



State of Georgia Department of Community Health

Medicaid and PeachCare for Kids ® Design Strategy Report

January 17, 2012





Table of Contents

Executive Summary

Chapter 1: Overview of Project Goals

Chapter 2: Study Methodology and Limitations

Chapter 3: National Environmental Scan

- A. The National Health Care Economic Environment**
- B. The National Medicaid Environment**
- C. Brief History of Innovations in Medicaid**
- D. State Medicaid Trends and Innovations**
 - 1. Medicaid Delivery Systems**
 - 2. Populations and Services**
- E. Other Emerging Models**
- F. Health Reform**
- G. Conclusion**

Chapter 4: Georgia-specific Scan

- A. Brief Overview of the State of Georgia**
 - 1. Quality of Care in Georgia**
 - 2. Access to Physicians and Other Health Professionals in Georgia**
- B. Medicaid and PeachCare for Kids® Programs**
 - 1. Georgia Families Program Features and Infrastructure**
 - 2. Fee-for-Service (FFS) Delivery System Program Features and Infrastructure**
 - 3. Other Georgia Medicaid Initiatives**
 - 4. Interview, Focus Group and Survey Findings**
 - 5. Conclusions**

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

- A. Overview of Approach to Evaluating Design Strategy Options**
- B. The Department of Community Health's Design Strategy Goals and Strategic Requirements**
- C. Multi-phased Evaluation**



Table of Contents (continued)

Appendices

Tab A: Federal Medicaid Waivers

Tab B: Overview of States Interviewed

Tab C: Case Studies of States Interviewed

Tab D: Eleven Managed Care Long-term Care State Programs

Tab E: Medicaid Reform Proposal Tracker (Aug 2011)

Tab F: States with Fully Integrated Care Programs for Dual Eligibles

Tab G: Medical Home Principles and Standards

Tab H: AHRQ: 2010 State Snapshots

Tab I: Supporting Information for Georgia-specific Environmental Scan

Tab J: Performance Measure Report for Georgia Medicaid and PeachCare for Kids®

Tab K: Georgia Families – Quality Strategic Plan Update – January 2010

Tab L: Behavioral Health

Tab M: Long-term Care

Tab N: Children in Foster Care

Tab O: Dental Services

Tab P: Non-emergency Medical Transportation Services

Tab Q: Pharmacy Services

Tab R: Projected Managed Care Savings

Executive Summary

Recognizing that this is a critical time for Georgia to carefully consider and plan for the future of its Medicaid program, including PeachCare for Kids®, Georgia's Department of Community Health (DCH) is conducting a comprehensive assessment of these programs and engaged Navigant to identify options for innovative redesign of these programs. The first phase of this project required developing this Design Strategy Report which identifies and assesses potential Medicaid redesign options that can be implemented statewide and that will meet DCH's goals for the Georgia Medicaid program:

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

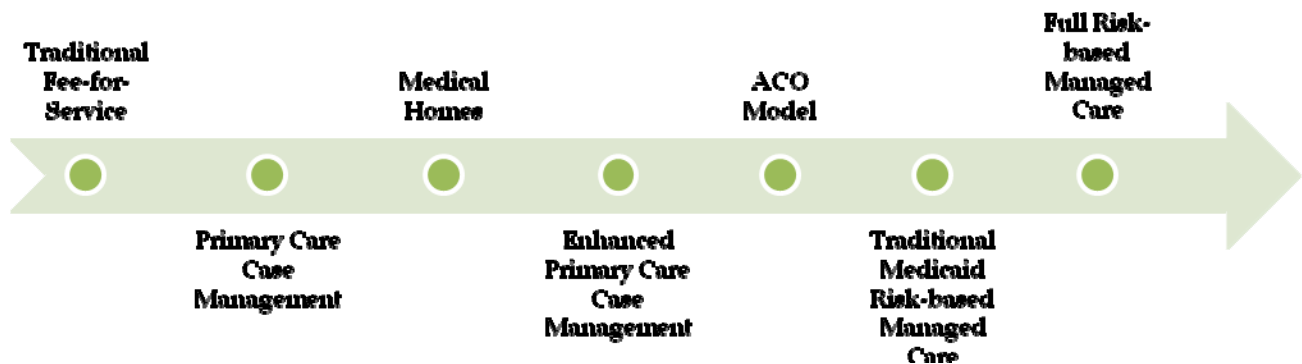
To achieve these goals, DCH identified the below strategies that must be employed through the redesign:

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

Navigant's assessment considers the full range of options reflected in the spectrum of service delivery options below, which presents a wide variety of options that have a reasonable opportunity of effecting change given Georgia's and the nation's current economic and political environments. Navigant also considered hybrid and phased models.

Executive Summary

Spectrum of Delivery Systems – Least to Most Comprehensively Managed



Navigant’s assessment determines that the following three options offer Georgia the greatest likelihood of achieving the above goals and strategic requirements. These three options build upon one another, with each adding features above and beyond the one before it.

- **Georgia Families Plus** – Expands upon the existing Georgia Families program by enrolling all categories of Medicaid members in Georgia Families Plus health plans and:
 - Incorporating value-based purchasing¹
 - Further encouraging use of medical homes, for example, through Patient Centered Medical Homes (PCMHs)
 - Reducing administrative complexities and burdens for providers and members²
 - Increasing patient compliance through incentives and disincentives
 - Increasing focus on health and wellness programs and preventive medicine
 - Continuing to build upon current efforts to focus on quality
 - Carving in more services (such as transportation) and populations (such as people who are aged, blind and disabled)

By making some significant changes to the current Georgia Families program to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to improve care for members currently served through Georgia Families as well as individuals currently in the fee-for-service (FFS) delivery system who do not have access to care management services or other benefits of managed care.

¹ See *Chapter 4: Georgia-Specific Scan* for a discussion about value-based purchasing.

² See *Chapter 4: Georgia-Specific Scan* for a discussion of administrative concerns and burdens identified by providers and members.

Executive Summary

- **Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program – Enrolls** – The ultimate aim under this option is to enroll many of Georgia’s Medicaid members in “commercial style” managed care. *Chapter 3: National Scan*, outlines some of the innovative approaches being employed by commercial insurers to encourage healthy behaviors by their members. Among the tools used by commercial managed care plans are copayments, deductibles, Healthy Rewards Accounts (HRAs), incentive payments and prizes and a myriad of other creative strategies. While some of these can be used in a limited fashion in traditional Medicaid managed care programs, the vast majority of these tools – most notably copayments and deductibles – are not permitted in Medicaid. Because designing the program, obtaining federal approvals for the program and implementing the program will require substantial time and investment, all categories of Medicaid members would initially be enrolled in Georgia Families Plus (described above). “Commercial style” managed care is not well suited to all Medicaid populations, so the following populations would not be targeted for enrollment in the commercial model initially: children in foster care; aged, blind and disabled individuals; and dually eligible individuals would remain in Georgia Families Plus.
- **Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program that Requires Inclusion of Accountable Care Organizations (ACOs) and Patient-centered Medical Homes (PCMHs)** – This model is the same as the model described above, except that under this model participating health plans would be required to include ACOs and PCMHs in their provider networks. Involving ACOs and PCMHs in this way offers potential for further enhanced care coordination and appropriate use of services.

This report is the first in a series of steps DCH will take to select an approach to Medicaid redesign. After gathering further stakeholder input and further considering the redesign options, DCH will select a redesign model.³

The next steps will depend to some extent upon the redesign options DCH ultimately selects. For example, DCH might need to develop a federal waiver application and procure contractors to assist with program administration. Regardless of the redesign options it selects, DCH will then need to conduct a planning process to further determine all key design and programmatic features. DCH will conduct these steps with the goal of implementation in 2014.

³ As DCH refines the design strategy through ongoing planning, it may wish to revisit the scoring of the various options. The initial scoring of options presented in this Design Strategy Report is a tool to help inform DCH’s decision-making and provides a framework for gathering stakeholder input and conducting a rational decision-making process.

Chapter 1: Overview of Project Goals

The Georgia Department of Community Health (DCH) Medicaid Division oversees the Georgia Medicaid program including its Children's Health Insurance Program, PeachCare for Kids® which together cover nearly 1.7 million members. In many regards, Georgia's health care profile mirrors that of the nation. Like many other states, Georgia's population is growing, state budget pressures are increasing each year, and the health care delivery system is pressured to care for increasing numbers of residents while facing a potential physician shortage.

Although Georgia has achieved much, the State, like most states around the nation, must continually explore opportunities to improve access to and quality of care, contain costs and anticipate the potential impacts of federal health care reform.

Recognizing that this is a critical time for Georgia to carefully consider and plan for the future of its Medicaid and PeachCare for Kids® programs, DCH is conducting a comprehensive assessment of these programs. To assist in this initiative, DCH engaged Navigant Consulting (Navigant) to:

- Conduct a comprehensive environmental scan of the Medicaid and CHIP programs on both a national and Georgia-specific basis
- Identify options for innovative redesign of the current Medicaid and PeachCare for Kids® managed care and fee-for-service programs
- Assist with implementation of the design strategy selected by DCH

Navigant's first task is to develop this Design Strategy Report which identifies potential Medicaid delivery system options that can be implemented statewide and to assess the degree to which each of those options will meet DCH's goals and strategic requirements for its future design strategy. DCH developed its goals and strategic requirements through an internal collaborative process and shared them publicly to assure the goals were appropriately vetted prior to Navigant's evaluation of options for the redesign.

Chapter 1: Overview of Project Goals

DCH's goals for the Georgia Medicaid program are to:

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

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

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

This Design Strategy Report presents Navigant's assessment of the likelihood with which each identified design strategy option would enable Georgia to achieve the above goals. This report is deliberately focused on the analysis of delivery system options that have a reasonable opportunity of effecting change given Georgia's and the nation's current economic and political environments.

This report is intended to provide DCH with valuable input as it develops strategies to ensure the future fiscal and programmatic sustainability of the Medicaid and PeachCare for Kids® programs and is the first in a series of steps DCH must take to fully develop a new program design.

Chapter 1: Overview of Project Goals

The design strategy options considered in this report are focused on the macro level; they do not address every aspect of the Medicaid and PeachCare for Kids® programs. Once DCH selects a design strategy to implement, DCH will then need to conduct an extensive planning process to consider options for and define the program design on the micro level, ultimately addressing all key design and programmatic features.

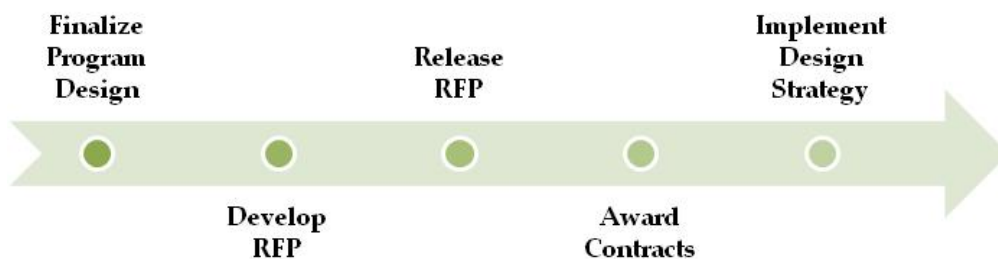
The design will dictate what types of federal approvals are required and the degree to which there might be some flexibility in seeking the necessary federal authorities. Similarly, the design will dictate whether state-level authorities, such as regulations or laws, are needed. The design will also dictate what types of and how many vendors to procure via what types of and how many distinct procurements.

The intricate decisions made during the program design and planning process will influence the degree to which the design strategy is able to achieve its potential. *Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®* outlines some of the key issues DCH should consider and key steps it should take as it conducts its planning process.

As described in *Chapter 2: Study Methodology and Limitations* and in *Chapter 5: Options for Georgia's Future Design Solution for Medicaid and PeachCare for Kids®* the evaluation methods and tools employed in this report can be used by DCH as it refines the design strategy options through ongoing discussions and planning. *Chapter 5* presents Navigant's initial scoring of delivery system options and provides a framework for DCH's use in conducting a rational decision-making process.

