21-64 who meet criteria for nursing home admission. The program currently services about 600 individuals with approximately 200 individuals on the waiting list.

Once individuals are accepted into the waiver, they are advised to contact a case manager. Qualified case managers enroll themselves directly through the Medicaid program and waiver enrollees may choose among those case managers who have a contract with Medicaid. The case manager prepares a plan of care that is authorized by the GMCF before services are provided. Case managers must meet with their enrollees on a monthly basis to review progress and make necessary adjustments to the plan of care. Each year, a physician must certify that an individual in the waiver still meets nursing home level of care.

Model Waiver: This program provides home and community-based services for children under the age of 21 who are respirator or oxygen-dependent and meet the nursing home level of care criteria. Children enter the waiver with a letter of recommendation from their primary care physician and are eligible for either medical day care or in-home nursing services.

Providers, who are nursing agencies, must meet specific conditions of participation, including an ability to provide appropriate transportation to children receiving medical day care. Plans of care must be developed and approved by GMCF prior to the delivery of services.

There are currently 160 children in the Model Waiver program. The program staff continues to search for creative ways to address this very costly population, as well as other medically fragile children.

Other Waivers

Deeming Waiver. This program extends Medicaid coverage to certain children who would otherwise be ineligible for Title XIX services. Georgia does not currently charge a premium for services provided to children receiving services under this program.

Non-Emergency Transportation Waiver: The state has a selective contracting waiver to authorize the provision of non-emergency transportation services through a single broker

in each of the 5 regions of the State. Brokers are paid a fixed PMPM for the monthly eligible members in their respective regions.

HealthCheck

Georgia's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is called HealthCheck. Services are provided to children up to age 21 by GBHC PCPs, and in some cases the county health department as well as rural and community health centers.

DFCS, under contract with DCH to determine Medicaid eligibility, is supposed to inform newly eligible individuals about the program and how to access services. However, DFCS has had difficulty with this responsibility and while the new claims contractor, ACS, is due to assume this function, the linkage between eligibility and HealthCheck information is currently weak.

Georgia has a verifiable 47% compliance rate with federally prescribed EPSDT measures, although that data is understated since it is reported only from paid claims and it does not include services provided through many county health departments.

Prior to the implementation of GBHC, health department nurses were doing all HealthCheck screenings. But physicians objected and, as a part of GBHC, undertook greater responsibility for HealthCheck success. Today there is no consequence for failing to assure that children receive the required screenings and immunizations under HealthCheck. There is no specific training for private physicians and no incentives built into the GBHC system to reward physicians who perform EPSDT screenings and referrals for treatment. This is a major area of concern for the DCH and one that should be addressed by respondents to this RFI.

Program Administration

In an effort to maximize administrative efficiency, DCH, with its vendor ACS, is in the process of developing a state-of-the-art electronic health care administration system that will give patients, doctors, pharmacists and other health care providers easy, secure and efficient access to information about Georgia's Medicaid, PeachCare, State Employee Health Benefit Plan and the Board of Regents Health Plans. Once fully implemented, this health care administration system will offer many online services to all State benefit plan providers and members. The new system will enable Medicaid and PeachCare members to:

- Query prior authorization and referral status;
- Select a primary care physician; and
- Search providers and agencies by location and specialty.

Medicaid and PeachCare providers will be able to:

- Enter information for presumptive, newborn and breast and cervical cancer eligibility;
- Submit Georgia Better Health Care referrals for members and inquire about referral status;

- Submit online prior authorization request forms for an individual member;
- Receive a member's prior authorization and precertification status;
- Update demographic information;
- Track HealthCheck appointments and update a tracking screen when a member keeps an appointment;
- Obtain a list of members assigned to a provider;
- Inquire about procedure code coverage; and
- View rate schedules by code or procedure.

The role of the new health care administration system must be considered by respondents addressing how best to build on existing State infrastructure investments.

Programs Operated by the Department of Human Resources

Operational Overview

DHR is the largest state human service delivery agency in Georgia. As stated earlier, DCH contracts with DHR to provide a number of services for Medicaid beneficiaries. DHR is made up of four divisions:

- The Division of Aging Services administers the Community Care Services Program (CCSP). The Division is responsible for the oversight of service providers, case management, and developing care plans to authorize statefunded services.
- The Division of Public Health is responsible for traditional public health programs and several limited Medicaid-funded services.
- The Division of Mental Health, Developmental Disabilities and Addictive
 Diseases (MHDDAD) is responsible for the provision of community mental health
 services for persons with mental illness, mental retardation/developmental
 disabilities, or substance abuse problems, including Medicaid beneficiaries. The
 Division also administers the State's home and community-based services
 waiver program for the MR/DD population.
- DFCS is responsible for completing initial and on-going Medicaid eligibility determinations, including eligibility determinations for individuals who are Medicaid eligible under one of the State's waiver programs. As a part of the eligibility process, DFCS is required to inform Medicaid recipients of the HealthCheck program, provide an explanation of the Medicaid program(including the use of the Medicaid card and covered services), provide other informational pamphlets, make referrals to the Women, Infants, and Children's (WIC) program, and collect Third Party Liability information. Other services provided by this Division to Medicaid recipients include: providing intervention services to severely emotionally disturbed Medicaid recipients under age 21 in therapeutic foster care or intermediate care facilities.

Division of Aging Programs

The Division administers two community-based service programs that serve older Georgians. These programs are administered by twelve Area Agencies on Aging, known as Triple As, through purchase of service contracts. The primary Medicaid responsibility for the Division of Aging is managing the home and community-based services waiver for the elderly. Known as the Community Care Services Program (CCSP) Waiver, this program has been in place for 20 years. The Division also manages an array of other State-funded home and community-based services.

In addition to the support of services provided through the federal Medicaid program, the Division receives its funding from the allocation to the State under the Older Americans' Act, the Social Service Block Grant, Title V, and the United State Department of Agriculture under its Nutrition Programs for the Elderly. The State's share of funding for services provided to the elderly through the CCSP waiver is appropriated by the Legislature to the Division's budget.

Consistent with the Older Americans' Act, each region's Regional Development Center (RDC) has the right of first refusal to be designated as the Area Agency on Aging. In Georgia, 10 of the 12 Triple As are operated by the RDCs; the other two are private, non-profit organizations—one based in Albany and serving southwest Georgia, and one in Gainesville serving north Georgia.

The CCSP program operating under an approved Section 1915(c) waiver provides home and community-based care to older Georgians with disabilities. Services provided include: adult day health, alternative living services, emergency response services, home delivered meals, home health services, personal support services and respite care.

The Triple As are the local administrators of the program and it is their responsibility, once Medicaid eligibility is determined and a waiver slot becomes available, to develop a service plan and authorize services. In order to be eligible for the CCSP waiver, an individual must be eligible for admittance into a nursing home and meet certain Medicaid income requirements.

The Triple As are the local administrators of the CCSP waiver services. Once an individual is determined eligible and a slot opens up in the waiver, it becomes the responsibility of the Triple As to develop a service plan and authorize services. The Triple As also train local networks of providers; authorize, arrange and broker services; and participate in the quality assurance system that has been developed by the State. Because the RDCs cannot, pursuant to state law, actually provide services, the Triple As that are within RDCs contract with an array of service providers. The two non-profit, private Triple As may provide services directly.

The Division, in partnership with the regional Triple As, uses an intake system it calls Gateway, an operational model designed to assure a standardized intake and screening process. The Gateway staff use a screening tool that enables the staff person performing the intake to make, among other things, an initial determination as to whether the person might be eligible for Medicaid and the CCSP waiver.

The State Division of Aging believes that the system it has established with its emphasis on the participation of the local Triple As and their knowledge of community resources has served its clients well. Currently, the Triple As process services for 55,316 individuals and have a waiting list of 10,000 for non-Medicaid services and a waiting list of 3500 individuals for the CCSP waiver.

Division staff reports that the most significant service gaps for the elderly population are general transportation services, adult day care and adult day health programs. The Division has attempted to alleviate this problem somewhat by instituting a mobile day care model. The mobile unit moves from one small town to another and sets up day care in churches, community centers, and other local sites on a rotating basis. While this model is, to date, a non-medical model, it might serve as a basis for a mobile adult day health program to help alleviate the shortage of such programs.

In addition, Division staff would like to explore a Targeted Case Management model to provide better care coordination for the chronically ill elderly and to assist in better prevention strategies to enable this population to continue to live in the community.

Aging Division Issues

Division staff is proud of the system it has built and believes that one of its major strengths is that it is "owned" by local communities. It has been their experience that when the local community stops being intrinsically involved with the development of resources and the provision of services, everyone loses something of value. Building on the best elements of existing infrastructure will be important to increasing the capacity of the system to handle additional numbers of elderly as the population ages. The Division is also aware of the necessity for expanding home and community supports as a part of the State's Olmstead compliance responsibilities.

Division staff acknowledges the difficulty of building a system of community services and supports for the elderly when Medicaid dollars are involved. Medicaid law has changed in many dramatic ways over the years but it is still essentially a "medical model" and does not always fit nicely over a structure that is essentially non-medical in nature.

<u>Division of Mental Health, Developmental Disabilities, and Addictive Diseases</u> (<u>DMHDDAD</u>)

The DMHDDAD has the responsibility to provide or arrange services for individuals who rely on public services for treatment of their mental health or substance abuse issues or who have mental retardation or developmental disabilities. In fiscal year 2002, the Division served 130,620 people with mental illness; 14,890 people with mental retardation/development disabilities; and 40,309 people with substance abuse problems. (Note that in some cases the same individual received services through two or more of these programs.)

Services are funded through a combination of state grant in aid, the ADAMH block grant, and Title XIX. The state match for most Medicaid outpatient services resides primarily in the DHR budget, although the Department of Community Health has the match for inpatient psychiatric services and psychiatric pharmacy services. This has created a divided responsibility for members with chronic and persistent mental illness.

In 1993, the Georgia legislature created the framework for a new MHDDAD public service system with more local planning and decision-making and strong input from consumers and family members. Through this reform, thirteen regional boards that were sub-state governing boards planned, coordinated, and contracted for mental health, mental retardation and substance abuse services across the State. The boards were made up of a majority of consumers and family members and were appointed by county commissioners.

During the 2002 General Assembly, the reform was modified due to calls for increased accountability, uniformity, and statewide standardization. As a result of new legislation, there are now seven DHR regional offices, each of which has a planning board that is made up of consumers, family members, and community leaders. The regional offices are responsible for the management of all services in the region. The Regional Coordinator supervises the region's state-operated hospital (if there is one) and is responsible for the purchase of community services for the region.

Regions contract with public and private providers to offer a broad range of services to people with mental illness and addictive diseases. The primary provider of mental health and addictive disease services are public entities called Community Service Boards (CSBs). There are 26 CSBs, each with an assigned service area. These are much like Community Mental Health Centers in other areas of the country.

Services provided include outpatient services, residential services, supported employment, day programs for treatment or training, crisis intervention, and case management. Additionally, there are a small number of state-operated mental health and addictive diseases community programs managed through the hospital system.

Clients can access the mental health system a number of ways. They can come to a CSB, a Regional Office, a state hospital, and, if an individual seeks Medicaid services through DFCS, can be directed to local services during the eligibility determination process. Once "in the system", the individual is assessed and a plan of care is developed, usually through the auspices of one of the CSBs although this may also occur through a contract that a Regional Board has with a private provider.

The State has contracted with an External Review Organization (ERO), American Psychiatric Services (APS) Health Care, Inc. APS prior authorizes Title XIX rehab services to assure that the right level of service is provided and each client has a care plan that matches the needs identified during the assessment process. Additionally, the Division is soliciting contractors to provide the assessment and case management for the MR Waivers they operate. While the current assessment and plan of care is performed by a single provider, the State is moving towards a separation of these functions. Services provided to Medicaid enrollees are reimbursed on a fee-for-service basis.

The system of care for the mentally retarded and developmentally disabled is administered through the same infrastructure as the mental health system. The Regional Boards provide local planning for the development of community services. The provider network has historically involved more private providers than the mental health system.