Once the program design process is complete, DCH can move forward with procurement, contracting and other implementation steps, as outlined in the Figure 1.1.

Figure 1.1: Program Design and Implementation Workflow



Chapter 2: Study Methodology and Limitations

This Chapter presents a brief overview of the approach Navigant used to conduct our assessment and outlines study limitations. Below we describe our tasks and methodologies followed by a discussion of study limitations.

A. Navigant's Tasks and Methodologies

Below is a description of Navigant's approach to conducting the national environmental scan the Georgia-specific environmental scan and the evaluation of design strategy options.

Conduct of National Environmental Scan

Navigant conducted a national environmental scan that included research of innovative approaches to and best practices in service delivery within Medicaid and Children's Health Insurance Programs nationwide, of developments at the federal level and of trends and best practices within commercial health plans. To conduct this scan, we identified focus areas most relevant to the goals and strategies identified by the Department of Community Health (DCH) for a redesign strategy, as outlined in *Chapter 1, Overview of Project Goals*. We conducted literature reviews and stayed abreast of continual developments in the Medicaid environment throughout the study period.

Through this research, our knowledge of particular innovations, proposed reforms being considered and level of experience within current state programs, we presented to DCH a recommended list of the state programs to survey to supplement our research findings. Below is a listing of states we surveyed based on our recommendations and subsequent input from DCH:

- Arizona
- Florida
- Illinois
- Indiana
- Michigan
- New Jersey
- North Carolina
- Oklahoma
- Pennsylvania
- Texas
- Virginia
- Wisconsin

Additionally, as part of our focus groups with health plans (as described below), we asked questions about innovations the health plans have implemented or are aware of occurring nationally. *Chapter 3, National Environmental Scan*, provides additional information gathered from our research and state surveys.

Chapter 2: Study Methodology and Limitations

Conduct of Georgia-specific Environmental Scan

Navigant also conducted an environmental scan specific to the Georgia Medicaid and PeachCare for Kids® programs. DCH requested that Navigant make this study as inclusive as possible; therefore, we conducted the following activities to obtain comments from a variety of stakeholders:

- Interviews of DCH staff
- Interviews of sister agency staff, including the Departments of Behavioral Health and Developmental Disabilities, Human Services, Juvenile Justice and Public Health
- Statewide focus groups with the following stakeholders:
 - Consumers and consumer advocates
 - Behavioral health providers
 - Dental providers
 - Durable medical equipment (DME) providers and pharmacists
 - Hospitals and Emergency Medical Services (EMS) providers
 - Long-term care, home health and home- and community-based service (HCBS) providers
 - Physicians
- Focus groups with Legislative representatives
- Focus groups with currently contracted vendors and other organizations not currently contracting with DCH
- A Pediatric task force
- Online surveys for consumers, consumer advocates, providers and vendors
- Review of proposals which a variety of individuals and organizations submitted to DCH and which, in turn, DCH provided to Navigant

Please see *Chapter 4: Georgia-specific Environmental Scan* for a listing of focus groups conducted across the State. To identify individuals interested in attending the focus groups, Navigant

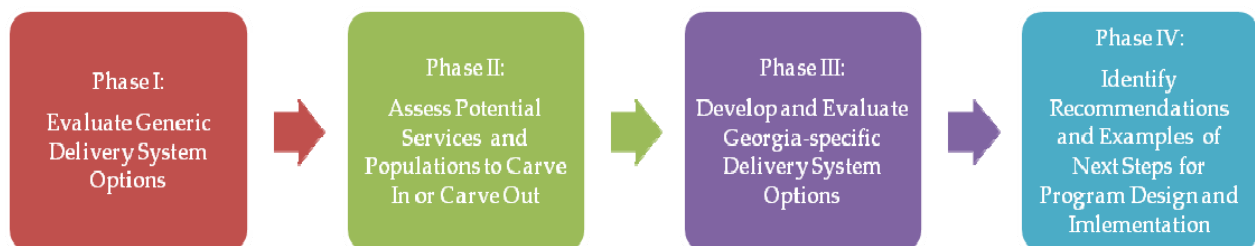
provided an online application on DCH’s website. Additionally, DCH worked with advocacy organizations and provider associations to outreach to other potential focus group participants. DCH also published information about the focus group opportunity through provider email blasts, press releases and public service announcements. For focus groups where interest was low, DCH selected a random sample of providers who were located in proximity to the focus group locations, and DCH and Navigant made cold calls to invite those providers to participate in the focus groups. In addition, DCH mailed notices to a random sample of consumers to encourage their participation. Navigant also reviewed program data provided by DCH. In the interest of economy and efficiency, our analysis relied, wherever possible, upon data which was aggregated or otherwise analyzed by DCH, and did not rely heavily on original data analysis.

Evaluation of Redesign Options

This Design Strategy Report is part of an extensive public process to evaluate options and select a Medicaid redesign approach for Georgia. Such a public process requires that the assessment of redesign options be conducted using an explicit approach, where redesign options are clearly described and evaluated and where the basis for the assessment’s conclusions are detailed and clear to the reader. Likewise, the decision must be based upon the likelihood that the redesign will enable Georgia to achieve its goals. Therefore, a design strategy that is preferred by another state might not be the design strategy that is best suited for Georgia.

Thus, for our evaluation, Navigant has used a modified version of the Kepner-Tregoe decision-making method. The Kepner-Tregoe decision-making method is a helpful tool in strategic decision-making and, for the purposes of this report, is used to evaluate the likelihood that each option will enable the State to achieve its goals. The evaluation is conducted using a four-phased process as outlined in Figure 2.1.

Figure 2.1: Multi-Phased Process to Evaluate Potential Redesign Options



Chapter 2: Study Methodology and Limitations

This four-phased evaluation process, the modified Kempner-Tregoe method and other aspects of the evaluation process are described in detail in *Chapter 5, Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®*.

B. Study Limitations

Navigant identified a variety of limitations that could impact our overall findings and recommendations for a design strategy for Georgia Medicaid. These limitations are outlined below.

- The due date for this report was soon after or just prior to significant actual or planned changes to Georgia Medicaid. As noted below, the timing of these changes prohibited Navigant from analyzing the impact of these program changes in our findings.
 - September 2011: DCH terminated its primary care case management (PCCM) program, Georgia Better Health Care. Given the timing of the termination, information is not available to understand impacts, if any, of that change.
 - Ongoing: Georgia has an interagency team appointed coordinating the State's analysis and response to provisions of the health reform legislation. Last month, the team released its recommendations for the State's implementation of a Health Insurance Exchange, and these recommendations have been delivered to the Governor; however, questions remain about how Georgia will move forward with a Health Insurance Exchange.
 - January 2012: An estimated 16,000 additional children, whose parents have coverage through the State Health Benefit Plan, became eligible to enroll in PeachCare for Kids®.
 - January 2012: DCH is allowing two of Georgia Families three Care Management Organizations (CMOs) to operate statewide.
- This report is being issued prior to the Supreme Court reviewing the constitutionality of the Affordable Care Act (ACA) (Public Law 111-148) and prior to Georgia's interagency team making recommendations for and Georgia fully deciding if and how it will proceed with ACA requirements.

- The majority of state Medicaid programs are in flux – most, if not all, are in the midst of program reforms given the downturn of our national economy, the increasing number of individuals eligible for Medicaid and potential requirements of the ACA that impact Medicaid. Articles about new Medicaid program developments are being published each day. The information presented specific to our national environmental scan section was obtained through literature reviews of reliable sources and surveys of state officials. Navigant used reliable sources of data and information. Given the pace at which states are making changes to their Medicaid programs, it is possible that the information available from these sources has become outdated during publishing of this report or since publication of this report.

The information presented specific to our scan of Georgia is based on self-reported data and information conveyed to us orally through interviews and focus groups and data and information provided to us by DCH and other stakeholders. We have not conducted an audit of DCH data and operations or validated data or information provided to us. Furthermore, our assessment of the opportunities and risks associated with Georgia Medicaid's current design and with potential future designs is based, in part, upon this self-reported data.

Chapter 3: National Environmental Scan

The current health care environment is undergoing a period of rapid change as the federal government, states, health plans and consumers deal with the implications of health care reform in an era of budget deficits, high unemployment and grim forecasts for short-term economic growth. In this type of environment, states and commercial payers are pursuing new, innovative program designs. As Georgia undertakes efforts to study and evaluate its Medicaid program and Children's Health Insurance Program (CHIP) (PeachCare for Kids®), other programs nationwide may provide the state with important information about current trends, best practices and lessons learned.

In the weeks prior to publication of this report, there were significant announcements that provide more information that may influence states' Medicaid program design decisions. New information is available every day. The information contained in this report is current as of January 12, 2012. For example, as this report was being finalized, the following new developments occurred:

- States have announced major changes to their Medicaid programs, including:
 - **Connecticut:** Ending its risk-based managed care program and in January 2012 will move to a non-risk arrangement with a single entity with a focus on implementing a patient-centered medical home (PCMH) initiative. Connecticut's decision stands out in the national Medicaid environment where many states are moving more enrollees into managed care.
 - **Kentucky:** Implemented statewide mandatory managed care for most populations, excluding long-term care recipients and dual eligibles, effective November 1, 2011.
 - **Kansas:** Expanding managed care program statewide to include almost all Medicaid populations, including long-term care recipients, to be operational by 2013.
 - **Oregon:** Oregon will be the first state in the nation to develop a Medicaid Care Coordination Organizations (CCO) model, which is much like an Accountable Care Organization (ACO), to provide coordinated physical, behavioral and dental services to certain Oregon Health Plan Medicaid recipients. Stakeholders are currently developing specific criteria for the CCO and are planning to

introduce the plan to the Legislature in February 2012 and implement the plan in July 2012.

- **Texas:** Received approval from the Centers for Medicare and Medicaid Services (CMS) to expand managed care statewide through an 1115 waiver authority.
- **Ohio:** Launched an effort to adopt value-based purchasing for their Medicaid program. As the state rebids contracts for 2013, it will base more of its payments to managed care plans on quality and treatment effectiveness. State officials are currently establishing quality and savings goals to monitor success.
- The Supreme Court announced it would review the constitutionality of the Affordable Care Act (ACA), as early as summer 2012.
- In an attempt to gain control of health care costs, the Obama Administration, through the ACA, launched the Health Care Innovation Challenge. This initiative will award up to \$1 billion in grant money to applicants who propose the most innovative payment and delivery models to produce improved health care at lower costs to people enrolled in Medicare, Medicaid and CHIP.

This chapter focuses on the results of the national environmental scan, including interviews with several states that have delivery system models of interest to the Department of Community Health (DCH). The following subsection discusses the current state of the national health care environment. Then, we discuss trends in Medicaid, including various Medicaid delivery system models and the results of state interviews. The sections following state examples, discuss innovations and trends in the commercial marketplace.

A. The National Health Care Economic Environment

Since the beginning of the economic downturn in 2008, the US debt increased from \$9 trillion to \$14 trillion and unemployment rose from 5.8 percent of the civilian population in 2008 to 9 percent in 2011.¹² Rising health care costs coupled with an economic slowdown and rising federal deficit is placing great stress on governments, employers and consumers. Health care costs in the United States have been rising exponentially in recent years:

¹ U.S. Treasury as of January 2011.

² U.S. Bureau of Labor and Statistics. Labor Force Statistics.

Chapter 3: National Environmental Scan

- From 2008 to 2009, national health care expenditures grew 4.0 percent, to \$2.5 trillion or \$8,086 per person, and accounted for 17.6 percent of Gross Domestic Product (GDP).³ This is more than three times the \$714 billion spent in 1990.⁴
- Nationwide, Medicaid spending grew 9.0 percent from 2008 to 2009 to \$373.9 billion, or 15 percent of total national health care expenditures.⁵
- Our nation's health care costs have grown from 12.5 percent of GDP in 1990, to 13.2 percent in 2000 to 17.6 percent of GDP in 2009.⁶ If trends continue, health care costs are expected to be nearly 20 percent of GDP in 2019.^{7,8}

States continue to manage the effects of the recent economic recession and many are facing budget deficits. In Federal Year 2012, 42 states and the District of Columbia are working towards closing budget gaps. Figure 3.1 provides a timeline showing state budget gaps between 2002 and 2005 and between 2009 and 2013. State budget gaps more than quadrupled between 2005 and 2010.⁹ Due to the recession, state tax revenue is decreasing while more individuals become eligible for social programs; states face the difficulty of cutting costs and balancing their budgets in the midst of increased demand.