Each region is in the process of contracting with a provider who can perform screening and evaluation services, level of care determinations, development of care plans and authorization of services. If, after evaluation, an individual is eligible for nursing home level of care but desires services in the community, the individual's needs are prioritized and they are put onto either a short or long-term waiting list for services provided through one of the two waivers for people with mental retardation. If an individual is a priority client (in immediate danger of institutionalization), some level of services is provided within 14 days to support the client until a waiver slot that meets their needs becomes available.

The Division is considering a self-determination waiver under which the client can self-direct a package of services within the dollar limits established for his or her needs.

MHDDAD Division Issues

The Division believes that good case management for all of its clients will improve the coordination of services and the quality of the services provided. However, there is concern that a traditional managed care model has never been demonstrated to work well for its populations and that one danger from such a model is the transfer of high-risk patients to the state hospitals. Staff has also expressed concern that the imposition of a "medical model" on the MH/MR population tends to ignore the social needs that must also be addressed in order for clients to live successfully in the community.

Additional concerns have been voiced about the quantity and quality of community services. Georgia ranks 50th among the states for spending on community services and there is a specific need for additional residential placements and family supports for the MR/DD population.

Developing a strategy for the management of the populations under the purview of the Division will require careful attention to the incorporation of the existing community infrastructure and sensitivity to the concerns of both Division staff and the advocacy community.

Medicaid Services and Reimbursement

Hospital Services

Inpatient hospital services are provided when treatment on the outpatient level is inappropriate. Inpatient care is reimbursed on a DRG-based system similar to Medicare's. The system was implemented in July 1998 and has been re-based twice since, most recently in July 2002. The rates paid are equivalent to approximately 90% of costs. There are 25 Critical Access Hospitals in Georgia that receive cost-based reimbursement from Medicaid, based on Medicare payment principles. While child admissions are generally not prior authorized, adult admissions generally do require prior authorization (PA). The State uses a Prospective Review Organization to operate the PA function. The most recent version of InterQual Criteria is used.

There are 160 hospitals across the State, 92 of which qualify for the State's Disproportionate Share Hospital (DSH) program. Last year the State distributed a total of \$366 million in DSH funds. Small rural hospitals get 100% of their costs reimbursed through DSH while large rural and urban private hospitals can be reimbursed 50% of

their OBRA cap through DSH. The remaining portion is distributed on a proportionate basis among the rest of the hospitals. DCH does not pay DSH to its own psychiatric hospitals.

Outpatient costs are reimbursed with interim payments based on a percent of charges and a retrospective cost settlement at the end of the year. Most hospitals are settled at 90% of costs but the state-owned facilities are cost settled to full cost reimbursement.

It should be noted that DCH is considering a 10% reduction in inpatient reimbursement rates prior to adjustments for inflation. The 10% reduction would be partially offset by increases for inflation.

Nursing Facilities

Nursing facilities are reimbursed at a provider specific per diem based on the most recent year for which an audited cost report is available. The State looks at peer groups, outlier thresholds, and applies a fixed rate for property costs and an inflation factor to derive a facility specific rate.

There are 362 nursing facilities in the State. Of these, 50 are hospital-based. There are 352 nursing facilities that participate in Medicaid. About 40,000 patients live in the facilities and, of these, 32,000 are Medicaid enrollees. Nursing facility reimbursement is middle to below average relative to national rates and while there has not been any freeze or reduction in rates to date, there is one proposed to take effect February 2003.

It should be noted that DCH is considering a 10% reduction in reimbursement rates prior to adjustments for inflation. The 10% reduction would be partially offset by increases for inflation.

Physician Services

Physicians are reimbursed pursuant to the Medicare Resource Based Relative Value Scale (RBRVS). Reimbursement rate is established at 90% of the 2000 RBRVS applied to the procedure codes billed. In addition, those PCPs who are enrolled as GBHC providers also receive an aggregate average of \$2.00 per member per month case management fee.

It should be noted that DCH is considering a 10% reduction in reimbursement rates prior to adjustments for inflation. The 10% reduction would be partially offset by increases for inflation.

Pharmacy Services

Pharmacy reimbursement is the average wholesale price (AWP) minus 10% plus a dispensing fee or most favored nation pricing, whichever is lower. Actual rates paid during the first quarter of the current fiscal year, including an aggressive MAC program, averaged a discount of 18.4%. Rebates are received from manufacturers and offset program expenditures. Pharmacy claims are adjudicated through the PBM's point of sale system.

Other Practitioner Services

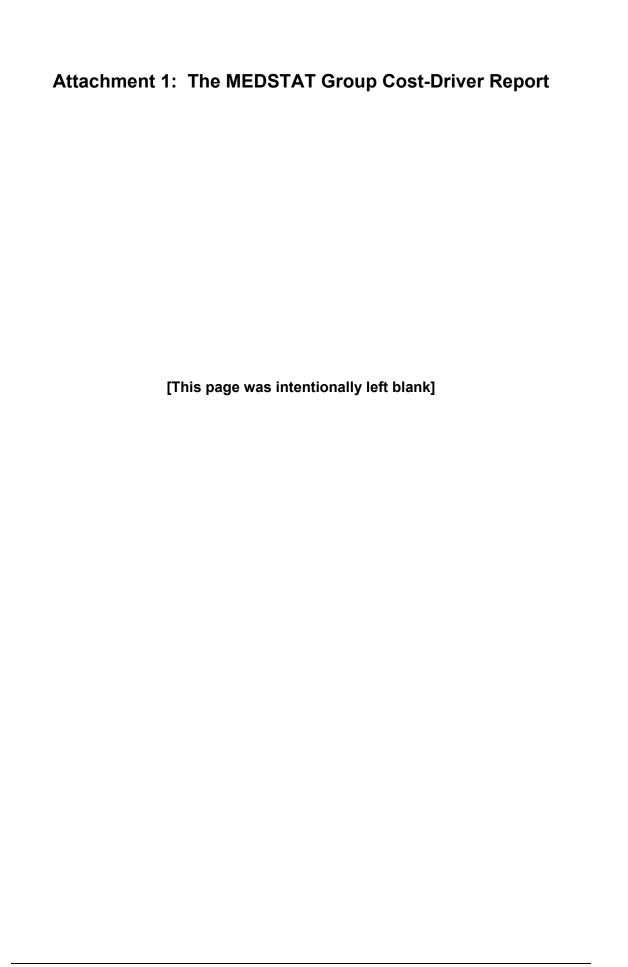
Reimbursement for services provided in other categories include dental, optometric, podiatry, psychological, and services provided by physician's assistants, registered nurse anesthetists and county health departments. The services are reimbursed on either a percentage of the RBRVS, a state-specific rate that may be cost-based, or submitted charges, whichever is lower.

Moving Toward the Future

The State of Georgia has benefited from the health care delivery infrastructure it has built over the last decade. After attempts at a traditional managed care delivery system met with resistance by the provider community and a desire to "cherry-pick" the easiest clients to serve by the HMOs, the State steered towards a program design that accommodated its community delivery systems. DCH desires to take advantage of the best parts of the community infrastructure—the loyalty, support, or community involvement in the care of its own citizens. However, the time has come to take additional steps towards the design, development, and implementation of a more integrated and coordinated system of care.

To that end, DCH solicits ideas and proposals through this RFI. However, respondents must be mindful of and sensitive to the preservation of the best in the system while making recommendations for progressive change.

For example, respondents to this RFI must take into account physician loyalty to the GBHC model and when proposing changes must be prepared to state specifically what benefits would accrue to physicians, consumers and DCH. Similarly, while the State desires continued improvement in its pharmacy program, potential respondents must be prepared to state specifically what they would suggest for controlling pharmacy costs without inappropriately decreasing access to necessary medications. Specific questions that DCH would like respondents to address can be found in Attachment 2.



Project Objectives

The primary objective of this project is to update the Medicaid Cost Driver analysis provided to the Office of Planning and Budget (OPB) and the Department of Community Health (DCH) in November 2001. In our previous project we explained FY01 cost increases and budget variances in the Georgia Medicaid program. Our focus for this project is to update cost and utilization experience for services incurred in FY02. We examine current cost and utilization trends and update the budget or cost impact of enrollment, reimbursement and other policy changes. We also update experience for key focus areas (e.g., pharmacy) while assessing trends that have emerged since our previous analysis.

Organization of Report

Following a review of Analytic Methods, the report presents an Overview of Cost Trends with comparisons to benchmarks. Next, we draw Comparisons to the FY02 Budget Projections and Evaluate the FY02 cost increases in light of program and policy changes, including eligibility/coverage expansions, revenue maximization, provider rate enhancements, and new initiatives. We then present a Variance Analysis that quantifies the relative contributions of enrollment, price and use changes to the FY02 cost trend.

The next section of the report presents detailed findings for three Focus Areas chosen because they represent the greatest areas of management opportunity:

- Outpatient Hospital
- Prescription Drugs
- Inpatient Hospital

In this section, we also review several other areas showing large cost increases in the most recent year, such as Physician, Nursing Homes, and Dental. We then examine Emerging Trends for four areas of special interest to Georgia:

- Emergency Room utilization
- Total Medicaid costs for DHR-funded programs
- High cost recipients
- Mental Health

The last section of the report summarizes Other States' Plans to Reduce Medicaid Spending and DCH Initiatives to Date. The report concludes by highlighting the most promising short- and long-term program management opportunities.

Analytic Methods

The analysis focuses on updated cost trends for Medicaid claims incurred during the period July 1, 2000 through March 31, 2002 (State Fiscal Years 2001 and 2002 YTD), based on claims paid through June 30, 2002. Unless otherwise specified, payments represent total funds (State and Federal) adjusted for claims incurred but not yet reported.

Fiscal Year 2002 experience (and FY 2001 inpatient hospital experience) has been adjusted using completion factors calculated based on 30 months of historical claim payment experience. The completed FY02 YTD data are then annualized to represent 12 months of experience based on current trends. This time frame allows for a similar claims lag to that used last year.

The completion factors are similar to those developed by DCH's actuarial consultants. However, there are slight differences between the methods used here and those used by DCH to develop budget projections. To achieve the precision necessary for budgeting, DCH and its actuaries take a number of additional steps beyond those that were feasible in the time frame available for this analysis. For example, DCH develops completion factors for each individual Category of Service, whereas for this analysis Medstat used an overall completion factor for the smaller Categories of Service. DCH and its actuaries also apply a smoothing factor to account for monthly variations in the data and adjust for seasonality. As a result, DCH projections of FY02 incurred expenditures are 1% to 2% higher than the figures shown here.

PeachCare enrollees and their claims are excluded, consistent with the previous report. The analysis also excludes non-claim expenses (e.g., Part B insurance premiums) or offsets (e.g., prescription drug rebates, transfer funds). Cross-over claims are included in the Overview of Cost Trends, to provide a complete picture of total costs, but excluded from the Variance Analysis and all drill-down analysis of key focus areas.

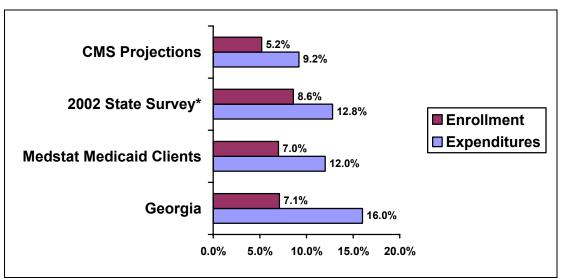
Overview of Cost Trends

Our previous analysis found that between FY00 and FY01 Georgia Medicaid incurred claims expenditures grew from \$3,504 to \$3,917 million (after completion for IBNR and including crossover claims), an increase of \$413 million. With the more complete data now available for FY01, actual expenditures in FY01 are \$3,916.6 million, matching the earlier projections and confirming the 11.8% FY01 total cost trend we reported last year.

Between FY01 and FY02, Medicaid incurred claims expenditures grew from \$3,917 to \$4,544 million (including crossovers), representing a 16.0% overall increase. This trend exceeds the CMS national Medicaid projections of 9.2% for FY 2002. It is also above, but much closer to, the 13.3% trend in Medicaid State Funds reported in NASBO's May 2002 Survey².

Net Payments (Includes Medicare Crossover Claims)						
FY00				FY01-FY02 % Increase	CMS <u>Projections</u>	
Total (in millions)	\$3,504	\$3,917	\$4,544	16.0%	9.2%	
Top COS (ranked by	% Increase)				
Outpatient	\$287.3	\$378.6	\$447.1	18.1%	N/A	
Rx Drugs	\$540.7	\$648.6	\$758.1	16.9%	13.5%	
Physician	\$348.8	\$440.0	\$510.8	16.1%	8.2%	
Inpatient	\$731.8	\$875.3	\$986.4	12.7%	6.7%	
ICF Private*	\$706.8	\$745.8	\$792.8	6.3%	4.6%	
Other COS						
Residential Therapy	\$26.0	\$35.1	\$60.3	71.5%	N/A	
Dental	\$32.1	\$61.6	\$85.1	38.2%	5.8%	
Outpatient Mental	\$61.6	\$61.4	\$81.6	32.7%	N/A	
MRWP	\$24.8	\$39.5	\$51.3	29.7%	N/A	

Based on the most recent benchmark data available, Georgia's FY02 trend exceeds the average of other states. Findings from the recent Kaiser Family Foundation Survey¹² as well as the combined experience of Medstat's Medicaid clients show a national trend in the range of 12% to 13%.



^{*} Kaiser Commission on Medicaid and the Uninsured. Medicaid Spending Growth: Results from a 2002 Survey.

We identified several factors that would have contributed to Georgia's FY02 trends being higher than the national average. They include (but are not limited to):

- Expanded waiver programs and stepped up revenue maximization initiatives
- Increased provider rates at a time when other States were cutting fees
- Greater enrollment impact due to slowed economic growth for Technology, Transportation and Service industries

In evaluating Georgia's trend compared to other states, it is important to note that Georgia has been very aggressive in the past two years in its efforts to maximize Federal revenue-sharing by shifting to the Medicaid budget services that were previously paid entirely out of State funds. If payments for services targeted for federal funds had trended at the same rate as other medical services, the overall Medicaid trend would have been one to two percentage points lower. To the extent that Georgia was more active in this area in FY02 than other states, revenue maximization alone accounts for much of the variation from the benchmarks.

Viewed on a per member per year (PMPY) basis, which controls for enrollment changes, Georgia Medicaid expenditures increased 8.4% in FY02, slightly up when compared to the FY01 PMPY increase of 7.0%. The increase is also slightly above the National Health Expenditure (NHE) projected FY02 per capita trend of 7.7%. PMPY trends for the major categories of service are shown below, with the largest increase observed for Outpatient Hospital services. The double-digit increase for All Other is driven largely by increased Medicaid spending for community-based waiver programs and other services that have been targeted for revenue maximization.

Payment Per Member Per Year (Includes Crossovers)						
Category of Service				FY01-02		
	<u>FY00</u>	<u>FY01</u>	FY02	<u>% Change</u>		
30 - Drug	\$572	\$652	\$711	9.1%		
07 - Outpatient Hospital	\$363	\$380	\$420	10.3%		
01 - Inpatient Hospital	\$823	\$879	\$925	5.2%		
43 - Physician	\$427	\$442	\$479	8.4%		
11, 14, 15, 16 - ICF	\$746	\$749	\$744	(0.7%)		
All Other	\$771	\$833	\$985	18.2%		
Total	\$3,702	\$3,935	\$4,264	8.4%		
Aid Category Group						
Aged	\$11,713	\$12,642	\$14,255	12.8%		
Blind/Disabled	\$7,080	\$7,739	\$8,923	15.3%		
LIM-TANF	\$1,745	\$1,940	\$2,209	13.9%		
RSM Child	\$1,429	\$1,613	\$1,693	5.0%		
RSM Adult	\$5,172	\$5,590	\$5,784	3.5%		
Refugee*	\$2,852	\$13,981	\$16,802	20.2%		
* Note - the Refugee population was reclassified in FY00, therefore FY01 trends are skewed.						

Comparisons to FY02 Budget

Anticipated Enrollment Expansions. At the time that the FY02 budget was developed, the State did not anticipate significant enrollment growth, even though unemployment had started to increase. The FY02 budget included \$89 million in total funds for growth in Medicaid enrollment and utilization. As the Variance Analysis in the next section indicates, actual costs due to enrollment increases alone were approximately \$150 million.

In FY02, DCH began seeing claims for the Women's Health Medicaid Program, which offers the full range of Medicaid covered services to women diagnosed with breast and cervical cancer whose incomes are under 200% of the Federal Poverty Level (FPL). The FY02 data show 413 covered enrollees and approximately \$6.8 million in expenditures for this program.

A number of enrollment expansions originally budgeted for FY02 did not go forward because of the State's worsening economic conditions. The following expansions, projected to add \$15 million in FY02 costs, were removed in the Amended FY02 budget:

- Children in families with incomes up to 150% of the FPL
- Adults with Cystic Fibrosis under 235% FPL
- Adults with Sickle Cell Anemia under 235% FPL
- Medicaid buy-in for the working disabled

Revenue Maximization. The FY02 DCH budget included \$114 million in total Medicaid funds (excluding administrative costs) for efforts to increase federal revenue matching, as shown below. These funds cover community-based waiver and state nursing facilities funded by the Department of Human Resources (DHR) and previously paid for entirely with state funds. As described in more detail below, the increase in FY02 claims for all DHR-funded services is projected at \$136 million, above the budgeted amount.

	Budgeted
FY02 Budget Enhancements	Total <u>Funds</u>
Increase funds for CPS/APSTargeted Case Management	\$ 999,012
Increase funds for medical services through public health clinics	\$ 3,246,756
Increase MH for children in community-based settings	\$ 38,472,284
Increase MH, MR, SA services to adults in community settings	\$ 23,579,945
Enhance nursing services in state facilities	\$ 14,731,500
Additional federal funding for new slots in CCSP	\$9,825,573
Additional federal funding for new slots in MRWP	\$17,647,832
Increase ICWP funds for slots and provider reimbursement	\$5,588,215
Total	\$ 114,091,117

Reimbursement Changes. The variance from budget for reimbursement increases is shown below for major categories of service and discussed in more detail in the sections that follow. Results varied by Category of Service:

- For Inpatient Hospital and Nursing Home, the observed increases due to changes in price per unit exceeded budget by approximately 15% to 20%. This variance is most likely explained by the fact that the base year figures used in budgeting may have been underestimated because of claims lag.
- For Outpatient Hospital, the increase that can be attributed to changes in the cost per unit
 far exceeds the budgeted enhancements, which were limited to hospitals providing a high
 level of indigent care. Continuing a trend observed last year, the budget variance
 demonstrates the inflationary effects of retrospective cost-based reimbursement. It is
 important to note that Outpatient Hospital services are reimbursed based on a
 determination of allowable and reimbursable costs, versus a "fixed" fee schedule or ACG
 reimbursement.
- For Physician Services, the payment impact of price per service appears significantly below budget. This may reflect changes in the mix of services, i.e., higher frequency of lower cost services due to the influx of comparatively low cost Low Income and RSM recipients.

Major Category of Service	Budgeted Enhancement (millions)	Increase Due to Price / Unit Cost (millions)
Inpatient Hospital	\$19.0	\$22.6
Outpatient Hospital	\$2.9	\$21.5
ICF (Private)	\$42.2	\$49.8
Physician	<u>\$15.1</u>	<u>\$9.3</u>
Total	\$79.2	\$101.8

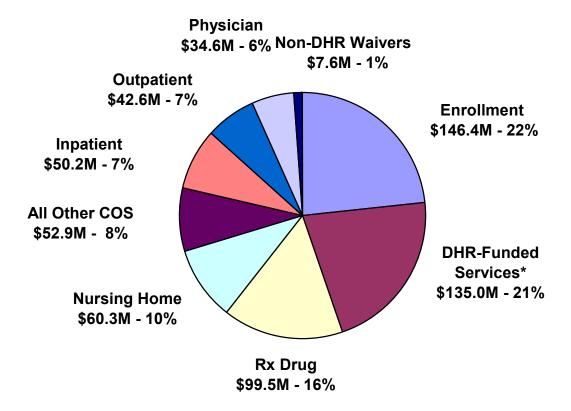
In addition to the major categories of service shown above, budgeted rate increases for other provider types totaled approximately \$4.8 million.

<u>Pharmacy</u>. A separate budget enhancement of \$133.5 million in total funds was included to cover rapidly rising prescription drugs cost and use. In the Amended FY02 Budget, this was offset by \$11.7 million in anticipated savings from prior authorization and other policy changes, for a net increase of \$121.7 million. The actual increase in drugs came in below this, at approximately \$100 million (after accounting for the enrollment impact on pharmacy utilization).

Variance Analysis

Excluding crossover claims, payments rose from \$3,769 to \$4,398 million between FY01 and FY02, an increase of \$629 million, or 16.7%. MEDSTAT performed a variance analysis to quantify the <u>independent</u> contributions of enrollment and category of service to this increase in expenditures. The category of service amounts shown below represent the combined impact of utilization (services per eligible or per 1000 eligibles) and price (payments per service) in each of these areas, <u>above and beyond the impact of</u> enrollment. This analysis helps to prioritize management opportunities.

Key Cost Drivers: Contribution to FY02 Increase of \$629 Million



^{*} DHR Programs include Categories of Service 10, 14, 15, 17, 44, 59, 65, 68, 70, 71, 76, 79, 87, 94, 96

Enrollment was the largest cost driver, accounting for 22% of the overall FY02 increase. Growth in the LIM/RSM population alone drove an increase of \$194 million; however, this was offset by a slight decrease in Aged/Blind/Disabled enrollees and the termination of the Family Planning Waiver in July 2001, resulting in a new impact of \$146.4 million.

DHR-Funded Programs accounted for approximately 21% of the overall cost increase, or \$135 million. This increase reflects a shift of dollars into Medicaid of services that had previously been paid with State-only funds, and it is partially offset in the overall State budget by an increase in federal funds.

Changes in *Pharmacy* cost and use contributed \$99.5 million to the overall increase (excluding savings from manufacturer rebates, which grew by \$16 million). Although pharmacy's dollar impact is very similar to that in FY01, its relative contribution declined from 23% in FY01 to 16% in FY02.

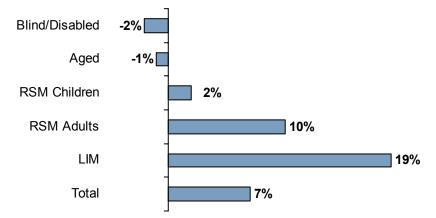
Nursing Home cost increases accounted for 10% of the overall cost increase. This is similar to last year's findings. **Inpatient and Outpatient Hospital** services each contributed 7%. The inpatient contribution is half that observed for FY01, because of the bigger impact this year of enrollment and the DHR programs. Increases in **Physician** cost and use drove only 6% of total cost growth.

Increases for "All Other" Categories of Service accounted for 8% of the total year-over-year cost increase. Dental and Adult Dental together account for about half of the \$52.5 million increase shown above

Enrollment Contribution to Variance

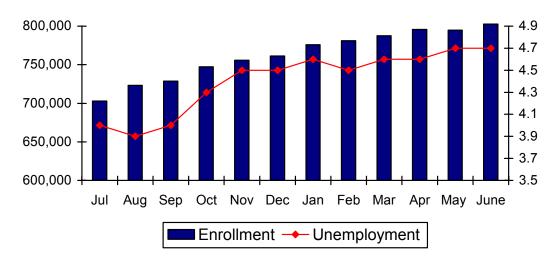
Based on annualized trends through March 2002, average enrollment increased by 7% over FY01. Growth was concentrated in the Low Income Medicaid aid category, which saw a 19% increase. Lesser increases were seen for RSM Children and Adults (10% and 2%, respectively) and Aged without Medicare (7%). The other Aged, Blind, and Disabled Categories showed slight but steady enrollment decreases, continuing a trend confirmed by DCH.