³ Center for Medicare and Medicaid Services, National Health Expenditure Data. Available online: <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>

⁴ Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, January 2010. Available online: https://www.cms.gov/nationalhealthexpenddata/01_overview.asp

⁵ Center for Medicare and Medicaid Services, National Health Expenditure Data. Available online: https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp

⁶ Center for Medicare and Medicaid Services, National Health Expenditure Data. Available online: <https://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf>

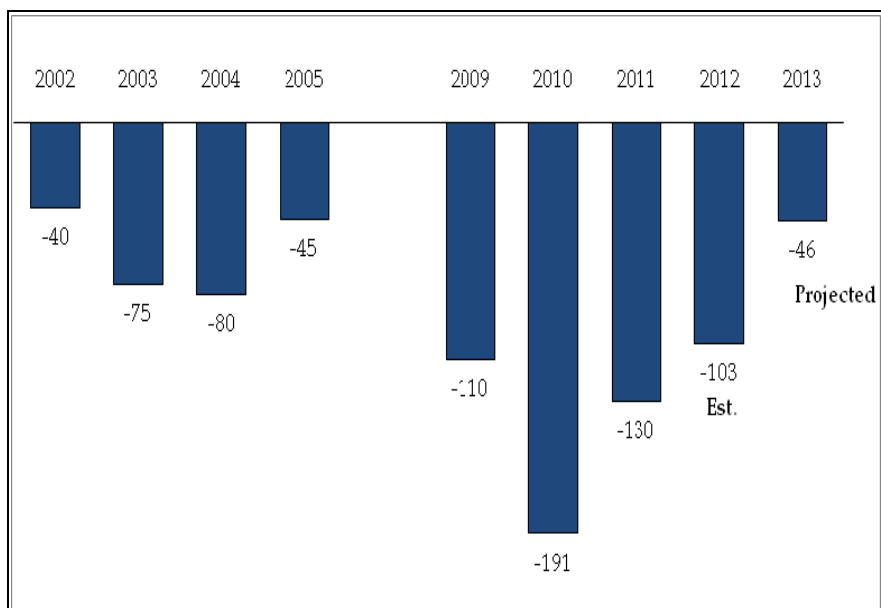
⁷ World Health Organization, Total Health Expenditures as Percent of GDP, 2002-2005 - Country Rankings Available at: http://www.photius.com/rankings/total_health_expenditure_as_percent_of_gdp_2000_to_2005.html

⁸ Center for Medicare and Medicaid Services, National Health Expenditure Data. Available online: <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>

⁹ Center for Budget and Policy Priorities. States Continue to Feel Recession's Impact.. Revised June 2011.

Chapter 3: National Environmental Scan

Figure 3.1: State Budget Gaps State Fiscal Years (SFYs) 2002-2005 and 2009-2013, in Billion Dollars¹⁰



While governments employ unique solutions to rising health care costs, private employers and workers are also struggling to finance health care. Since 1999, family premiums for employer-sponsored health coverage have increased by 131 percent, making it more difficult for private employers to afford health care for their employees.¹¹ Additionally, with workers' wages growing at a much slower pace than health care costs, many workers have difficulty affording health care expenses. High private insurance premiums for employers coupled with high-priced insurance premiums and an increase in the unemployed population resulted in an increase in the number of uninsured, from 36.6 million in 2000 to 49.9 million in 2010.^{12,13} Further, the rising number of high deductible plans may also lead to delayed routine or other basic care because of the cost.

In addition to the challenges related to financing, our nation faces a provider shortage:^{14,15}

¹⁰ Center for Budget and Policy Priorities. States Continue to Feel Recession's Impact. Revised June 2011.

¹¹ Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits 2009 Annual Survey. September 2009

¹² U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010. Sept. 2011).

¹³ Note: Aggregate state budget shortfalls or gaps between expected revenues and the amount needed to fund current services. Data represent shortfalls prior to actions to close the shortfalls and prior to accounting for offsets from ARRA. Figures are estimates for fiscal years 2011 and 2012 and projections for 2013. Source: States Continue to Feel Recession's Impact. Center on Budget and Policy Priorities, June 17, 2011.

¹⁴ Managed Care, <http://www.managedcaremag.com/archives/0706/0706.shortage.html>

Chapter 3: National Environmental Scan

- Medical associations and industry organizations are predicting that the demand for primary care doctors will outpace the number of physicians taking on such careers in the years ahead.
- The physician workforce is aging, and fewer new physicians are selecting primary care specialties.
- The population is aging, and older patients tend to use more physician services.
- Through health care reform, a large number of currently uninsured individuals will be covered, creating a new demand for services.

Although 56 percent of patient visits in America are primary care, only 37 percent of physicians practice primary care medicine, and only eight percent of the nation's medical school graduates go into family medicine.^{16,17} People who are uninsured, low-income, members of racial and ethnic minority groups, or living in rural or inner-city areas are disproportionately likely to lack a usual source of care.^{18, 19}

There are also different physician workforce challenges in rural versus urban areas. There have been longstanding provider shortages in rural areas, due to difficulties recruiting and retaining providers. As a result, there continue to be disparities in rural and urban physician supply.²⁰ Rural providers may face additional difficulties in delivering care; rural physicians work longer hours and see more patients than urban physicians and are twice as likely to work in solo practices, which may mean that if they do not employ physician extenders, rural physicians have fewer options for sharing patient care duties. Rural residents also face unique challenges

¹⁵ Wall Street Journal, April 12, 2010,

<http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html>

¹⁶ Halsey, A. June 20, 2009. Primary Care Shortage May Undermine Reform Efforts. Washington Post.

¹⁷ Health Resources and Services Administration, Bureau of Health Professions. The physician work-force. Rockville MD: HRSA, Dec 2008.

¹⁸ Ruddy, G. et al. July 2005. The family physician workforce: The special case of rural populations. *American Family Physician*, 72(1):147

¹⁹ National Association of Community Health Centers. March 2007. Access Denied: A Look At America's Medically Disenfranchised.

²⁰ General Accounting Office. *Physician Workforce: Physician Supply Increased in Metropolitan and Nonmetropolitan Areas but Geographic Disparities Persisted*. Washington, DC: General Accounting Office; 2003.

Chapter 3: National Environmental Scan

in accessing care. They may experience longer travel times to reach their usual source of care and more difficulty accessing after-hours care than their urban counterparts. ²¹

Some states are concerned about losing medical residents to other states after they complete their training programs. There are a variety of reasons that physicians may choose to leave the state in which they received training. In some states, physicians may choose to leave based on economic reasons. For example, the Michigan State Medical Society notes a trend of physicians leaving the state after residency, with 27 percent of Michigan-licensed physicians working outside the state in 2005. The medical society notes concern that cuts to Medicaid reimbursement could worsen the situation.²² In contrast, there are many non-economic reasons why physicians may leave a state after training. The Georgia Board for Physician Workforce reports that 56 percent of physicians who completed residency training in 2010 plan to stay in Georgia to practice, which is a three percent increase from the previous year. The report indicates that the top reasons for leaving Georgia included: proximity to family; better jobs in desired locations outside of Georgia; better salary offered outside of Georgia; and never intended to practice in Georgia.²³

As illustrated in Figure 3.2, the shortages are more pronounced in some states than in others, with approximately eight states having the most severe physician shortages.

²¹ Maine Rural Health Research Center, Rural-Urban Differences in Health Care Access Vary Across Measures. June 2009.

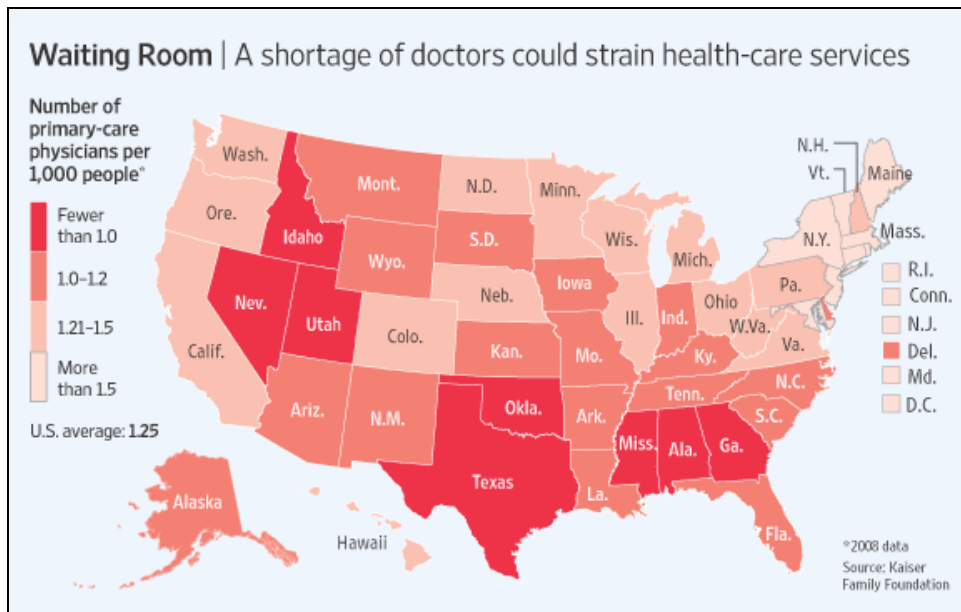
²² Michigan Policy Network, Doctors Leaving Michigan After Residency. February 2010.
http://www.michiganpolicy.com/index.php?option=com_content&view=article&id=708:doctors-fleeing-michigan-after-residency-programs&catid=43:health-care-policy-briefs&Itemid=159

²³ Data from the Georgia Board for Physician Workforce annual survey includes respondent physicians with confirmed practice plans, who completed training during the period July 1, 2009 – June 30, 2010, reported plans to practice in Georgia.

Source: Georgia Board for Physician Workforce, Graduate Medical Education Exit Survey Summary Brief, January 2011.

Chapter 3: National Environmental Scan

Figure 3.2: Primary Care Physicians per 1000 People, by State, 2008²⁴



The Association of American Medical Colleges estimates that closing the gap could require 10 or more years, because physicians must train for so many years. However, some of these shortages might be offset by:²⁵

- Efficiencies gained through electronic medical records, telemedicine and other information technologies allowing providers access to better and more complete information needed to provide more efficient care.
- Team-based approaches, like the PCMH, might also create efficiencies (please see Section 1: Medicaid Delivery Systems of this chapter for more information regarding the PCMH model).
- Increases in the number of medical school slots, realized via the creation of new medical schools and through the expansion of existing medical schools with decreased tuition or fast track programs for primary care.

²⁴ Wall Street Journal, April 12, 2010, <http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html>

²⁵ American Association of Medical Colleges, https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf

- Title V of the ACA includes provisions to that may add 15,000 new primary care providers (PCPs) to the workforce by 2015 through increased funding for training.²⁶ Additionally, the 2009 Economic Stimulus package included \$300 million for the National Health Service Corps, which recruits the primary care workforce in underserved areas.²⁷

Additionally, there has been interest by some states in reforming medical malpractice laws, or “tort reform” as a method for decreasing health care costs while encouraging more providers to practice in their state. For many years, there has been ongoing debate about the potential savings that may result from tort reform. The Congressional Budget Office (CBO) determined that “liability costs, including insurance premiums and settlements, make up two percent of health care providers' annual spending”, and tort reform could save \$54 billion over 10 years. The CBO Director Doug Elmendorf said, “changes to current federal liability laws would significantly reduce costs to health care providers and thus to federal government programs like Medicare and Medicaid that reimburse them for their services.”^{28,29} Some states have made efforts to implement tort reform. For example:

- In May 2011, Florida legislators passed laws to protect health care facilities against lawsuits. One bill restricts the use of expert witnesses in malpractice cases. It requires “out-of-state expert witnesses to obtain a certificate from the state health department, and allows the state Board of Medicine to discipline expert witnesses whose testimony is fraudulent, deceptive or misleading.” Legislators indicated part of their rationale for implementing reforms was to encourage provider support of Medicaid managed programs.³⁰
- Texas passed tort reform in 2003 that limited medical malpractice lawsuits. While there are conflicting reports as to the success of this law, Governor Rick Perry’s Office released findings that the number of physicians practicing in the state has outpaced population growth by 84 percent. Also, the Governor’s Office indicated that medical liability premiums in the state have decreased by almost 30 percent since enactment of tort

²⁶ The Patient Protection and Affordable Care Act (HR 3590). March 23, 2010.

²⁷ Kaiser EDU, <http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx#footnote1>

²⁸ The analysis included a cap on non-economic damages at \$250,000, a cap on punitive damages at \$500,000 and shortening the statute of limitations for filing lawsuits.

²⁹ Murphy, P. The Capitalist. Tort Reform Could Save Health Care \$54 Billion, Says CBO. 2009. <http://www.politicsdaily.com/2009/10/12/tort-reform-could-save-health-care-54-billion-says-cbo/>

³⁰ Jackson, S. Florida’s Hospital-Friendly Tort Reform Could Spark a Wave. May 5, 2011. <http://www.fiercehealthcare.com/story/florida-tackles-tort-reform-piecemeal/2011-05-05>

reform, employer-sponsored coverage premiums are lower than those in 34 other states and the cost of medical liability insurance decreased by almost 30 percent.³¹

B. The National Medicaid Environment

As Medicaid spending absorbs more and more of states' budgets, many states view Medicaid as one of the reasons they are experiencing a fiscal crisis. In 2011, Medicaid spending increased 7 percent across all states from 2010. Much of the increase in Medicaid spending is attributed to enrollment growth, which averaged 5.5 percent in 2011.³²

In times of economic recession, Medicaid enrollment tends to increase, as the worsening economy and rising unemployment causes individuals to lose private health insurance coverage.³³ Between June 2009 and June 2010, after several years of slow or negative growth, Medicaid enrollment increased nationwide by 7.2 percent, or 3.37 million individuals, and exceeded 50 million enrollees for the first time in the program's history. Medicaid enrollment increased 7.6 million (17.8 percent) between December 2007 and June 2010.³⁴ Figure 3.3 compares total Medicaid spending with Medicaid enrollment growth from 1998 and 2012.

³¹ Gallegos, A. Texas Tort Reform Advocates Dispute Critical Report. October 31, 2011. <http://www.ama-assn.org/amednews/2011/10/31/prsc1031.htm>

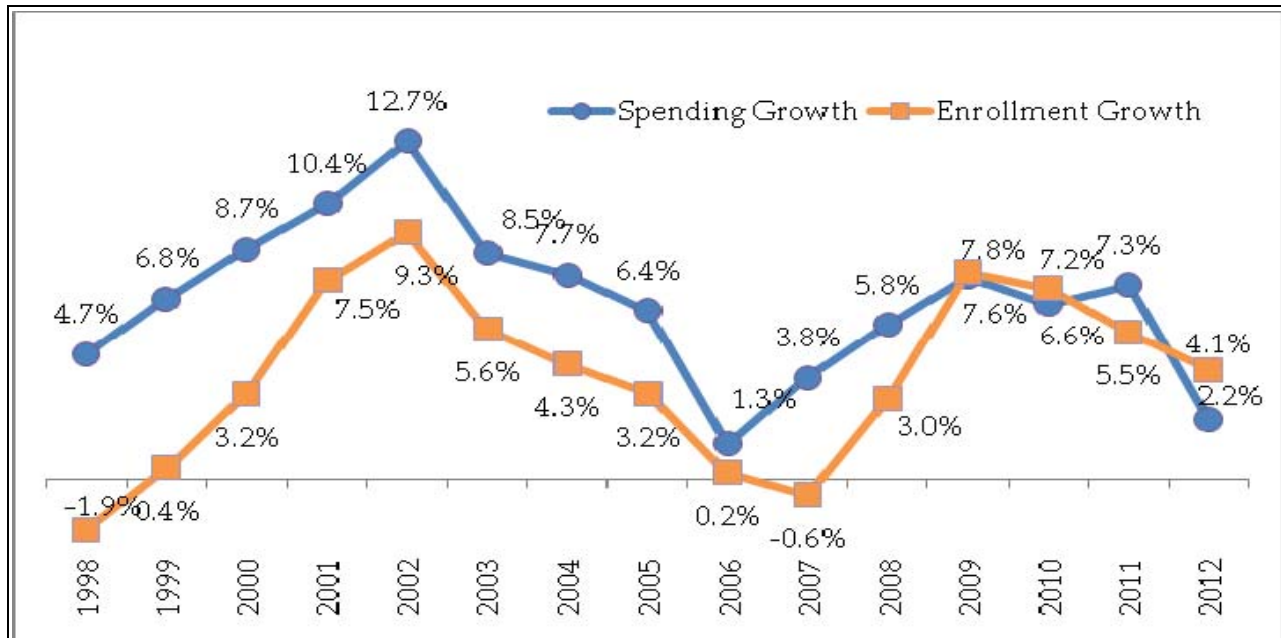
³² Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

³³ According to a study from the Kaiser Commission, an estimated 6.9 million fewer American receive health coverage through the workplace due to job losses from 2008 to 2009 and correspondingly, Medicaid enrollment and the nation's uninsured increased 2.8 and 3.0 million respectively.

Source: Kaiser Commission on Medicaid and the Uninsured, Rising Unemployment Medicaid and the Uninsured, January 2009.

³⁴ Kaiser Family Foundation, Medicaid Enrollment: June 2010 Data Snapshot, February 2011. Available online: <http://www.kff.org/medicaid/upload/8050-03.pdf>

Figure 3.3: Total Medicaid Spending and Enrollment Percent Change, FY 1998 – FY 2012 ³⁵



In light of rising costs, states are taking action to increase efficiencies and reduce costs in their Medicaid programs, in hopes these actions will reduce their growing budget deficits. States have implemented numerous traditional Medicaid cost containment strategies to control spending. In 2011, states reported the following traditional cost containment activities:

- 36 states imposed provider rate restrictions
- 18 states restricted, eliminated or reduced benefits. Restrictions most often included dental, therapy, medical supply, durable medical equipment (DME) or personal care services
- Five states increased copayments, mostly for adult prescription drug payments³⁶

While traditional cost containment activities, such as benefit or eligibility reductions, and provider rate decreases, may reduce costs in the short term, the long-term impacts may

³⁵ Note: Enrollment percentage changes from June to June of each year. Spending growth percentages for state fiscal year. Source: Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

³⁶ Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

Chapter 3: National Environmental Scan

negatively affect the overall Medicaid population by disrupting access to care. Additionally, due to the American Recovery and Reinvestment Act of 2009 (ARRA) and ACA maintenance of effort provisions, states are prevented from restricting Medicaid eligibility standards, methodologies or procedures.³⁷ In 2011, 33 states reported positive eligibility changes, such as eligibility expansions or enrollment simplifications.³⁸ For example, Minnesota expanded Medicaid coverage to childless adults under a new option in the ACA and several other states expanded coverage to this population through 1115 waivers.³⁹

States are increasingly looking towards new and innovative ways to decrease costs that focus on providing benefits more effectively with greater administrative efficiencies rather than solely focusing on traditional cost containment strategies. Because state and federal governments are especially interested in innovative strategies, the state and federal Medicaid environment is rapidly changing.

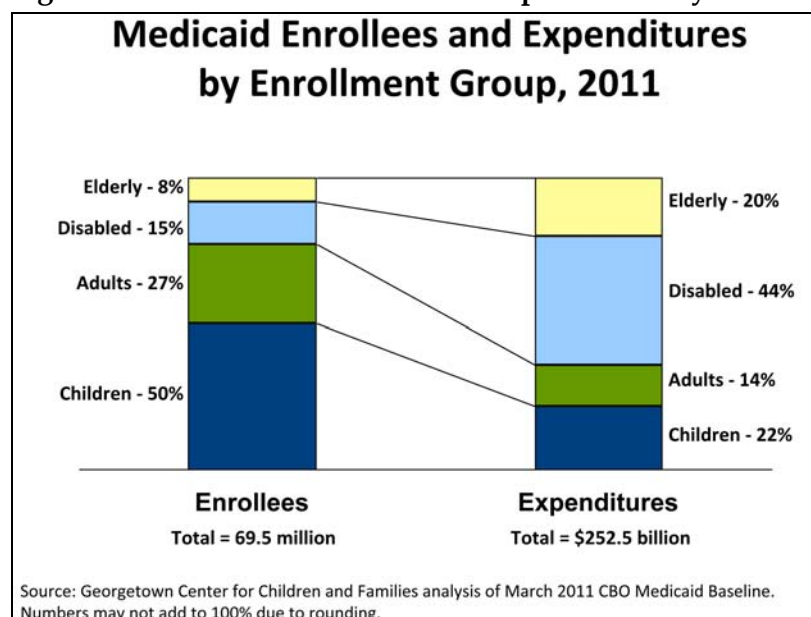
States are continuing to focus efforts on Medicaid spending on high-cost populations. Figure 3.4 shows the Medicaid enrollees and expenditures by enrollee group in 2011. In this example, the elderly and disabled population accounted for 64 percent of spending but only 23 percent of the total Medicaid populations. There is tremendous opportunity for states to control costs and improve outcomes by better managing high-cost populations.

³⁷ H.R. 1--111th Congress: American Recovery and Reinvestment Act of 2009. (2009).

³⁸ Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

³⁹ Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

Figure 3.4: Medicaid Enrollees and Expenditures by Enrollment Group⁴⁰



In this context of the economic downturn, decreased revenues, increased Medicaid enrollment and increasing health care spending, there are many challenges ahead for states as they try to develop or maintain a sustainable Medicaid program. To meet these challenges, states have implemented a variety of innovative program designs, which are described in the next section of the report.

C. *Brief History of Innovations in Medicaid*

Since the initiation of Medicaid in 1965, care delivery systems have evolved from mostly fee-for-service (FFS) to more managed care arrangements. Lessons learned, emerging health care trends and innovations have prompted states to alter their delivery systems, often transitioning FFS systems to ones that place more emphasis on care management. Historically, states have looked to other states for new Medicaid innovations.

In the early 1980s, most states were providing services to Medicaid enrollees using FFS delivery systems. During this time, Arizona was the only state not operating a Medicaid program. In 1982; however, Arizona implemented Medicaid for acute care services through managed care system rather than fee-for-service. This program has since expanded to include additional populations and services. Arizona was one of the first states to develop a mandatory Medicaid

⁴⁰ Georgetown Center for Children and Families analysis of 2011 CBO Medicaid Baseline.

Chapter 3: National Environmental Scan

managed care program, and its example in part initiated the national trend towards managed care (which is further discussed later in this chapter in the Medicaid Delivery Systems section).⁴¹

In the 1990s, states increased activity in managed care implementation and, “wanted more discretion in administering the Medicaid program and more independence from federal oversight.”⁴² The mid-to late 1990s were a prosperous time for states. The growth in Medicaid caseloads declined at the same time that states implemented cost-control measures to limit their exposure to Medicaid expenditures and states were operating with budget surpluses.⁴³ The Clinton health reform plan had been rejected, and states were interested in expanding coverage to populations who were previously excluded from Medicaid. These factors led to an increased interest in managed care, for its ability to provide access for expanded populations while containing costs.⁴⁴ Additionally, the 1997 Balanced Budget Act made it easier for states to mandate managed care.⁴⁵ At this time, state innovations in Oregon and Tennessee gained much attention. Oregon expanded eligibility and moved the non-disabled population to managed care. Tennessee moved all enrollees into managed care and instituted new premiums.