The steady climb in LIM/RSM enrollment over the course of FY02 paralleled the rising Georgia unemployment rate, which increased from 4.0% in July 2001 to 4.7% in June 2002 (seasonally adjusted)⁴. The correlation between LIM/RSM enrollment and the seasonally adjusted unemployment rate during this period is 0.92. This is a much stronger association than suggested by published studies. For example, the enrollment elasticities reported by Holahan and Garrett in an Urban Institute report³, which were used to project enrollment growth in last year's analysis, would suggest only a 3.5% increase in LIM/RSM enrollment, compared to the 13% observed.

FY02 LIM/RSM Enrollment and Georgia Unemployment Rate



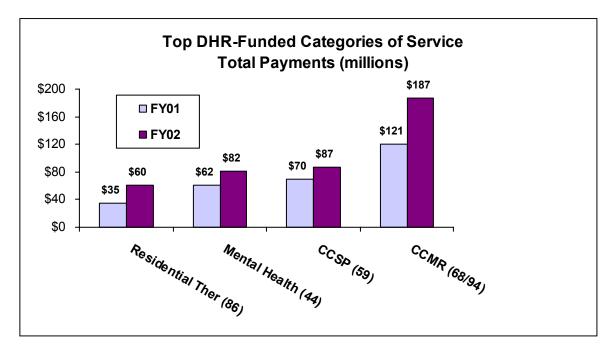
There are at least two reasons why Medicaid enrollment may be tracking more closely with unemployment in Georgia than elsewhere, or than in previous years. First, Atlanta has suffered more severe and lingering effects from the recession that many other areas, because of its concentration of employers in the high technology, communications, and travel/hotel industries. Second, DCH improved the ease with which people can apply for Medicaid, by simplifying the application form and making it available through the internet. As a result, people needing the Medicaid safety net are enrolling and accessing benefits more quickly than in the past.

DHR Programs' Contribution to Variance

Total costs for the DHR-funded programs covered under Medicaid grew from \$465.8 million in FY01 to \$600.7 million in FY02, an increase of 29%. Specific Medicaid services funded by DHR are listed in the table below.

COS	<u>Description</u>	COS	<u>Description</u>
10	Mental Health Case Management	14	SNF State (LTC)
15	ICF State (LTC)	17	MR, NF State (LTC)
44	Community Mental Health	59	Community Care (CCSP)
65	At Risk of Incarceration	68	MR Waiver CCMR
70	Child Protective Services	71	Adult Protective Services
76	Children at Risk	79	Diag Scrng & Prev Svcs (DSPS)
87	Residential Therapy Services	94	MRWP – DI (CHSS)
96	Child Interv. – School Svcs (CISS)		. ,

Among the DHR programs, the most striking cost increase was observed for the CCMR waiver program, which grew by more than 50%. Other programs with large increases included Mental Health, Residential Therapy Services, and CCSP.

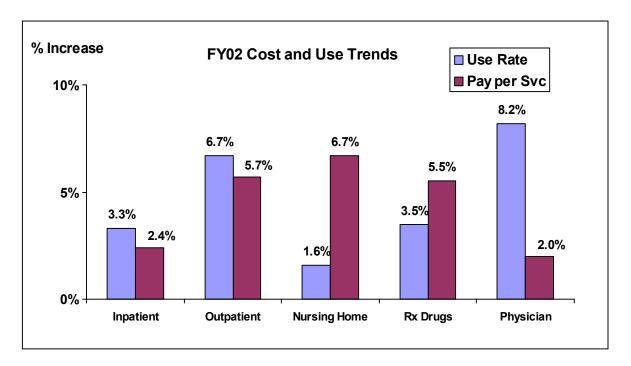


Excluding all of the DHR-funded services, Medicaid expenditures grew from \$3,303 to \$3,798 million in FY02, an increase of \$494 million. This represents a 15.0% trend, compared to the 16.7% trend for total (DHR plus DCH) Medicaid costs. To better understand growth in the DCH budget, we repeated the variance analysis without the DHR-funded programs. When looking solely at DCH-funded services, the contributions of enrollment and pharmacy increase to 30% and 20%, respectively. The other Categories of Service are less affected, increasing 1-2%.

Cost and Use Contribution to Variance

Across all DCH-funded services, utilization and cost per service (price) contributed equally to FY02 cost increases. Trends differ by Category of Service, as follows:

- Inpatient Hospital had modest increases (2-3%) for both use and price.
- Outpatient Hospital saw more than double the inpatient rate of increase (6-7%).
- Nursing Home increase was driven by payments per day.
- Prescription Drugs experienced increases of 4-6% for both use and price.
- Physician utilization increases had four times the impact of rate increases.



Note: Percentages above are not additive contributions to the variance, but represent the individual increases in Use (Services per 1,000) and Price (Payments per Service) within each Category of Service.

These trends are described more fully in the sections that follow on Top Categories of Service.

Focused Analysis -- Top Categories of Service

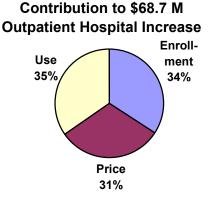
This section provides in-depth drill down of three of the top Categories of Service -- Outpatient Services, Pharmacy, and Inpatient Services. These categories were selected because of their double-digit trends, impact on the DCH budget, and potential cost savings opportunities. After reviewing findings for these areas, we briefly summarize higher-level findings for Nursing Home, Physician, and Dental Services.

Outpatient Hospital

This analysis compares claims cost and use in FY02 to FY01 for Category of Service 07, excluding crossover claims and cost settlement adjustments. Outpatient Hospital showed a 20% increase and was the only major Category of Service with a double-digit increase in net payments per member.

Outpatient Hospital Cost and Use Indicators				
	FY00	FY01	FY02	FY01-02 <u>% Change</u>
Claims Net Payments (millions)	\$287.3m	\$332.0m	\$400.7m	20.7%
Claims Net Payments per Member	\$304	\$334	\$376	12.7%
Services per 1,000 Members	4,645	4,844	5,168	6.7%
Net Payments per Service	\$65.36	\$68.87	\$72.75	5.6%
ER Services per 1,000 Members	533	564	637	13.0%
Allowed Charge per ER Visit	\$60.82	\$80.98	\$90.97	12.3%
Unique Recipients (with an ER Visit)	280,081	309,085	357,211	15.6%
ER Services per Recipient	1.79	1.82	1.86	2.2%

<u>Variance Analysis</u>. Increases in use accounted for the largest share (35%) of the \$68.7 million increase between years. Enrollment contributed 34%, and price per service the remaining 31%, to the growth in costs.

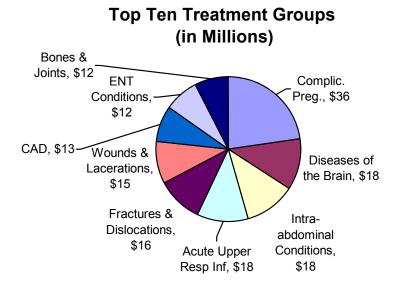


<u>Utilization</u>. Outpatient hospital services per 1,000 (use) increased 7%, higher than the FY00-FY01 increase of 4%. A key driver was Emergency Room use (detailed below). Other key areas of increased utilization (as measured in services per 1,000) were Diagnostic X-Ray (7%) and Pharmacy (6%). Typical pharmacy services in the outpatient setting include chemotherapy and injectable medications. Utilization increased across all aid category groups, with the LIM-TANF population showing the highest increase of all groups (except Refugees) at 9%.

<u>Price/Unit Cost</u>. At 5.6%, the FY01-FY02 trend in payments per Outpatient Hospital service is slightly lower than the FY00-FY01 trend of 6.8%, but higher than observed for all other major categories of service except Nursing Home. Since outpatient hospital reimbursement is cost-based, this area is less controllable than categories of service with fixed rates. The only increase specifically budgeted for FY2002 was \$2.9 million associated with increasing reimbursement for Critical Access Hospitals to 100% of costs. The observed payment growth attributable to increased payments per service was over \$20 million. The difference reflects cost inflation as well as any changes in the mix of Outpatient Hospital services between years.

<u>Top Hospitals</u>. The top fifty hospitals account for approximately 75% of total outpatient hospital expenditures. Between FY01 and FY02, this mix of hospitals remained constant. The increase in payments per service is therefore not explained by changes in the facilities used by recipients.

Type of Care. The top ten diagnostic groups for outpatient hospital net payments in FY02 were the same as those in FY01 and accounted for 47% of total outpatient hospital net payments, similar to last year. These diagnostic groups are shown below. The top diagnosis, Complicated Pregnancies, experienced a 9% increase in total net payments and in FY02 accounted for 9% of total outpatient costs. Acute upper respiratory infections experienced a 43% increase in net payments, growing to 4% of total costs.



A group of conditions that are amenable to disease management -- asthma, diabetes, hypertension, coronary artery disease, and cancer (all types) – represents approximately 9% of total outpatient hospital services in FY02. Moreover, the number of outpatient services for these diseases increased by 12% from the previous year.

Operating Room services grew 23% between years. With rising outpatient costs, programs sometime find that outpatient care can be more expensive than inpatient care for the same treatment. To prevent this, Medicaid policy sets a maximum for outpatient hospital services based on the inpatient DRG rate. To investigate how costs for outpatient surgery compare to inpatient costs, we evaluated four procedures -- laparoscopy/hysteroscopy, cataract removal, excision of breast tissue, and repair of inguinal hernia – that can be performed either inpatient or outpatient. Among DCH patients, more than 90% of these procedures are performed in the outpatient setting. When these conditions are performed inpatient, they are three to four times more expensive. In large part, this is because patients with chronic conditions, such as asthma or diabetes, are more likely to likely to be admitted for surgery so that they can be monitored for complications. This cursory review confirms that the payment policy and hospital pre-certification appears to be working as intended.

Emergency Room (ER). ER services per 1,000 members increased 13% from the previous fiscal year. The Refugee, Blind/Disabled and LIM-TANF populations all experienced double-digit increases. The LIM-TANF population was the highest user of ER services, with a rate of 845 ER services per 1,000 in FY02, followed by RSM Adults and the Blind/Disabled population, at 760 and 670 services per 1,000, respectively. Corresponding with the increase in enrollment, the number of recipients (actually having an ER visit) increased 15.6%, while the number of services per recipient remained relatively stable at 1.8 services per recipient.

The top fifty diagnoses in the ER remained relatively constant from FY01 to FY02 and were consistent with the top diagnoses from last year's analysis. Last year's analysis found that more than 44% of the ER services had diagnoses that can be considered non-emergent. As such, these patients are potentially treatable in a less costly setting, such as a physician's office. The top ER diagnoses by service volume are: Acute Upper Respiratory Infections, Otitis Media (ear aches), Fever, Acute Pharyngitis (sore throats), and Non-infectious Gastroenteritis (ulcer-related). These diagnoses are consistent with the 2000 National Hospital Ambulatory Medical Care Survey (NHAMCS) findings for the most frequently reported primary diagnoses in the ER.⁵

From a cost perspective, Emergency Room accounts for 17% of total outpatient hospital allowed charges. Allowed charges per ER service increased 12.3%, from \$81 to \$91 between years. There were no sharp increases observed, rather a steady increase each month.

More detailed information on patterns of Emergency Room use is presented below in the Emerging Trends section.

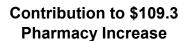
Prescription Drugs

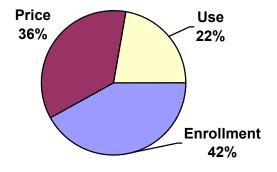
This analysis compares claims cost and use in FY02 to FY01 for Category of Service 30. Express Scripts Inc., the new Pharmacy Benefit Manager (PBM) began administering the program in October 2000, the beginning of 2QFY01. However, many of the new pharmacy policies were not fully implemented until February 2001 or after.

Note that the cost statistics below exclude pharmacy rebates, which are projected at \$155 million in FY02, above the \$139 million in FY01. Claims payments trended at 16.9%, below last year's increase of 20.1%. On a per member basis, the trend fell even more, from 14.9% in FY01 to 9.1% in FY02. Despite these improved trends, total claims costs increased by more than \$100 million between years, approximately double the original budget projections.