Innovations slowed in the early 2000s. There was waning interest on the part of managed care organizations (MCOs) to participate in the Medicaid market, and some MCOs left or curtailed their participation.⁴⁶ Instead, states focused on building upon models introduced in the previous decades and continued to move more populations to managed care. In recent years, state and federal budgetary crises have revamped the push towards innovative solutions and states are again looking for new and ways to deliver services. Examples of state innovations are discussed later in this Chapter in Section 1- Medicaid Delivery Systems.

Many of the delivery system innovations states have implemented and are pursuing require the states to obtain authority to operate the innovative delivery system via either a state plan amendment or a federal waiver.

⁴¹ The Urban Institute. Medicaid Managed Care: State Flexibility in Action. March 2002.

⁴² Tenzer, Joshua, Reaching the Final Frontiers in Medicaid Managed Care. August 2006. Available at: http://law.nyu.edu/ecm_dlv4/groups/public/@nyu_law_website__journals__annual_survey_of_american_law/documents/documents/ecm_pro_064608.pdf

⁴³ States ended fiscal year 1996 with a total of \$25 billion in general and reserve funds and 1997 with \$27 billion. Source: Congressional Budget Office, “States’ Use of Surplus Funds”, November 1998.

⁴⁴ The Urban Institute, “Medicaid Managed Care: State Flexibility in Action”, March 2002.

⁴⁵ Tenzer, Joshua, Reaching the Final Frontiers in Medicaid Managed Care. August 2006. Available at: http://law.nyu.edu/ecm_dlv4/groups/public/@nyu_law_website__journals__annual_survey_of_american_law/documents/documents/ecm_pro_064608.pdf

⁴⁶ Kaiser Commission on Medicaid and the Uninsured, “Commercial Health Plan Participation in Medicaid Managed Care: and Examination of Six Markets”, November 2000.

Chapter 3: National Environmental Scan

The Balanced Budget Act of 1997 included provisions enabling states to require Medicaid beneficiaries to enroll in managed care, including Primary Care Case Management (PCCM) programs, by amending their state plans rather than seeking a waiver. The only populations excluded from this state plan option are certain children with special needs (including children receiving social security income [SSI]), beneficiaries dually eligible for Medicare and Medicaid, and American Indians/Alaska Natives.

Through a waiver, the U.S. Department of Health and Human Services allows a state to waive certain Medicaid statutory requirements. States are often then able to cover a broader range of services not included through the State Plan, cover additional populations or offer certain services to a limited population or geographic area. There are several types of waivers available to states:

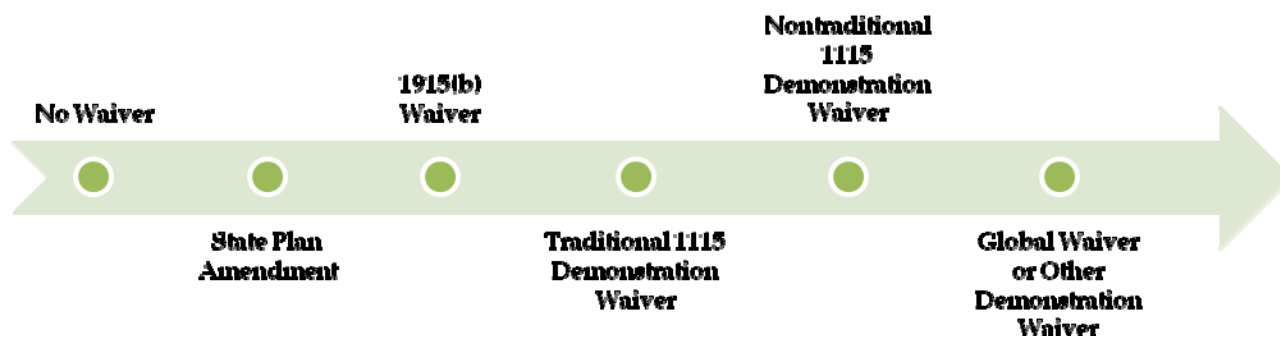
- Managed Care/Freedom of Choice 1915(b): Allows implementation of managed care delivery systems and waives requirements that individuals' can freely choose to see any provider under Medicaid.
- Home- and community-based services (HCBS) 1915(c): Allows states to offer traditional medical services as well as non-medical services to a specific population, such as certain disabled and/or elderly populations.
- Combined 1915(b)/1915(c): Allows states to provide a continuum of services to disabled and/or elderly populations. 1915(b)/(c) waivers allow states to provide institutional long-term care services and HCBS in a managed care delivery system rather than a FFS arrangement.
- Research and Demonstration Projects Section 1115: Used by states to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. There are comprehensive Section 1115 Medicaid waivers and more narrow Section 1115 waivers that focus on specific services and populations. As currently used, 1115 waivers do not exclusively apply for demonstration projects. Many states use 1115 waivers, for example, for family planning initiatives.
- Global Waiver: A Section 1115 waiver that allows states to terminate all individual waivers and administer all programs through a single 1115 waiver, which offers some flexibility and administrative efficiencies for states in combining and managing multiple programs through a single authority.

Chapter 3: National Environmental Scan

Also worth noting is the block grant concept, which was considered by some states and CMS under the George W. Bush Administration and which is currently being discussed by some states and politicians as an option for future Medicaid reforms. Global waivers are sometimes considered a means to achieve a block grant type of arrangement between states and the federal government by allowing, for example, capped federal funding and elimination of some federal standards governing benefits, cost sharing, and the entitlement to coverage for many beneficiaries.⁴⁷ More information detail later in this chapter in Section E. Other Emerging Models.

Appendix A provides a more detailed overview of the types of waivers commonly used by states and a description of the waiver authority. Many states use one or more of these waivers to implement more innovative aspects of their programs. Figure 3.8 provides an overview of the types of federal approvals that could be required, ranging in order from least to most complex.

Figure 3.8: Spectrum of Federal Approvals – Least to Most Complex*



*Children receiving SSI or in foster care, dual eligibles and Native Americans require waiver authority to be enrolled mandatorily in managed care.

States have used the waiver authorities available to them to implement innovative programs. The next sections of this report discuss specific state programs and delivery system models of particular relevance to Georgia. Varying levels of federal approval have been necessary for the innovations discussed in the next sections of this chapter.

⁴⁷ Kaiser Commission on Medicaid and the Uninsured, "Vermont's Global Commitment Waiver", April 2006. Available online: <http://www.kff.org/medicaid/upload/7493.pdf>

D. State Medicaid Trends and Innovations

This section of the report reviews recent trends and innovations across the nation in Medicaid and CHIP and in commercial health plans, including results of literature reviews and surveys of select states based on innovations and current proposals of interest, as well as their historical experiences with a variety of delivery systems. The examples cited in this section of the report are focused on the following states that were chosen for interview based on elements of their delivery systems of particular interest to Georgia:

- Arizona
- Florida
- Illinois
- Indiana
- Michigan
- New Jersey
- North Carolina
- Oklahoma
- Pennsylvania
- Texas
- Virginia
- Wisconsin

We discuss key findings from our research and surveys in this section, and supplement that information in the following appendices:

- *Appendix B: Overview of States Surveyed*
- *Appendix C: State Survey Case Studies*

To provide a high-level reference as to how Georgia's Medicaid program compares to the Medicaid programs of the states interviewed, Figure 3.5 below provides an overview of Medicaid spending and use of managed care delivery systems (including risk-based and PCCM models). The table also includes Georgia's neighboring states (South Carolina, Alabama and Tennessee and Florida).

Figure 3.5: Medicaid Spending and Enrollment Statistics for Select States ⁴⁸

State	Medicaid as a percentage of state budget SFY 2009 ⁴⁹	Number of Medicaid enrollees FFY 2008 ⁵⁰	Medicaid expenditures per person ⁵¹ FFY 2008	Percent of Medicaid enrollees in managed care FFY 2010 ⁵²
Georgia	10.8%	1,683,100	4,074	91.0%
Alabama	8.5	908,600	\$5,337	59.6
Arizona	13.4	1,539,100	4,701	90.5
Florida	14.5	3,021,800	4,573	64.5
Illinois	21.9	2,430,000	4,711	56.5
Michigan	18.3	1,967,800	4,688	86.2
New Jersey	13.7	976,100	7,982	76.8
North Carolina	14.1	1,705,000	5,706	77.5
Oklahoma	13.4	752,000	4,627	90.1
Pennsylvania	23.3	2,199,400	6,931	81.7
South Carolina	10.1	859,700	4,652	100
Texas	Not Available	4,278,300	4,665	67
Tennessee	21.7	1,488,300	4,678	100
Virginia	18.1	885,800	5,758	59.2
Wisconsin	8.5	1,028,300	4,628	62.4
National Average	15.7		5,337	71.4

⁴⁸ Please note data includes SFY 2009, FFY 2008, and FFY 2010

⁴⁹ Notes: Data are for state fiscal year 2009 and include general fund, federal funds, other state funds, and bonds.

Sources: 2009 State Expenditure Report, National Association of State Budget Officers, 2010. Available at <http://www.nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx>.

⁵⁰ Notes: Enrollment estimates are rounded to the nearest 100. Figures may not sum due to rounding.

Enrollees are presumed to be unduplicated (each person is only counted once).

Sources: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2011.

⁵¹ Notes: Spending includes both state and federal payments to Medicaid. These figures represent the average (mean) level of payments across all Medicaid enrollees. Spending per enrollee does not include disproportionate share hospital payments (DSH).

Sources: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) and CMS-64 reports from the Centers for Medicare and Medicaid Services (CMS), 2011.

Definitions: Enrollees: Individuals who participate in Medicaid for any length of time during the federal fiscal year. Federal Fiscal Year, which runs from October 1 through September 30. For example, FY 2009 refers to the period from October 1, 2008 through September 30, 2009.

⁵² Notes: Data as of July 1, 2010.

The data shown here are unduplicated managed care enrollment figures that include individuals in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards and enrollees receiving comprehensive and limited benefits.

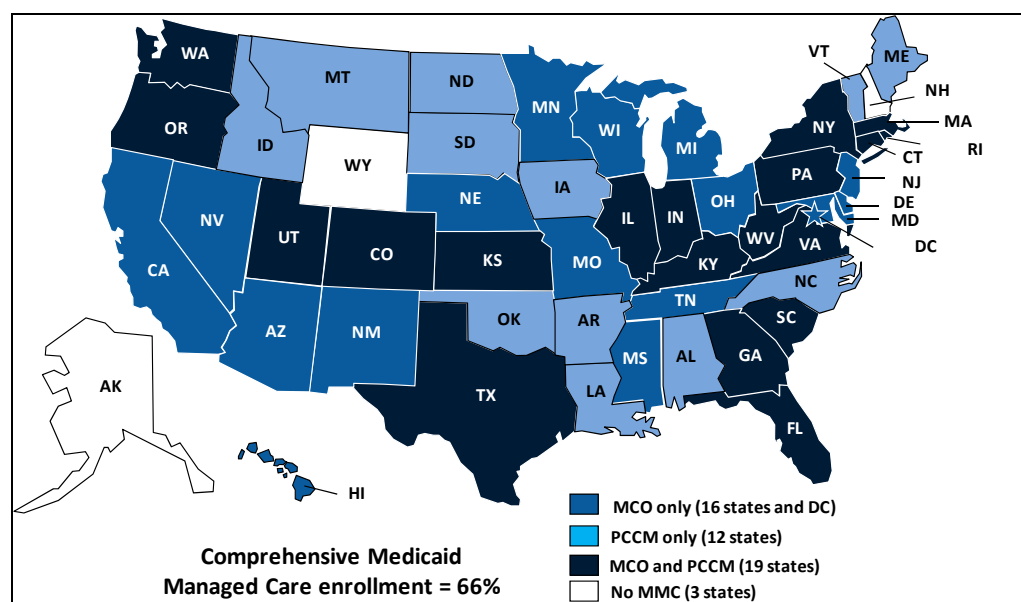
Sources: Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 2011. Available at: https://www.cms.gov/medicaiddatasourcesgeninfo/04_mdmancrenllrep.asp

Central to any discussion of national trends and innovations is an understanding of state Medicaid delivery system models. We begin this section with a review of Medicaid delivery systems and their operational and structural characteristics.