Pharmacy	Cost and U	Jse Indicato	rs	FY01-02
Claims Net Payments (millions) Claims Net Payments per Member	<u>FY00</u> \$540.7m \$571	<u>FY01</u> \$647.6m \$652	FY02 \$756.9m \$711	% Change 16.9% 9.1%
Prescriptions per Member Payments per Script	14.4 \$39.63	14.8 \$43.97	15.3 \$46.37	3.5% 5.5%

<u>Variance Analysis</u>. Enrollment accounted for the largest share (42%) of the \$109.3 million increase between years. Price per service, not including the impact of manufacturer rebates, contributed 36% (or \$39 million) to the growth in costs.

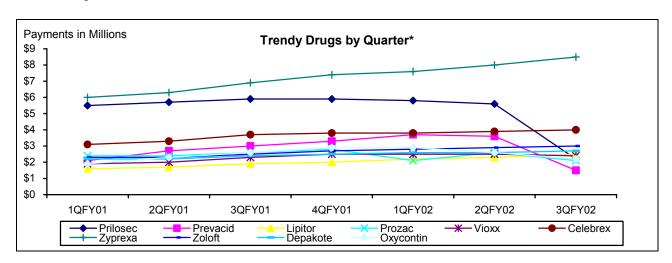




<u>Price/Unit Cost</u>. The 5.5% increase in payments per script in FY02 is half the rate of increase observed in FY01 and is consistent with the CPI-Rx increase for FY02 of 5.4%⁴.

<u>Generic Use</u>. The rate of generic efficiency - generic drugs dispensed as a percent of prescriptions for which generics are available - improved from 87% to 88% between the two years. The percentage of generic scripts as a percentage of total scripts remained stable at approximately 45%. On a positive note, the percentage of single source brand scripts also remained stable at 45%, in contrast to last year, when this category grew 8%.

Mix of Drugs. An analysis of the top drugs for FY02 yielded a comparable list to that observed for FY01. We continue to see growth in new-to-the-market and other "trendy" drugs. In the FY00-FY01 analysis, we drilled-down into the top nine "trendy" drugs for further analysis. When examining the trends for these popular drugs, this year we added an additional drug, for a total of ten: Prilosec and Prevacid (anti-ulcer medications), Lipitor (anti-hyperlipidemia), Vioxx and Celebrex (non-steroidal anti-inflammatory medications), Zyprexa (anti-psychotic), Prozac and Zoloft (anti-depressants), Depakote (anti-seizure), and Oxycontin (pain medication). Together, these ten drugs accounted for 20% of total drug expenditures, up slightly from 19% of the total last year. However, the 7% rate of increase this year was considerably lower than last year's trend of 28%. This lower rate of increase is partly the result of DCH's implementation in February 2002 of a prior-approval policy on two drugs - Prilosec and Prevacid. Additionally, the drug Prozac became available by generic prescription in Spring 2002, further reducing the trend in expenditures.



^{*} Quarterly net payments for FY02 are not adjusted for IBNR.

Prilosec and Prevacid are proton pump inhibitors used for treating gastroesophageal reflux disease (GERD). They are time-release capsules that reduce the amount of acid produced in the stomach. When used correctly, proton pump inhibitors can be 90% or more effective in eliminating GERD symptoms. Prior to the introduction of these drugs, GERD was generally treated with anti-acids such as, Tagment and Pepcid AC, which are now available as over-the-counter medications.⁸

Zyprexa, which accounts for the largest percentage of the "trendy" drugs, is trending steeply upward even before adjusting for IBNR (claims incurred but not yet reported). Zyprexa is an antipsychotic medication which is most commonly used for treating the symptoms of psychotic conditions, including hallucinations, delusions, and confusion. In addition to schizophrenia, Zyprexa is also used to treat bipolar disorder. At present, Zyprexa is the only antipsychotic medication that has been formally approved for treatment of bipolar disorder, however, others including Risperdal are commonly prescribed. Although expenditures for both of these drugs are trending upward, there may be some cost shifting occurring from Risperdal to Zyprexa. Further investigation is warranted to understand any impact of cost shifting.⁶

The top ten therapeutic groups shown below account for 91% of total FY02 pharmacy costs. Central Nervous System drugs alone account for one-third of Medicaid pharmacy expenditures. Seven of the ten "trendy" drugs are included in the Central Nervous System group. Most of the Therapeutic Groups experienced significant increases between FY01 and FY02. The reduction in payments for Gastrointestinal Drugs reflects the prior-approval policy for Prilosec and Prevacid.

	FY02	Incre	ease fron	n FY01
Top Ten Therapeutic Groups	Net Pay (in Millions)	Net <u>Pay</u>	<u>Use</u>	Pay per Script
Central Nervous System	\$254.8	18%	12%	5%
Anti-Infective Agents	\$97.6	19%	11%	8%
Cardiovascular Agents	\$90.0	11%	7%	3%
Hormones & Synthetic	\$69.7	24%	11%	13%
Gastrointestinal Drugs	\$50.3	-2%	8%	-9%
Autonomic Drugs	\$42.0	25%	15%	9%
Blood Form/Coagulants	\$29.0	21%	11%	9%
Antihistamines & Comb.	\$21.5	27%	14%	11%
Skin & Mucous Membrane	\$20.6	17%	13%	4%
Eye, Ear, Nose & Throat	\$17.2	14%	9%	5%

^{*} For additional detail by Therapeutic Class, please see Table 10 in the Appendix.

<u>Aid Category Group</u>. The Aged/Blind/Disabled population accounts for 76% of total prescription drug costs. The FY02 cost per member per year is \$2,405 for the Aged/Blind and \$2,072 for the Disabled, compared to \$291 for the LIM-TANF population. The top two therapeutic groups - Central Nervous System and Anti-Infective Agents - drive the experience for the LIM-TANF and RSM Adult populations.

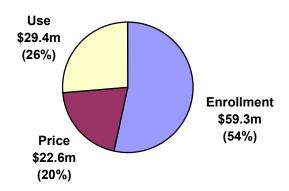
Inpatient Hospital

This analysis focuses on cost and utilization trends for Inpatient Hospital services (Category of Service 01) in Fiscal Year 2002. Due to the lengthy lag for Inpatient claims, an adjustment factor for claims that have been incurred but not reported (IBNR) has been applied to both FY01 and FY02.

Inpatient Hospital Cost and Use Ir	ndicators			
	<u>FY00</u>	<u>FY01</u>	FY02	FY01-02 <u>% Change</u>
Net Payments (millions)	\$731.8m	\$837.2 m	\$948.5 m	13.3%
Payments Per Member Per Year	\$773	\$841	\$890	5.8%
Admissions per 1,000 Members	195	203	210	3.3%
Net Payments per Admission	\$3,967	\$4,145	\$4,246	2.4%
Average Length of Stay	4.3	4.3	4.3	.0%

<u>Inpatient Variance Analysis</u> The year-over-year increase in inpatient payments is estimated at \$111 million, or 13.3%. In FY01 increases in enrollment, hospital rates, and utilization contributed relatively equally to the overall payment increase. However this year, increases in enrollment contributed \$59.3 million or 54% to the total inpatient variance.

Contribution to \$111.3 M Inpatient Hospital Increase



February 3, 2003

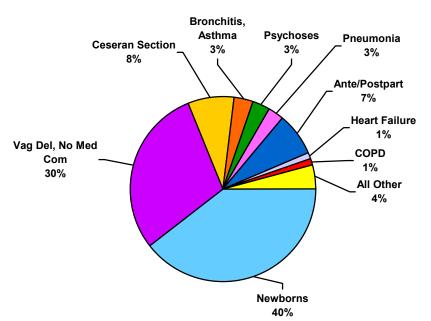
Reimbursement. Net payments per case increased 2.4%, contributing \$22.6 million to FY02 inpatient costs. This is slightly above the \$19 million in total funds appropriated in the FY02 budget to adjust rates by adding add one more year of DRI inflation to the calendar year 2000 cost data.

<u>Utilization</u>. After completion for IBNR, the number of cases increased by 10.6%. However, controlling for the enrollment increase, the rate of admissions increased by only 3.3% from 203 to 210 admits per 1,000 members. The average length of stay remained stable at 4.3 days.

Excluding dually eligible recipients, LIM-TANF recipients had the largest increase in total cases (up 35%) and rate of admission (up 13%). These increases reflect the enrollment growth for this population and their high rate of inpatient maternity care.

<u>Trends by Aid Category</u>. LIM-TANF, RSM Adults and RSM Children had the largest dollar increases in inpatient hospital expenditures, together representing 81% of the \$111.3 million year-over-year increase. The Aged Categories had large percentage increases in net payments – 44% and 20% for the Aged With and Without Medicare, respectively. Though these groups are small, and their trends will fluctuate more than the other groups, the trend for Ages with Medicare suggests increased cost-shifting from Medicare during this period.

Type of Care. The top 50 DRG's show below represent 82% of inpatient cases in FY02.

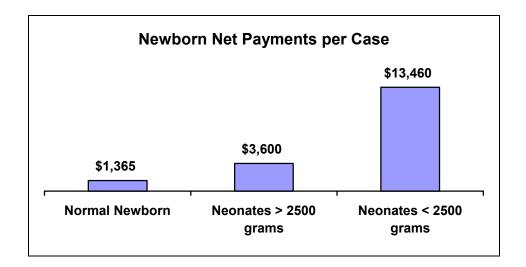


Distribution of Top 50 DRG's by Cases - FY02

While the increased LIM-TANF enrollment resulted in a slightly higher proportion of Maternity/Newborn care compared to FY01, some of the increased utilization has been

for more chronic conditions as well. Sixty-three percent (63%) of all Medicaid inpatient cases are for Newborn and Delivery care.

Thirty-six percent (36%) of the newborns in the Medicaid program had a diagnosis other than normal newborn because of lower birth weight or other complications (these are coded as DRGs 600-630 for <750 grams through >2499 grams, with complications). Neonates with birth weights less than 2500 grams represented 8.6 % of all deliveries, compared with the CDC's National Center for Health Care Statistics (NCHS) reported average of 7.6%. Costs for care of these newborns are significantly higher than costs for Normal Newborns, with payments for the most severe neonates (DRG 602, Neonates less than 750 grams) averaging more than \$96,000 per case for hospital costs alone.



<u>Impact of Prenatal Care</u>. Lack of prenatal care is strongly associated with an increased risk for low birth weight infants (less than 2,500 grams), preterm delivery and maternal and infant mortality. In FY01, there were 62,758 deliveries in the Georgia Medicaid program, representing 63% of all Medicaid admissions and 45% - 50% of all the deliveries in the State of Georgia. Of Medicaid's delivering mothers, 78% received at least one visit with a physician for prenatal care services. There was no claims-based evidence of prenatal care for the remaining 22%, which is similar to rates for other State Medicaid programs.

It is important to note that the claims payment process hinders analysis of prenatal care, in that the use of global billing creates one claim that combines the costs for prenatal care and the associated delivery. This makes it more difficult to identify the *number* of prenatal visits. However, in our analysis, we looked for *any* physician or physician-related service for pregnancy-related care, up to 280 days prior to delivery.

The criteria for program eligibility contribute to lower prenatal care rates in Medicaid, and Georgia's experience is comparable to other State Medicaid programs with similar eligibility criteria for maternity care. However, the Georgia rate for lack of prenatal care is significantly higher than the NCHS national rate of 4% and than the Georgia all-payor rate of 2% based on birth certificate data. Because the importance of prenatal care is widely accepted, inadequate prenatal care should be considered a cautionary health indicator directly related to the number of low birth weight births in Georgia. 11

<u>Top Hospitals</u>. Similar to FY01, we found that the distribution of providers of inpatient care changed only slightly in FY02. Below is a distribution of the top ten inpatient providers.

<u>Hospital</u>	Cases	<u>Days</u>	<u>Payment</u>	Pay per Case
Grady Memorial	9,690	55,145	\$50,553,939	\$5,217
Henrietta Egleston	2,890	17,974	\$34,464,552	\$11,925
Medical Center of Central	4,766	26,406	\$28,667,357	\$6,014
MCG Health Center	3,103	18,885	\$23,941,463	\$7,715
Memorial Medical Center	4,361	23,946	\$23,777,281	\$5,452
Scottish Rite	2,259	12,458	\$21,784,924	\$9,643
Atlanta Medical Center	3,926	17,427	\$18,985,246	\$4,835
Phoebe Putney	4,588	20,758	\$18,910,262	\$4,121
Dekalb Medical	5,620	20,797	\$16,093,755	\$2,863
Southern Regional	4,316	15,567	\$14,890,999	\$3,450

While the hospitals vary significantly on average payments per case, there are multiple The mix hospitals and their types of cases, program policies for reimbursement of disproportionate share and rural hospitals and the DRG payment methodology all contribute to the variance in payments by hospital.