Medicaid Delivery Systems

States use various delivery systems to provide services to their Medicaid and CHIP populations. Traditionally, states have used FFS, PCCM or risk-based managed care models, or a combination of those models, to deliver services. Figure 3.6 shows a map of states and the types of traditional delivery systems they have in place.

Figure 3.6: Comprehensive Medicaid Managed Care Models: MCOs and PCCMs Operating in the States, 2010⁵³



The need to be more cost-effective in the current economic climate, as well as states' goals for improving access, quality and health care outcomes, has led states to consider developing more innovative Medicaid models that incorporate coordinated care, case management and value-based purchasing.⁵⁴ Many states are also beginning to focus on their highest risk, highest cost

⁵³ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: A Summary From a 50 State Survey. September 2011.

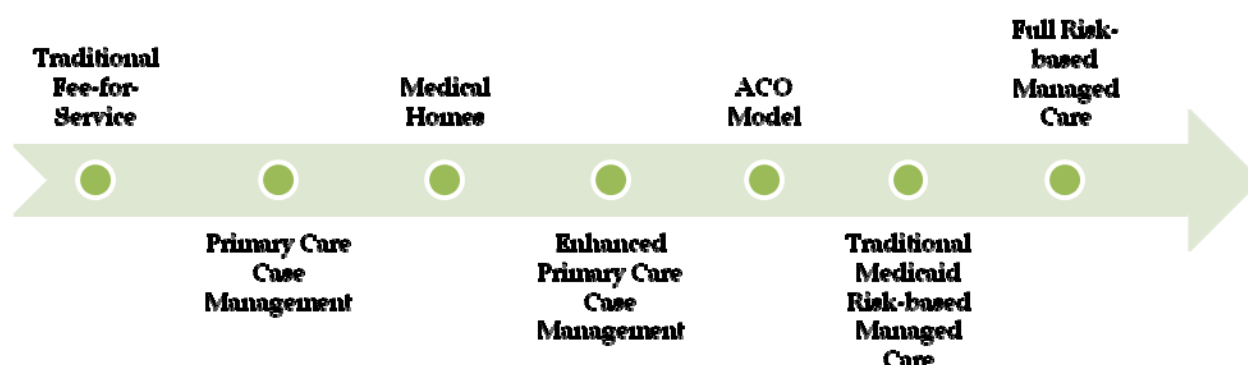
⁵⁴ Value-based purchasing is defined by the Agency for Health care Research and Quality as "any purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost." Source: U.S. Agency for Health care Research and Quality, *Evaluating the Impact of value-Based Purchasing*. May 2002.

Chapter 3: National Environmental Scan

consumers, as traditionally these populations have remained in FFS delivery systems and often have less access to case management services than some healthier populations.

Figure 3.7 provides a spectrum of delivery system options for Medicaid programs. At the left side, traditional FFS implies low or no care management or care coordination and potentially more unnecessary service utilization and lower potential cost savings. At the right side, full risk-based managed care implies a higher level of care management and care coordination, as well as potential for improved quality of care, reduced inappropriate utilization and cost savings.

Figure 3.7: Spectrum of Delivery Systems – Least to Most Comprehensively Managed



The traditional FFS system, in which enrollees may see any provider willing to accept Medicaid patients, offers no explicit mechanism for measuring or ensuring access to care, quality care or containing costs.⁵⁵ Moving across the continuum, states have more options for monitoring and improving key cost, quality and access indicators.

States implement many of these models through contracting with a vendor or directly with providers. Through these contracts, states can mandate that providers and contractors meet certain requirements designed to ensure access to care (such as those relating to office hours, credentialing, or case management) or to meet certain quality indicators. Contracts provide a mechanism for holding contractors or providers accountable for meeting performance standards relating to network adequacy, timely access to care, quality of care consistent with clinical and utilization benchmarks and providing data sufficient to evaluate performance.⁵⁶

The term is commonly used to refer to pay-for-performance or other reimbursement methodologies that incentivize quality over quantity.

⁵⁵ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: A Summary From a 50 State Survey. September 2011.

⁵⁶ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: A Summary From a 50 State Survey. September 2011.

Chapter 3: National Environmental Scan

At the far right side of the spectrum, states have the added benefit of the incentives that capitation payments provide. A capitation payment provides an MCO with a fixed per member per month (PMPM) payment rate. From this fixed rate, MCOs are responsible for arranging and paying for each enrollee's covered services (as defined in the contract). Because of the structure of payments, MCOs have an incentive to control costs through better management of utilization of high-cost services. As a result, mandatory managed care has led to less reliance on emergency rooms and hospitals for patient care, and has led to an increased reliance on PCPs.⁵⁷ This occurs because the MCOs have an incentive to provide care for patients before an illness becomes more severe, requiring more expensive types of care.⁵⁸

At the far right end of the spectrum, there are also more options for monitoring and improving quality of care. Federal rules require quality management for Medicaid managed care plans. Medicaid managed care plans are required to monitor service delivery and improve quality of services, state Medicaid agencies are required to monitor care and CMS must monitor states' quality strategies. Additionally, states frequently contractually require MCOs to use the Healthcare Effectiveness Data and Information Set (HEDIS[®]) to meet the federal requirements for performance measurement. HEDIS[®] is a standardized set of measures for Medicaid, Medicare and commercial risk-based managed care organizations. HEDIS[®] measures have detailed technical specifications that must MCOs must follow precisely to produce a valid HEDIS[®] rate; HEDIS[®] is a well-respected industry standard for measuring quality.

The National Committee for Quality Assurance (NCQA) first developed HEDIS[®] measures in 1992 with the goal of developing a standardized set of performance measures that could be used to compare and evaluate health plans. Currently, HEDIS[®] consists of 76 measures across eight domains, and the NCQA evaluates and updates the measures annually. The use of HEDIS[®] measures to monitor quality makes it possible to compare plans on an "apples to apples" basis. While many states use "HEDIS[®]-like" measures for non-risk-based managed care, no comparable set of standardized, national measures and benchmarks is available for PCCM or FFS delivery systems.

There is considerable evidence that supports the ability of risk-based managed care to contain costs. A report by the Lewin Group, which synthesized findings from 24 studies that looked at savings achieved when states have implemented Medicaid managed care, presents evidence that managed care arrangements yield savings. Key findings from the report include:

⁵⁷ Stephen Zuckerman et al., Has Medicaid Managed Care Affected Beneficiary Access and Use?, 39 INQUIRY 221, 224, 234 (2002).

⁵⁸ Stephen Zuckerman et al., Has Medicaid Managed Care Affected Beneficiary Access and Use?, 39 INQUIRY 224 (2002).

Chapter 3: National Environmental Scan

- Nearly all studies demonstrated a savings from the managed care setting (percentage of savings varied widely from half of 1 percent to 20 percent).
- Savings from Medicaid managed care can be significant for traditionally high-cost enrollees.
 - **Arizona:** 60 percent of the \$102.8 million Medicaid managed care savings achieved from 1983 to 1991 resulted from those receiving SSI.
 - **Texas:** STAR +PLUS achieved PMPM savings of \$4 in the first waiver period and \$92 in the second waiver period.
- Decrease in inpatient utilization largely contributes to Medicaid managed care cost savings.
 - **California:** Rates of preventable hospitalization were 38 and 25 percent lower in managed care than in FFS for the Temporary Assistance for Needy Families (TANF) and SSI populations, respectively.
 - **Ohio:** Inpatient costs decreased 27 percent under capitated Medicaid managed care, from \$76 PMPM to \$55 PMPM.⁵⁹

Further, evidence exists that risk-based managed care may improve access and quality of care when appropriately administered. For example, when comparing children enrolled in Medicaid managed care plans and in FFS nationally, one study found that children enrolled in Medicaid health plans were less likely to depend on an emergency room as a usual source of care, and were more likely to have visited a physician or dentist and have received preventive care. The following is a sampling of state examples that demonstrate quality improvements under managed care.⁶⁰

⁵⁹ The Lewin Group, Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies, 2009. Available at: <http://leg.mt.gov/content/Committees/Interim/2011-2012/Children-Family/Topics/Medicaid%20Monitoring/lewin-synthesis-of-managed-care-studies.pdf>

⁶⁰ Patrick J. Roohan, et al. "Quality Measurement in Medicaid Managed Care and Fee for Service," American Journal of Medical Quality, 21.3 (2006): 185 – 191.

Chapter 3: National Environmental Scan

- **Maryland:** HealthChoice program was successful in improving access to ambulatory care for children.⁶¹
- **New York:** 76 percent of managed care enrollees received a critical test for diabetes, compared with 39 percent of FFS enrollees. Similarly, 64 percent of children in managed care had immunizations in comparison to 50 percent of children in fee-for-service.⁶²

Rhode Island: Infant mortality rates dropped significantly following the adoption of Medicaid managed care in the state in the mid-1990s, dropping over a 10-year period from 4.5 deaths per 1,000 births to 1.9 per 1,000.⁶³

- **Missouri:** Managed care programs performed better on percent of low birth weight babies, percent of inadequate prenatal care and percent of preterm births, compared to the FFS programs between 2003 and 2008.⁶⁴
- **California:** The rate of hospitalizations for ambulatory care was 33 percent lower in mandatory managed care compared with FFS.⁶⁵

Based on the potential for cost savings and quality improvements, nationally, there has been a long-developing trend of moving more populations into managed care. Most states use some form of managed care, and most Medicaid consumers are enrolled in a managed care delivery system, either risk-based or PCCM. As of 2010, 66 percent of states enroll consumers in a comprehensive managed care program (including state-administered PCCM programs). Since 2000, the percent of Medicaid consumers enrolled in some form of managed care, including PCCM, has increased every year except one, and was 71.7 percent as of June 30, 2009.⁶⁶ Additionally, as some states may expect to use managed care to serve the populations who may

⁶¹ Neva Kaye, Medicaid Managed Care: Looking Forward, Looking Back, National Academy of State Health Policy, 2005, pp 79 – 90

⁶² Patrick Roohan. New York State Department of Health, (Presentation to the National Association of State Medicaid Directors, November 2008)

⁶³ “Rhode Island’s Infant Mortality Rate Drops significantly in 1990s,” Rhode Island Medicaid Research and Evaluation Reports, Issue Brief #4, December 2002

⁶⁴ Missouri Department of Social Services MO HealthNet Divisio. Comparative Analysis of Quality of Care and Access to Services in MO HealthN. 2009. Available at: <http://www.dss.mo.gov/mhd/oversight/pdf/ffs-mgdcare10feb18.pdf>

⁶⁵ Bindman, A. B., Chattopadhyay, A., Osmond, D. H., Huen, W. and Bacchetti, P. (2005), The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions. Health Services Research, 40: 19–38. doi: 10.1111/j.1475-6773.2005.00340.x

⁶⁶Centers for Medicare and Medicaid Services. National Summary of Medicaid Managed Care Programs and Enrollment as of June 30, 2009.

Chapter 3: National Environmental Scan

become newly eligible for Medicaid in 2014 due to the ACA, states will continue to expand their managed care programs.⁶⁷ Figure 3.9 below shows the total number of Medicaid enrollees in risk-based managed care programs for the 10 states with highest enrollment in MCOs.

Figure 3.9: Number of Enrollees in Risk-based Managed Care by State (2010)⁶⁸

No.	State	Total Medicaid MCO Enrollment
1.	California	4,079,334
2.	New York	3,001,571
3.	Ohio	1,729,602
4.	Texas	1,697,907
5.	Florida	1,286,884
6.	Michigan	1,251,434
7.	Pennsylvania	1,222,349
8.	Tennessee	1,219,443
9.	Arizona	1,209,559
10.	Georgia	1,133,405

Below we provide detail about a variety of longstanding and emerging Medicaid delivery systems.