Other Top Categories

In FY02 **Nursing Home** payments increased \$46.8 million or 6.3%. This amount does not include ICF – MR (COS 17/18) or Hospice (COS 69). Increases in price drove the overall variance in Nursing Home payments. While there were slight increases in enrollment for the Aged without Medicare population, these increases were off set by decreases in other groups utilizing Nursing Home services.

Payments per day increased 6.7% in FY02 compared to last year's increase of 3.5%, contributing \$49.8 million to the overall cost increase. This amount is higher than the FY02 budgeted rate increase of \$42.2 million. Utilization declined 0.5% between years to just under 10,500,000 bed days.

Physician Services increased \$72.7 million in FY02, a change of 18.2%. When controlled for enrollment, payments per member per month increased 8.4%. Use and enrollment together contributed 87% to the increase in physician payments in FY02.

Utilization rates for physician services rose by 8.2% in FY02, compared to a 3% increase in FY01. The increases were primarily driven by an increase in office visits, ER visits and other consultations. Rates of physician ER services increased 15% in FY02. The steep increase in ER use raises concerns about the appropriateness and cost-effectiveness of care. These concerns have led to a more in-depth study of ER utilization that Medstat is conducting in conjunction with the Georgia Better Health Care program.

Payments per physician service increased about 2%, accounting for \$9.3 million, below the budgeted FY02 increase of 3.6% or \$15 million. This modest increase in FY02 price follows an FY01 increase of 7.6% after the July 2000 rate change to 90% of the 1999 Medicare RBVS fee schedule. In part, the lower than expected impact of the FY02 rate increase reflect changes in the mix of services (i.e., the higher frequency of comparatively low-cost office visit services). One possible follow-up would be to examine physician payments using Relative Value Units, which adjust for the intensity of services.

Although **Dental Services** are not among the top Categories of Service in terms of payments, this category continues to experience large increases. Payments for dental services increased 38.2% or \$23.5 million in FY02. Adult dental also increased, from \$9.7 to \$12.5 million. While we saw similar increases in FY01, the majority of that increase was attributable to the rate enhancement effective July 2000, which raised Georgia's fees for dental procedures to the level of South Carolina's rates, or by at least 10%. However, while price drove 81% of the FY01 increase, in FY02 price increased only 3.6% (or \$2.9 million), and use drove 69% of the increase in dental payments.

The number of participating providers increased 11% from FY01 to FY02, consistent with the DCH goal of increasing access to care. The number of children receiving

services increased by 25% from FY01 to FY02, not adjusted for IBNR (with claims paid through July 2002).

The top ten procedures account for approximately 50% of the total costs and are primarily related to evaluation procedures, cavities and sealants, and stainless steel crowns. Steel caps have been a focus for fraudulent providers in other states. While the rate increase appears to be achieving its intended goal of improving access, continued monitoring of utilization patterns is warranted. Reimbursement enhancements also create more incentive for Fraud, Waste and Abuse.

Emerging Trends

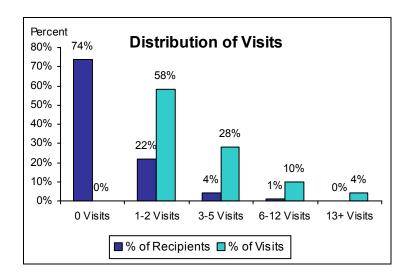
In addition to reviewing areas that contribute to ongoing growth in the Medicaid program such as Pharmacy, Enrollment, Inpatient and Outpatient services, we have also identified several areas that represent "emerging trends." These are areas for more in-depth analysis to support program planning and management. Though not an all-inclusive list, areas worthy more ongoing evaluation and monitoring include:

- Increased use of emergency room;
- Impact of DHR-funded waiver programs on Medicaid costs;
- Management of high cost recipients; and
- Impact of mental health care on total Medicaid costs.

Increased Use of Emergency Room

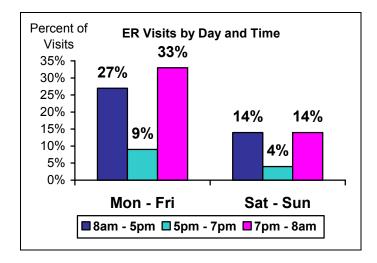
In a special study on Emergency Room utilization performed for Georgia Better Health Care (which includes PeachCare), Medstat found increasing utilization across all aid category groups. A regional view of ER visits found that the Metro Atlanta Region has the lowest ER rates, while the Northwest Region has the highest rates (801 per 1,000 for Calendar Year 2001, the most recent year included in that analysis).

The second phase of the GBHC ER study is completed and will be presented to DCH in December. As part of this phase of the study, we reviewed recipient patterns of utilization to identify potential action strategies. Preliminary results indicate that 74% of GBHC members do not visit the ER at all in a given year. Of the total ER visits, 58% are by members who visit only one to two times per year. At the other end of the continuum, 14% of all visits are incurred by the less than 1% of the population who visit the ER 6 or more times in a year.

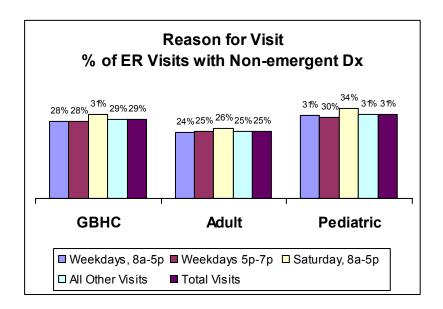


One focus of the ER study was to determine whether the increase in ER rates is associated with new enrollees or continuing enrollees. The same pattern of results as shown above was observed when the analysis focused only on members who were enrolled in GBHC nine months or more. Furthermore, when looking at ER use by length of enrollment, only 9% of ER users had been enrolled for only a month or two. Approximately 72% of ER users had been enrolled for nine months or more. This presents opportunities to intervene with high utilizers. Currently, GBHC Primary Care Providers receive semi-annual listings of all of their members who have visited the ER, so that they can encourage use of the office setting when possible in the future

Analysis of ER use by day of week and time of day reveals that approximately 27% of total ER visits occur during Monday through Friday during regular office hours (8 AM to 5 PM). Additionally, 9% of visits occur during Monday through Friday from 5 PM to 7 PM, when extended office hours could be available.



While most ER services are for emergency care, further analysis of the reason (or diagnosis) for the ER visit revealed that 29% of the total ER visits were for non-emergent care (compared to 44% for the just the *top 50* diagnosis mentioned previously). Continuing to drill-down by day of week and time of day showed that for total visits occurring during regular physician office hours (Mon. – Fri., 8 am to 5 pm), 28.4% were for a non-emergent diagnoses. The graph below indicates that most recipients using the ER for non-emergent care are not seeking more ER services after hours or on the weekend. They tend to have the same distribution of ER visits regardless of the time of day or day of week. These results confirm the importance of continued member education for guidelines when seeking Emergency Services.



Additionally, we wanted to determine if there was any relationship between ER use and the Medicaid program policy limiting recipients to 12 physician visits per year. Our preliminary analysis showed that for recipients with 13 or more office visits, approximately 65% of them also utilized the ER. Of those with an ER visit, about 27% had 3 or more ER visits. This indicates that a further review of expanding the 12 visit limit could decrease the number of overall ER visits. Similarly, we wanted to see how many of the "Frequent Flyers" or recipients with more than 13 ER visits, had also hit the 12 office visit limit. Of these heavy users, approximately 31% of them also had 13 or more office visits. Initially it appears that while some of the heavy users have hit the 12 visit limit, most are likely opting to use the ER instead of traditional physician visits.

Impact of DHR-Funded Waiver Programs on Medicaid Costs

Although several of the Medicaid waiver programs are funded by DHR, they have a substantial impact on total Medicaid expenditures. There are two ways these programs can impact Medicaid costs:

• By bringing in new enrollees. In last year's analysis, we found that this was not a major cost driver. In FY00 and FY01, most recipients (over 90%) in the ICWP,

MRWP and CCSP programs were already enrolled in Medicaid in the year prior to their waiver program enrollment.

• By providing access to non-waiver services. While these programs bring a comparatively small number of "new" recipients into the Medicaid program, these recipients have significant expenditures above and beyond the DHR-funded services. In FY02, 28% of services provided to recipients in waiver programs were for services outside the waiver Category of Service. These services contributed an additional \$115 million to Medicaid expenditures in FY02. For the CCSP (the largest waiver), approximately half of the services for recipients are for non-waiver services.

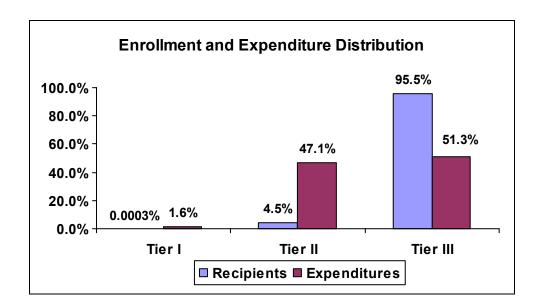
Waiver Program	Number of Enrollees*	Number of Recipients	COS only	Total Payments	Total Pay per Recipient	Non COS Payments as Percent of Total
66 Independent Care	561	508	\$ 19,353,829	\$ 25,306,843	\$ 49,817	23.5%
68/94 MRWP - Brook Run	8,055	8,264	\$ 187,423,295	\$215,044,942	\$ 26,022	12.8%
59 CCSP Total	15,012 23,628	14,012 22,784	\$ 86,743,494 \$ 293,520,619	\$168,057,113 \$408,408,898	\$ 11,994 \$ 17,925	<u>48.4%</u> 28.1%

^{*} Recipients are identified by COS where enrollment detail is not available

Management of High Cost Recipients

As observed in other healthcare programs, a relatively small number of individuals account for a significant share of total program payments. For Georgia Medicaid, we found that approximately 58,000 (or 4.5%) of Medicaid recipients had annual payments greater than \$15,000 and they accounted for approximately \$2 billion or (48.7%) of total Medicaid payments in FY01. We further divided this group into three cohorts to better evaluate areas for management opportunities: 1) Tier I - the top 300 recipients representing very high cost cases as a result of catastrophic illness 2) Tier II - high cost recipients (claims greater than \$15,000) which includes those with more chronic mental health and disability-related conditions, and 3) Tier III - the largest group of Medicaid recipients, representing non-acute maternity and pediatric care as well as more chronic conditions.

Tier I represents recipients with high individual claim experience. Tier II includes those with ongoing high costs related primarily to mental health and other disabilities. These recipients contribute the most to Medicaid costs. Tier III recipients, while the largest group, use significantly fewer services compared to Tier II.



<u>Top 300 Recipients (Tier I)</u>. The average annual cost per recipient for this cohort was \$210,308. Approximately 63% of these costs related to neonatal care. The primary diagnoses for this group were acute respiratory conditions, pneumonia and Cardiomegaly related to prematurity. Also present were conditions affecting the most costly Blind and Disabled population.

While these recipients are not candidates for long-term Disease Management programs due to the acute nature of their cases, there is a potential for costs to be better managed through high cost case management programs that identify these patients early in the treatment process and monitor their delivery of care through (and immediately following) the acute episode. Some commercial health plans also negotiate special reimbursement rates with hospitals and other providers that specialize in helping manage these high cost cases.

Other High Cost Recipients with Claims >\$15,000 (Tier II). The average annual cost per recipient for all high cost recipients (the top 4.5%) was \$31,894. Approximately 58% of these costs related to care for persons ages 21-65 (with 84% of these recipients in the Blind and Disabled Aid Category Group). The primary diagnoses for this group (though often related to acute complicating conditions) are mental retardation, chronic renal failure and respiratory conditions. However, such conditions as HIV/AIDS, oncology-related, heart disease, hypertension and bronchitis also begin to emerge in the top diagnosis categories. We would consider these recipients better suited for disease and case management programs targeted toward their chronic conditions and disabilities. They are likely experiencing more acute episodes (such as hospitalizations) related to their chronic conditions. Many of these individuals are already in waivered programs providing community-based services for the disabled, while others will be identified as the State continues to design and implement disease management programs.

<u>Lower Cost Recipients (Tier III)</u> The average annual cost per recipient for this group is significantly lower at \$2,133. This group represents almost 96% of Medicaid enrollment and includes mostly LIM-TANF recipients. This group tends to be the more "routine" users of Medicaid services for maternity, pediatric and less acute episodes of conditions such as Asthma, Hypertension and Diabetes. While care management and utilization interventions for targeted subset of this group could result in long-term costs savings, they would not likely be the focus of more short-term interventions aimed at more immediately reducing costs for the most expensive recipients.

Impact of Mental Health Care on Total Medicaid Costs

While costs for mental heath services have been an ongoing factor in Medicaid, these costs have increased more dramatically in recent years. This increase is partially due to deinstitutionalization and the escalating costs for prescription drugs used to manage mental health-related conditions. We took an initial look at this area of care as a potential focus for additional analysis and reporting. We focused on COS 44 (Mental Health) recipients and the full range of Medicaid services they receive during the year.

The distribution of payments for these Mental Health recipients by aid category is approximately 60% for Blind & Disabled and 40 % LIM-TANF. The top diagnoses for this population are Psychosis, ADHD, Schizophrenia and Bi-polar Disorders.

	Payments for Recipi	ients with Mental Healt	n Services
	FY01 Net Payments	FY02 Net Payments	% Change
COS 44 Only	\$61,504,570	\$85,777,870	39%
Other DHR-Funded Svcs	\$84,454,101	\$78,221,190	-7%
Other Medical	\$80,448,397	\$96,184,291	19%
Outpatient (includes ER)	\$23,963,593	30,373,986	26%
Long Term Care	\$4,882,296	\$4,008,875	-18%
Prescription Drugs	\$86,205,413	\$101,933,055	18%
Total	\$341,458,370	\$396,499,267	16%

Costs for DHR-funded Mental Health services increased 39% in FY02 while other DHR funded services decreased 7% for these recipients. Payments for inpatient and physician care ("other medical") increased 21% and prescription drugs costs increased 18%, contributing to a 16% overall increase in costs for these recipients.

The most frequently prescribed drugs for this population include Zyprexa and Risperidone. Zyprexa is currently the top drug in payments for the entire Medicaid program, of which these individuals are the primary recipients.

Further analysis of current treatments for this population could help identify opportunities to better manage care and have a significant impact on costs and quality of care.

States' Plans to Reduce Medicaid Spending Growth

Based on results from the Kaiser Commission's 50-state survey published in September 2002, most states are increasing pharmacy controls and freezing or reducing provider payments to address Medicaid spending growth. However, an increasing number of states are planning cuts that have an even more immediate impact on beneficiaries, including raising co-payments and eliminating optional benefits and aid categories. According to the survey, states are:

- Increasing controls on prescription drugs. The majority of states are changing their prescription drug policies. States are planning to seek larger discounts and rebates on their purchases of prescription drugs, increase their use of prior authorization and preferred drug lists, require beneficiaries to use generic drugs, and change dispensing fees. Six states are starting to limit the number of prescriptions that a Medicaid beneficiary may fill in a month, regardless of need.
- Cutting or freezing provider payments. More than half of the states reported that in FY2003 they would either reduce or freeze their payment rates for at least one category of Medicaid provider -- doctors, hospitals, nursing homes, and/or managed care plans. While many states will increase some provider rates in FY2003, the number of states planning to do so fell to 34 from 45 in FY2002.
- Eliminating benefits for Medicaid beneficiaries. Nine states scaled back Medicaid benefits in FY2002 and fifteen will make cuts in FY2003. A number of states, including Montana, North Carolina, and Missouri, reduced dental benefits for adults. In addition, Kansas reduced home health services and Missouri reduced coverage for vision services and some women's health services, including postpartum care.
- Increasing cost-sharing for Medicaid beneficiaries. Because most Medicaid beneficiary incomes are by definition quite limited, federal Medicaid law limits the amount of cost-sharing states may impose. But within these limits, 19 states plan to initiate or increase beneficiary co-payments for prescription drugs in fiscal year 2003. In addition, 15 states plan to begin charging co-payments for other services or to increase existing co-payments. Montana instituted coinsurance requiring beneficiaries to pay five percent of the cost of most services.
- Reducing the number of people who are eligible to enroll in Medicaid. For FY2003, 18 states plan to reduce eligibility for Medicaid. In most states, these changes were narrowly targeted. Some states, for example, changed the policies governing how individuals with high medical expenses qualify for Medicaid, or eliminated continuous eligibility. Some states are lowering the threshold at which parents become eligible, reducing transitional coverage for people moving from welfare to work, and changing the period of allowable medical expenses for the medically needy.

- *Managed Care and Disease Management.* States are also planning to achieve savings in their Medicaid programs by moving more people into managed care plans and instituting new disease management and program integrity programs.
- States also intend to make long-term structural changes through waivers. More than half of all states reported that they are considering or implementing waivers this fiscal year. Initially promoted as a mechanism for states to expand coverage within existing resources, state and federal financial constraints mean that these waivers could be used to reduce benefits, limit enrollment, or impose higher cost-sharing for some beneficiaries, beyond what is permitted under federal Medicaid rules.

	No. of States Taking Action		Georgia	Actions
	FY2002	FY2003	FY2002	FY2003
Pharmacy Controls	32	40	\checkmark	✓
Provider Payments	22	29		
Fraud and Abuse	16	19	✓	✓
Disease/Case Management	11	21	✓	✓
Managed Care Expansions	10	12		
Benefits Reductions	9	15	✓	
Eligibility Cuts	8	18	✓	✓
Long-Term Care	7	13		✓
Copays (other than Rx Drugs)	4	15		

Source: Kaiser Commission on Medicaid and the Uninsured. Medicaid Spending Growth: Results from a 2002 Survey.

Based on the Kaiser survey results, Georgia has implemented five of the nine cost containment programs in FY2002 and planned to implement initiatives in long-term care in 2003. The following section summarizes recent Georgia's recent cost containment activities and highlights current opportunities.

DCH Cost Containment Initiatives and Opportunities

<u>Pharmacy</u>. Georgia has been a leader among Medicaid programs in pharmacy cost containment, starting with the implementation of a Pharmacy Benefits Manager (Express Scripts, Inc.) in October 2000. Actions taken since that time include the following:

- Implemented concurrent Drug Utilization Review
- Implemented three-tier member co-payments
- Added to the list of drugs requiring Prior Authorization
- Removed the preferred brand dispensing fee incentive
- Restricted the number of drugs identified as Narrow Therapeutic Index and therefore exempt from mandatory generic policy
- Implemented additional therapy limitations or quantity level limits
- Reviewed and tightened policies, e.g., duplicate dispensing
- Enforced and recovered on Most Favored Nations Pricing
- Continued to aggressively pursue pharmacy fraud and abuse
- Significant increases in the number of drugs subject to the MAC, which resulted in discounts of 50%-70% off AWP

Georgia has implemented seven of nine pharmacy cost containment measures that states are implementing, according to a recent survey by the National Association on State Health Policy (NASHP).¹³ Georgia was ahead of many of its peers in this program area.

	<u>Georgia</u>	Other St	ates* Planned
PBM	✓	19	2
Joint Purchasing	✓	9	13
Cost-Sharing	✓	14	2
Disease Management		10	7
Counter-Detailing		7	2
Preferred Drug List/Formulary	✓	15	6
Prescription Limits	✓	11	4
Pharmacist Reimbursement	✓	11	3
Manufacturer Reimbursement	✓	10	5

Source: National Association on State Health Policy, 2002.

Because many of the FY2002 actions were taken in the middle of year or later, their impact is not fully measurable in the data available for this report. As described in the

Focus Areas section, the most immediate impact was observed for several high profile drugs added to the Prior Approval List. The Proton Pump Inhibitors Prilosec and Prevacid became subject to Prior Approval in February and a significant drop-off in claims was observed in the initial months. Combined monthly payments for these two drugs fell from an average of \$3.1 million before prior approval to less than \$300,000 in the two months immediately following program implementation.

Short-term Opportunity: Evaluate the Prior Approval program after sufficient time has passed to capture more lasting changes in physician and recipient behavior and outcomes. In FY02, providers and beneficiaries were still adapting to the program requirements. Medstat recommends a rigorous program evaluation of the impact of these program changes as more claims experience becomes available.

<u>Provider Payments</u>. Unlike many other states, Georgia did not cut or freeze payments for its major provider groups (hospitals, physicians, nursing homes) in FY2002. Instead, the State continued to incrementally increase rates to help providers keep pace with inflation. Prior to FY01, rates for physicians and dentists had not been increased in a number of years, raising concerns for provider participation and access. Rates were adjusted in FY01 and further enhanced in FY02 and FY03. As a result, in FY02 the number of participating dentists increased 11% and the number of children receiving care grew by 25%. These findings support the benefits of the recent rate increases for these critical provider groups.

Other recent steps the DCH has taken in provider reimbursement include:

- Selective contracting for non-emergency transportation and diabetic supplies.
- Reducing or eliminating rates for ancillary providers. In FY02, maximum allowable rates were lowered for Durable Medical Equipment and Orthotics and Prosthetics. In FY03, Georgia eliminated a rate increase for non-emergency transportation providers.
- Implementing case mix-adjustment for nursing home payments.
- ➤ Long-term Opportunity: Pursue prospective payment approaches for outpatient hospital care, the most rapidly growing category of service. Other states that plan to implement prospective reimbursement include Washington (which has developed a system based on the CMS Ambulatory Payment Classification (APCs) for its Medicaid and state employee plans) and New Hampshire (planning to implement a transitional system prior to APCs).
- > Short-term Opportunity: Preserve and enhance provider rates for maternity care, to ensure access to vital pre-natal care. Maternity rates have not been updated in a number of years.

Fraud and Abuse. Since expanding its Program Integrity Unit to 50 employees in 1999, DCH has stepped up its detection and investigation of fraud, waste, and abuse. DCH works in partnership with the Attorney General and other state agencies to support the Medicaid Fraud Control Unit. Recognized as one of the best units in the country, the

Georgia MFCU has obtained over 130 convictions and been awarded over \$35 million in fines and restitution. DCH's Pharmacy Task Force, formed in 2000 has been particularly productive in investigating local pharmacies, Oxycontin prescriptions, abuse of generic physician license number by pharmacies, and institutional pharmacies.

> Short-term Opportunity: Focus on ambulance, durable medical equipment, podiatry, independent labs, and dental, all of which are vulnerable to fraud and abuse and showed double-digit cost increases this year.

<u>Disease/Case Management</u>. DCH has been planning disease and case management programs for Medicaid, leveraging the experience of the State Health Benefit Plan and the capabilities of the PBM and targeting Asthma, Diabetes, Hypertension, certain Cancers and HIV/AIDS.

- Short-term Opportunity: Implement high cost case management for patients for whom the opportunity for impact and immediate savings are greatest. Ensure that current programs for high-risk neonates are effective and expand case management to high cost cases in the adult population, focusing on early intervention, coordination of care, and substitution of less intensive settings where appropriate.
- **Long-term Opportunity:** Explore opportunities to improve effectiveness of care for members with disabilities and chronic medical conditions, especially in the mental health arena.

<u>Managed Care</u>. DCH terminated its HMO plans several years ago and has instead focused on strengthening its Primary Care Case Management Program (PCCM). Recent initiatives include recertifying the Primary Care Providers and providing them with performance feedback through the PrimaryCarePlus program. However, the FY02 amended budget exempts certain eligibility groups (those with other coverage, including Medicare) from GBHC participation. Managed care strategies can be important in helping manage utilization, which has been a major cost driver the past two years.