⁶⁷Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

⁶⁸ Notes: Data are as of October 2010, unless otherwise indicated

Georgia reflects June 2010 data; Michigan enrollment includes PACE

Sources: A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, Kaiser Family Foundation and Health Management Associates, September 2011. Available at: <http://www.kff.org/medicaid/8220.cfm>.

Definitions: Comprehensive Medicaid Managed Care Plan: Defined in federal regulations as inpatient hospital services and any of the following services, or any three of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) FQHC services; (4) other laboratory and x-ray services; (5) nursing facility services; (6) early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) family planning services; (8) physicians services, and (9) home health services.

MCO: Managed Care Organization. States contract with MCOs to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitation basis. Data are for both Medicaid-only MCOs and MCOs that include commercially insured members.

Traditional Fee-for-Service Delivery Systems

In traditional Medicaid FFS delivery systems, the provider is paid a set amount for each type or unit of service rendered according to a fee schedule.⁶⁹ Members are not assigned to a medical home under FFS Medicaid, and the consumer is allowed to see any provider enrolled with the state Medicaid program.

The FFS delivery system is not able to disincentivize fragmented, high-cost health care. FFS providers have a monetary incentive to bill for more and more costly services, prescription medications or tests, regardless of their effectiveness, because they are paid per service; there is also no incentive for providing high quality, cost-effective care. Critics of the FFS delivery system assert that it rewards the overuse and duplication of the most costly services. Many charge the FFS system for many of the fraud, abuse and waste issues facing the national health care system. It is difficult to detect fraud in this system. Traditionally, the initial bill screening process focused on consistency and completeness, and because states may not track monthly billing volume, high volumes of services to individual patients or by individual providers may not necessarily trigger further review before payment.⁷⁰ Additionally, a traditional FFS delivery system without disease management or other enhancements provides limited management for chronic conditions or care coordination, which may lead to greater duplication of services by providers and additional increases in cost.⁷¹

Patient-Centered Medical Home (PCMH) and Health Home Models for Care Management

A “medical home” is a key mechanism for organizing and delivering care to patients that is central to the concept of PCCM and other managed care programs. The general “medical home” concept was first introduced by the American Academy of Pediatrics as a delivery model for children in the 1960s; since then it has expanded to other populations but maintained the traditional meaning, referring to the single PCP with the responsibility for coordinating care as a consumer’s “medical home.” Recently, the concept of the “medical home” has evolved beyond only referring to the PCP “medical home” referred to in PCCM and other managed care programs to the PCMH. The PCMH refers to a team of providers caring for a consumer.

⁶⁹ Center for Medicare and Medicaid Services. Available online: <https://www.cms.gov/apps/glossary/>

⁷⁰ Water, Paul, Assistant Director Budget Analysis Division Congressional Budget Office Fraud, Waste, and Abuse in Medicare, CBO Testimony. July, 1995.

⁷¹ Davis, Karen. Paying for Care Episodes and Care Coordination. *New England Journal of Medicine*. 2007; 356:1166-1168

Chapter 3: National Environmental Scan

Additionally building off this model, the ACA introduced the “health home” concept specific to individuals with chronic conditions.

Patient-Centered Medical Homes (PCMH)

Generally, the PCMH is a primary care delivery approach designed to increase health care efficiency while decreasing cost. However, state definitions of the PCMH vary. States may have different provider requirements, and target different populations.

Private organizations, such as the NCQA, URAC (formerly the Utilization Review Accreditation Commission), The Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC), have developed standards to define medical homes.⁷² States have adopted standards developed by these organizations, developed their own standards or merged standards developed by these and other organizations with their own standards to create standards that best fit their Medicaid population.

In PCMHs, teams of health care providers attend to the whole scope of patients’ health care needs. PCPs or practices work with patients to efficiently access and coordinate care provided outside the primary care setting. PCMHs often focus on preventive care and screenings, patient education, medication management and disease management. Although definitions vary, most agree on the same set of core functions and attributes. According to the Agency for Healthcare Research and Quality (AHRQ), these functions and attributes include:

- **Comprehensive Primary Care:** A team of care providers is accountable for meeting the large majority of a patient’s physical and mental health care needs.
- **Patient-centered:** The PCMH provides primary health care that is relationship-based with an orientation toward the whole person.
- **Coordinated Care:** The PCMH coordinates care across all elements of the broader health care system.

⁷² Note: A collaboration between American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and the American Osteopathic Association (AOA) resulted in the development of The Joint Principals of the Patient Centered Medical Home (see Appendix D). NCQA has also developed medical home standards that include a multi tier accreditation survey (please see Appendix D). The standards developed by the AAFP, AAP, ACP and AOA have been adopted by the Patient-Centered Primary Care Collaborative (PC PCC).

Chapter 3: National Environmental Scan

- **Accessible Services:** The PCMH delivers accessible services through decreases waiting times for urgent needs, enhanced in-person hours, increased access to a member of the care team, and alternative methods of communication.
- **Quality and Safety:** The PCMH demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.⁷³

PCMHs often operate as part of a Medicaid service delivery system. Practices or provider teams acting as a PCMH receive either FFS or PMPM base payments that are often supplemented with a monthly PMPM case management fee or varying incentive payments for quality indicators, NCQA medical home classification or other pay-for-performance measures.

While initiating a PCMH may require additional funds from the state, it is widely believed that effective PCMHs lead to long-term health savings by decreasing the number of hospitalizations and emergency department visits.⁷⁴ According to the National Association for State Health Policy, 41 states either have implemented a PCMH (defined as an “enhanced model of primary care that provides whole person, accessible, comprehensive, ongoing and coordinated patient-centered care”) model or are considering doing so in the future as part of their Medicaid or CHIP program.⁷⁵ For example⁷⁶:

- **Connecticut** is ending its risk-based managed care program, and in January 2012 moving to an arrangement administered by a single entity with a focus on implementing a PCMH initiative. The state believes this model will help improve health care outcomes and reduce costs.⁷⁷ Under this model, individual doctors, practice groups and community health centers may qualify to serve as PCMHs.

⁷³ Agency for Health care Research and Quality, Patient Centered Medical Home Resource Center. Available at: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_defining_the_pcmh_v2

⁷⁴ Reid, Coleman, Johnson, et, al. The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. Health Affairs.

⁷⁵ National Association for State Health Policy, “Medical Home and Patient Centered Care”. <http://www.nashp.org/med-home-map>

⁷⁶ State examples describe current state initiatives using initiative name assigned by the state. Not all states refer to their program as a PCMH.

⁷⁷ Details of cost savings estimates are not available.

- **Community Care of North Carolina (CCNC)** is one of the oldest and largest state PCMH programs in the country, and was the first to use the term “medical home” to refer to the patient’s designated team of PCP and case managers within its PCCM model. The Department of Medicaid contracts with 14 non-profit community networks comprised of physicians, hospitals, social service agencies and county health departments that provide and manage care for adults and children enrolled in Medicaid. These enrolled populations include the Aged, Blind and Disabled (ABD) and those who are dually eligible for Medicaid and Medicare with chronic conditions and/or in need of (long-term care services are not currently included in CCNC). CCNC is a unique model – it provides PMPM payments to the network for care management and to the PCP for serving as the medical home.⁷⁸ Various studies have indicated that CCNC has decreased costs and increased outcomes, however, estimates of savings vary widely, perhaps illustrating the difficulty of determining cost savings. One study indicates that CCNC saved approximately \$147 million, or 11 percent, in SFY 2007 compared to what costs would have been in that program without the program. Another study notes:
 - Cumulative savings of \$974.5 million over six years (2003-2008)
 - Decreased hospitalizations for asthma by 40 percent
 - Decreased emergency department visits by 16 percent⁷⁹

The most recent study of costs indicates that CCNC saved the state nearly \$1 billion in health care costs in the four years (FY 2007 to FY 2010) the program has been operational. The majority of these savings resulted from reductions in emergency room use and hospitalizations.⁸⁰ However, it is important to note that these cost savings do not include the state’s administrative costs for managing the program, which were estimated at \$10.3 million in 2003 (the latest year available).⁸¹

⁷⁸ A Profile of Medicaid managed Care Programs in 2010: Findings from a 50 – State Survey. Kaiser 2011
Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from
Prospective Evaluation studies in the U.S. Patient Centered Primary Care Collaborative November 2010.

⁷⁹ Grumbach, and Grundy. Outcomes of Implementing Patient-Centered Medical Home Interventions:
A Review of the Evidence From Prospective Evaluation Studies in the United States. Center for Excellence in
Primary Care. November 2010.

⁸⁰ Milliman, Analysis of Community Care of North Carolina Cost Savings December 15, 2011.

⁸¹ Center for Health Care Strategies, Inc. Enhanced Primary care Case Management Programs in Medicaid. September
2009.

Chapter 3: National Environmental Scan

- **Oklahoma’s medical home program**, which the state refers to as a “medical home”, is part of a SoonerCare Choice, the state’s partially capitated statewide PCCM program for Medicaid and CHIP members (excluding dual eligibles and waiver recipients), with care management programs focusing on children, pregnant women and women in breast and cervical cancer prevention and treatment programs. SoonerCare Choice links each member to a PCP who serves as his/her medical home and provides care management and medical services. There are 400,000 SoonerCare Choice members and over 1,000 PCPs.⁸² The program uses a three-component payment, which includes a visit-based FFS component, a monthly care coordination payment, and performance-based incentives. Providers receive bonus payments for reaching targets on childhood testing, cancer screenings, reduced emergency room use, appropriate drug use and immunization goals.⁸³ A nurse care management program, a health management program for care coordination and disease management, practice management facilitation and health access networks, which are not-for-profit, administrative entities that work with SoonerCare providers to coordinate and improve the quality of care, support the program.
- **Minnesota’s Health Care Homes Program** provides services including comprehensive care plans and health risk assessments for enrollees with at least one chronic condition through eleven “health care homes”, or PCMHs, certified by the state. Provider’s payments are based on the complexity of the enrollee’s medical condition. Providers assess patients and assign enrollees to one of four state defined complexity tiers, which indicates provider payment rate. Enhanced care management payments are also available for enrollees with severe mental illness, or for enrollees whose primary language is not English.

Health Homes

A “health home” is a specific term defined in the ACA that refers to a means of facilitating the coordination of physical and behavioral health care, and long-term community-based services and supports. The concept expands on the medical home or PCHM feature that is already a part of many states’ Medicaid programs. The health home further enhances care coordination

⁸² Oklahoma Health Care Authority. http://okhca.org/providers.aspx?id=648&menu=74&parts=8462_8464_8466_8468

⁸³ Devers, Berenson, et. al. Innovative Medicaid Initiatives to Improve Service Delivery and Quality of Care: A Look at Five State Initiatives. The Urban Institute. September 2011. Available at: <http://www.urban.org/uploadedpdf/412411-Innovative-Medicaid-Initiatives-to-Improve-Service-Delivery-and-Quality-of-Care.pdf>

Chapter 3: National Environmental Scan

for Medicaid enrollees who have multiple chronic illnesses.⁸⁴ Section 2703 of the ACA allows states the option to implement health homes for enrollees with specified chronic conditions. The ACA makes funding available through federal planning grants, which are awarded to states for developing state plan amendments relative to the health home provision. Funding began in January of 2011 and will continue indefinitely.⁸⁵ Additionally, the ACA provides for states to temporarily (for eight quarters) receive 90 percent federal matching funds for payments to health homes.