- > Short-term Opportunity: Leverage the foundation GBHC has established to further improve coordination of care, reduce emergency room utilization, and increase preventive services and prenatal care. Continue provider feedback, roll out member education, and consider reimbursement incentives targeted to specific areas for improvement. For example, Massachusetts provides enhanced fees for certain primary care services and Oklahoma provides an incentive bonus for well child care.
- Short-term Opportunity: Continue reporting and monitoring efforts that identify areas for improvements in the quality and cost-effectiveness of care. For example, as a follow up to findings in this report, further assess why a large percentage of delivering Medicaid mothers women show no claims for prenatal care (linking in birth certificate data, if possible). This would help identify appropriate interventions that could increase the number of pregnant women receiving adequate prenatal care and reduce the incidence and cost of low birth weight neonates.

➤ Long-term Opportunity: Evaluate managed care models that have proven successful in the private sector and other Medicaid programs and that can work in Georgia.

Benefits and Eligibility: DCH was forced to make only one cut in FY02, eliminating the second year of Medicaid coverage for people transitioning from welfare to work. In FY03, funding for a number of planned expansions was eliminated. Until this past year, DCH had made progress in expanding coverage, adding eligibility for women with breast and cervical cancer and raising the income level for Right from the Start Medicaid pregnant women and infants to 235% of the Federal Poverty Level (FPL).

➤ Long-term Opportunity: Explore options for more flexible benefit plan designs for optional and expansion eligibles under Health Insurance Flexibility and Accountability (HIFA) waivers, as a means to maintain and build on Georgia's recent success in expanding coverage. The need to expand health insurance continues -- U.S. Census bureau data released this month show that in 2001 Georgia had the fourth highest increase in the rate of uninsured among all states, rising to 15.5% or 1.2 million residents¹⁴, and this was before the recession worsened. In considering potential HIFA waivers, the State needs to find ways to prevent private employers from dropping their coverage if state-sponsored options become available.¹⁵

<u>Member cost-sharing</u>. Georgia implemented tiered pharmacy co-payments in FY2002 to encourage cost-effective prescription drug utilization.

> Short-term Opportunity: In moving toward a benefit design that incorporates best practices from commercial plans, explore adding nominal co-payments for select services to encourage cost-conscious member behavior. Commercial plans have implemented co-payments to encourage members to make healthcare delivery choices that provide the most appropriate care in the most appropriate setting, thus impacting such service areas as ER use. Current federal regulations limit member cost-sharing in Medicaid to no more than \$3 per service and exclude certain eligible categories (children) and services (ER). DCH could begin with select services today and expand on these in the future through waivers. Care should be taken to avoid introducing co-payments that could present barriers to necessary care (e.g., office visits that help manage chronic illnesses).

<u>Long-term Care</u>: Georgia is implementing case-mix adjusted payments and capitating pharmacy reimbursement for long-term care providers. DCH and DHR have also been continuing to expand slots in home- and community-based waiver programs to provide more individuals with alternatives to institutional care.

> Short-term Opportunity: Continue monitoring and reporting efforts to better understand the total costs of individuals in the home and community-based waivers and to monitor and evaluate the impact of these programs.

References

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² <u>Fiscal Survey of the States: May 2002</u>. National Association of State Budget Officers, June 2001.

³Holahan, J. & Garrett, B. "Rising Unemployment and Medicaid." The Urban Institute, www.urbaninstitute.org, October 16, 2001.

⁴Bureau of Labor Statistics, www.bls.gov.

⁵National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary. National Center for Health Statistics, April 22,2002.

⁶Rowett, Dana L. "Atypical antipsychotics for the treatment of bipolar disorder." WebMD, http://my.webmd.com, October 23, 2000.

⁷<u>Facts on Children's Hospitals</u>. National Association of Children's Hospital and Related Institutions, http://www.childrenshospitals.net, 2001.

⁸Smith, Trish. "Proton pump inhibitors for gastroesophageal reflux disease (GERD)." WebMD, http://my.webmd.com, March 21, 2000.

⁹Current Trends State-Specific Trends Among Women Who Did Not Receive Prenatal Care - United States, 1980-1992. Center for Disease Control, December 1984.

¹⁰National Vital Statistics Report, Volume 50, No. 5, Prenatal Care. National Center for Health Statistics, Center for Disease Control, 2000.

¹¹ Georgia Department of Public Health – Maternal and Child Health Epidemiology

¹² Smith, V., Ellis, E., Gifford, K, Ramesh, R., & Wachino, V. <u>Medicaid Spending Growth: Results from a 2002 Survey</u>. Kaiser Commission on Medicaid and the Uninsured, September, 2002.

¹³ National Association on State Health Policy. <u>Summary of Selected State Efforts to Contain Cost and Increase Consumer Access</u>. July 2002.

¹⁴ The Atlanta Journal-Constitution. "Uninsured Rate Grows in Georgia." October 1, 2002.

¹⁵ Milligan, C. & Forbes, M. <u>Medicaid Budget Options</u>. The Lewin Group. Prepared for Princeton Conference, June 6-8, 2002.

Attachment 2: RFI Questions

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THIS RFI IS ISSUED TO OBTAIN INFORMATION ONLY AND IS NOT INTENDED DIRECTLY TO RESULT IN CONTRACTS OR PROVIDER AGREEMENTS WITH ANY RESPONDENT.

INSTRUCTIONS

Please provide concise conceptual responses to the questions in Attachment 2 for consideration by DCH decision-makers. Respondents should note that the State may publish responses to facilitate internal decision-making, but will not attribute responses to a specific respondent. Responses that include "Proprietary" information should be clearly marked; the State may show latitude in releasing proprietary information under the Freedom of Information Act.

ADDITIONAL CONTACT INFORMATION

Additional information related to DCH programs, policies and procedures, which may be of use to respondents, can be found at www.dch.state.ga.us. Respondents may request detailed cost and utilization data in the form and format created by DCH by sending a written request to:

Kathrine R. Driggers, Chief
Division of Managed Care & Quality
Georgia Department of Community Health
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159
gamedicaidrfi@dch.state.ga.us (email)
1-877-656-9714 (fax)

The request for detailed cost and utilization data must be accompanied by a signed RFI Confidentiality Statement that can be downloaded from the DCH website at www.dch.state.ga.us and must include the requestor's name, company and mailing address. All pertinent data will be provided on CD. DCH will not accept requests to provide data in alternate formats or for additional types of information. Only written requests including the signed Confidentiality Statement and received via U.S. Mail, Fax or Email, will receive a response.

RESPONSE DUE DATE

Responses to the questions on the following pages must be received by **10:00 a.m. Eastern Standard Time, May 1, 2003**, to be considered by the State. Responses may either be mailed hard copy or attached electronically to an email. A hard copy submission must also include an electronic copy on CD or diskette. Responses should be addressed to the above-stated contact.

After the State has reviewed the responses, the State will present a proposed model(s) to a variety of stakeholders throughout the State. Once consensus is obtained on the best model for the State of Georgia, the State will acquire the necessary review and or waiver approval for purposes of releasing a Request for Proposal to identify the vendor or vendors that can best assist the State in managing its system of care. The target start date for implementation is the Summer of 2004.

A. CORPORATE BACKGROUND AND EXPERIENCE

Please provide the information requested below about your organization.

1.	Corporate Information:					
	Name:					
	Address of Corporate Headquarters:					
	Telephone Number:					
	Fax Number:					
	Web site:					
2.	If subsidiary or affiliate of a parent organization, corporate information of parent organization.					
	Name:					
	Address of Corporate Headquarters:					
	Telephone Number:					
	Fax Number:					
	Web site:					
3.	Type of Ownership (Check All Applicable Types):					
	 a. Health Plan b. Hospital c. Provider Network d. Other type of Provider (Please Specify): 					
	 e. Proprietary f. Partnership g. Corporation 					
4.	State of incorporation or otherwise organized to do business:					

5.	Contact Information		
	Name:		
	Title:		
	Address:		
	Telephone Number:		
	Fax Number:		
	E-Mail Address:		
6.	Please indicate all services that your or provides. If the function is subcontracted as a subcontracted function (check all	ted to an outside	entity, please list it
		Direct	Subcontractor
	a. Physical Health Benefits		
	b. Dental Benefits	<u>u</u>	
	c. Vision Benefits		
	d. Non-Emergency Transportation e. Behavioral Health Benefits		
	f. Pharmacy Benefits g. Long-term Care Benefits (e.g.,		
	home-health, nursing home, home	<u> </u>	
	and community-based services)	_	<u>_</u>
	h. Claims processing and		
	adjudication	П	П
	i. Recovery of third party resourcesj. Quality Assurance		
	k. Utilization Management		
	I. Case Management/Disease		
	Management	_	_
	m.Provider Credentialing		
	n. Enrollment Assistance (e.g.		
	Enrollment Broker)		
7.	Medicaid Program Experience		
	 a). Are you currently a Medicaid program question 7.b. If no, proceed to question Yes No 		If yes, proceed to

programs in which you are participating.
c) If you are currently a Medicaid program service vendor, please specify which populations you are serving (check all that apply):
Recipients who receive both Medicare and Medicaid
Aged, Blind, and Disabled
TANF
TANF-Related
SCHIP

b) If you are currently a Medicaid program service vendor, please identify the state and provide a brief description of the services you provide and the

8. If you are currently not a Medicaid program service vendor, please provide a brief description of the services you provide and the populations you are serving.

B. MODEL

- Please describe the service delivery model (or models) that your organization would recommend for the State of Georgia in order to achieve the goals articulated in this document. Please describe the specific components and characteristics of the model and specify how you would integrate the following features:
 - a) Care management for all enrolled members;
 - b) An easily accessible point of entry for all Medicaid beneficiaries and PeachCare members regardless of type of eligibility or level of service need;
 - c) A streamlined, more efficient and cost-effective eligibility determination process;
 - d) Better coordination of services across traditionally fragmented systems of care (acute, behavioral health, long term care);
 - e) Incorporation of the best elements of the State's existing infrastructure:
 - f) Incentives throughout the system for the appropriate management of the services:
 - g) Program and provider accountability obtained through a quality improvement program;
 - h) Care delivery in the most appropriate setting; and
 - i) A reduced rate of growth in costs.
- 2. What specific issues identified in the RFI or other issues that your organization has identified about Georgia's Medicaid/PeachCare Program will your model address and resolve? Please be specific.

3.	How will your model and /or your organization provide effective management of the services provided by the Division of Mental Health, Mental Retardation and Addictive Diseases and Division of Aging and enable these Divisions to fulfill their responsibilities under state law? How do you plan to incorporate existing community infrastructure?
4.	How will your model achieve cost savings? (e.g., reimbursement rates, reduction in emergency room use the use of lower levels of care where medically appropriate, etc).
5.	The State is interested in working with a vendor who is willing to share financial risk. Ideally, what type of payment method would your organization require for the model you have proposed? Specify if your payment requirements change over time.
	 □ a. Fully at risk for a capitated rate □ b. Partially at risk Fee-based reimbursement with up and down-side
	profit/loss sharing □ c. No risk with penalties for failure to meet program objectives □ d. Other (please describe)
6.	What type of payment method, if any, would preclude your organization from responding to a Request for Proposals?
7.	How will provider be organized under your model: closed network, preferred network, and any willing provider? Please specify if any provider types will be organized differently than other.
8.	Please specify any capacity limitation your organization would have in terms of the number of participants, types of services, or service areas.
9.	How would your model identify beneficiaries with special health care needs and improve the delivery of services to this population?
10.	Is the model you propose being used elsewhere?

C. **RELATED EXPERIENCE**

- 1. Briefly describe your organization's direct experience providing the services and serving the populations your proposed model includes.
- 2. Identify any services or types of expertise that your proposed model would include for which your organization would delegate responsibility or partner with another entity to provide.

D.

TR	ANSITION
1.	How would you propose that DCH transition to your proposed model? Please explain why.
	 By Geographic Region – please specify order of regions By population (e.g., TANF, TANF-related, SSI, Medicaid/Medicare Dual eligibles, etc.)
	By system of care (e.g., acute care, behavioral health, long-term care, etc.)
2.	In light of your proposed transition approach, please provide a timeline from contract award to statewide implementation.
3.	How do you propose to work with providers during the implementation of this model?
4.	What type of assistance would be made to providers currently providing services who may not meet your organization's requirements?