This health home option builds upon the PCMH concept by enhancing care coordination and access to care but is targeted to individuals with one or more chronic condition, including: a mental health condition, a substance use disorder, asthma, diabetes, heart disease, obesity (as evidenced by having a Body Mass Index over 25), or other federally-determined conditions. The health home model focuses on coordinating medical and behavioral health care for these individuals. This option became available on January 1, 2011.⁸⁶

- **Arizona** has a pilot program for individuals with serious mental illness that is funded by a federal health home planning grant awarded in March 2011. The pilot model fully integrates behavioral health and physical health care for these individuals. The state is considering contracting with one or more at-risk vendor in Maricopa County beginning in October 2013 and may consider expanding to other geographic and service areas in the future.⁸⁷
- **Missouri** is the first state approved by CMS to implement a health home model and receive 90/10 Federal matching funds; the program was initiated on January 1, 2012. Twenty-seven mental health facilities in Missouri coordinate medical care using health information technology (HIT) for their clients with chronic conditions, including dual eligibles. Service coordination includes primary, acute, behavioral health and long-term medical services.

⁸⁴ The Henry J. Kaiser Family Foundation. "Medicaid's New Health Home Option" January 2011. <http://www.kff.org/medicaid/upload/8136.pdf>

⁸⁵ Medical Home Provisions in the Patient Protection and Affordable Care Act. Available online at: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/state/statehcr/pcmhppaca.Par.0001.File.tmp/pcmhinhcr.pdf

⁸⁶ Medicaid's New "Health Home" Option. Focus on Health care Reform . Kaiser Reports January 2011. Available online at <http://www.kff.org/medicaid/upload/8136.pdf>

⁸⁷ Arizona Department of Health Services. Available online at: <http://azdhs.gov/diro/integrated/rbha/index.htm>

Traditional Primary Care Case Management and Enhanced Primary Care Case Management

The concept of having a “medical home” is central to the ability of PCCM and enhanced primary care case management (EPCCM) programs to organize and deliver services. PCCM programs have evolved from the original programs of the 1980s to EPCCM programs operating more frequently today. The first Medicaid PCCM programs began in the 1980s as states attempted to move away from FFS and into programs that provided more care management. Traditional PCCM programs typically involved a FFS payment for medical services and a \$3 PMPM payment to PCPs who served as the enrollee’s “medical home” and provided a limited range of care management activities such as providing authorization for emergency room (ER) and specialty visits. Specialist networks are generally not included in traditional PCCM programs. Some states have operated these programs “in-house” using state staff or through a contracted vendor to administer the program.

Traditional PCCM programs lack vendor financial incentives in the form of capitation to MCOs. Instead, the state contracts directly with providers and is responsible for paying claims, rather than for paying MCOs a predetermined PMPM rate from which the MCO must pay claims. Like in FFS, providers are paid based on the volume of claims. Without financial incentives to vendors or providers to contain costs through appropriate care management, states must design programs using other incentives, or “levers”, to achieve the desired results from the program in terms of care management and care coordination. For example, states may perform provider profiling of utilization trends and provide information to PCPs. States may also measure quality through various indicators and provide financial incentives to PCPs in the form of pay for performance.⁸⁸ Traditional PCCM programs may not be able to achieve cost savings, unless they can provide a reduction in costly services, like hospitalizations or emergency room visits. However, most PCCM programs operating today have some enhanced design elements. Below are examples of typical state approaches to PCCM programs:

- Virginia operates the MEDALLION PCCM program for TANF and ABD populations in certain geographic regions where risk-based managed care is not available or available only on a limited basis. In areas of the state where risk-based managed care is voluntary because there is only one MCO, Virginia operates the PCCM program. A single PCP serves as the “medical home” and coordinates the enrollee’s health care services, such as referrals to specialty providers. Virginia pays for

⁸⁸ Center for Health Care Strategies, Inc. Enhanced Primary care Case Management Programs in Medicaid. September 2009.

Chapter 3: National Environmental Scan

services on a FFS basis and additionally reimburses the PCPs a PMPM care management fee. PCCM will be offered in fewer regions of the state as Virginia proceeds with its initiatives to expand risk-based managed care.

- Illinois's PCCM program, Illinois Health Connect, operates statewide for the TANF and ABD populations. Enrollees choose a PCP, who coordinates health care services. Providers are paid FFS for services and receive an additional PMPM care management payment. The program offers all enrollees a "medical home" (a PCP to coordinate services), as well as care management for those with certain chronic conditions. The state reports that together, the programs saved \$180 million during the 2008 fiscal year and \$320 million in the 2009 fiscal year. Medicaid savings were calculated by comparing costs per patient before and after the launch of the programs.⁸⁹

There is evidence of quality improvements from implementation of PCCM programs, but the results have been inconsistent. Some states that have implemented PCCM programs have reported a decrease in emergency room use and specialty services, but an increase in preventive care services when compared with FFS delivery systems. However, one study indicates that, "Children enrolled in the Alabama and Georgia Medicaid programs were less likely to use emergency departments but were also less likely to use wellchild and other primary care (e.g., a visit for an acute illness or chronic condition) after the implementation of PCCM."⁹⁰

By the late 1980s it became evident that the initial intentions of the traditional PCCM program were not fully realized. Because traditional PCCM programs typically focus on primary and not specialty care, they pose a risky likelihood of continued issues with lack of care coordination. Incentives were not aligned with stakeholder or consumer interest. Additionally, the programs were limited in budget predictability as providers were still commonly paid on a FFS basis, in addition to the PMPM case management fee.

In an attempt to improve upon the traditional PCCM program with more care coordination and decreasing costs, many states, during the 1990s, transitioned their PCCM programs to risk-based managed care programs or evolved their PCCM programs to EPCCM programs which, "incorporate strengthened quality assurance, case management, and care coordination."⁹¹ These

⁸⁹ American Academy of Family Physicians News: <http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100721illinoismedicaid.html>

⁹⁰ The Child Health Insurance Research Initiative, Impact of Primary Care Case Management (PCCM) Implementation on Medicaid and SCHIP. March 2009.

⁹¹ The Kaiser Commission on Medicaid and the Uninsured, A Profile of Medicaid Managed Care Programs in 2010:

Chapter 3: National Environmental Scan

programs are often maintained in rural areas after states determine that risk-based managed care may not be feasible. Also, some states prefer to offer choice and to increase competition, and therefore operate side-by-side risk-based managed care and PCCM or EPCCM programs.

EPCCM programs include more intensive care management and care coordination¹ for high-need beneficiaries, improved financial and other incentives for PCPs, and increased use of performance and quality measures such as HEDIS®, Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider profiles, and similar measures.

EPCCM programs are often administered by a vendor and include disease management or care management programs. Various payment structures exist and vendors may or may not be at some risk. States reimburse PCPs directly for services, either FFS or on a semi-capitated basis (providers receive a fixed payment that covers certain primary care services provided by a PCP), and additionally provide a PMPM fee for case management.⁹² Some states have incorporated pay-for-performance incentives for vendors and providers into their EPCCM programs.

EPCCM programs include more intensive care management and care coordination for certain consumers and use financial incentives for providers by tracking performance and quality measures. Proponents of EPCCM models report savings similar to full-risk managed care models programs with less administrative burden on providers.⁹³

Below are examples of some state EPCCM programs.

- **Massachusetts:** Operates a Primary Care Clinician (PCC) program alongside a traditional managed care programs. Medicaid enrollees, other than those who are over 65 or dually eligible for Medicare, choose between the PCC and managed care program. The PCC program provides services and coordination including behavioral health coordination, to Medicaid enrollees. Providers are paid FFS with an enhanced rate for specified primary care services including some childhood screening and behavioral health tests.⁹⁴

Findings from a 50-State Survey. September 2011. Available online: <http://www.kff.org/medicaid/upload/8220.pdf>

⁹² Center for Medicare and Medicaid Services. Available online: <https://www.cms.gov/apps/glossary/>

⁹³ Center for Health Care Strategies. Medicaid Best Buys: Critical Strategies to Focus on High-Need, High-Cost Beneficiaries. April 2010

⁹⁴ Commonwealth of Massachusetts Executive Office of Health and Human Services Primary Care Clinician PCC Plan Provider Contract. 2007

- **Oklahoma SoonerCare:** In 2004, Oklahoma transitioned its risk-based managed care program to this EPCCM program due to MCOs leaving the marketplace and a strained budget. This change was driven by both contextual circumstances and a desire for a more cost-effective delivery system. MCOs were leaving the market to the point that only two MCOs operated in some regions of the state – the minimum to meet the federal requirement. Additionally, Oklahoma’s Medicaid budget was strained. As a result, the state offered a lower rate increase than plans were willing to accept. MCOs were not willing to compromise on the rate. The Oklahoma Health Care Authority developed analyses indicating that the state could operate its own program, in three urban areas, at a fraction of the administrative cost incurred under risk-based managed care. These findings, and the inability for compromise, led to implementation of SoonerCare in the three urban areas and later statewide. SoonerCare is unique from other EPCCM programs is the only state that adopted a partial capitation approach to paying PCCM providers, and it has the largest in-house staff of nurse case managers. Oklahoma reports that its their annual per member costs have been significantly below the national average. In 2005, per-member costs for children and adults in Oklahoma were six to 10 percent below the national average, and for the aged and disabled recipients costs were about 20 percent below the national average.⁹⁵ Additionally, Oklahoma’s own analysis estimated that SoonerCare saved more than \$2,000 per member in 2007 over previous costs trended forward using national health insurance inflation.⁹⁶
- **Pennsylvania ACCESS Plus:** In 2005, Pennsylvania implemented this EPCCM program in 42 rural counties of the Commonwealth where it had not yet expanded its mandatory risk-based program, HealthChoices. The Commonwealth contracted with a vendor to administer the program and to provide disease management under a guaranteed savings arrangement. The program also includes pay-for-performance programs for vendors, providers and dentists that reward completion of quality improvement activities and meeting goals for high-priority quality and access to care measures. The program has achieved improvements in a variety of areas, such as decreased emergency room visits, increased well child care and pediatric dental visits and use of appropriate medications. Mercer estimated the program costs (medical expenses) for the ACCESS Plus program to be \$203.76 PMPM, approximately six percent below the \$216.26 PMPM program costs Pennsylvania’s

⁹⁵ Mathematica Policy Research, Inc. SoonerCare 1115 Waiver Evaluation: Final Report January 2009.

⁹⁶ Oklahoma Health Care Authority, Average SoonerCare Per Member Cost Compare to Cost Trended Using National Health Insurance inflation. No date.

the voluntary MCO program, after adjustment for the different health risks of enrollees in each program.⁹⁷

- **Indiana Care Select:** Indiana implemented Care Select, which is a statewide mandatory program for the ABD population, in 2008. To provide care management for this population, Care Select stratifies members into low and high needs classifications, and focuses intensive effort on managing the care of the high-needs members with multiple chronic conditions. Providers receive a PMPM care managed fee and are paid FFS for services provided. Indiana contracts with two vendors to administer the Care Select program.⁹⁸

Risk-Based Managed Care

In risk-based managed care models, states contract with health plans, or MCOs, to deliver services to Medicaid consumers. The MCO receive a PMPM capitation payment, which is a fixed, monthly payment regardless of how many services consumers receive, thus putting the MCO at financial risk.⁹⁹ The MCO contracts with PCPs and specialists to be in their network and is responsible for paying for services rendered to enrolled consumers. Medicaid consumers must choose an MCO in which to enroll and then select a PCP. They are generally required to receive services from providers in the MCO's network.

There are many ways to structure and design risk-based managed care programs. For example, some programs offer comprehensive services that include most services and some have particular services, such as behavioral health, “carved-out” and provided through other delivery systems. Populations may also be included or excluded. As illustrated earlier in this Chapter, pregnant women, infants and healthy children (or TANF populations) are the population most often enrolled in Medicaid risk-based managed care. Some states also include the ABD population and dual eligibles. Additionally, the program may be mandatory, or voluntary for certain populations, and others may be excluded entirely.¹⁰⁰ Below are examples of some state risk-based managed care programs:

⁹⁷ Center for Health Care Strategies. Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States. September 2009.

⁹⁸ Center for Health Care Strategies. Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States. September 2009.

⁹⁹ Center for Medicare and Medicaid Services. Available online: <https://www.cms.gov/apps/glossary/>

¹⁰⁰ States may not require dual eligibles, American Indians, or children with special health care needs to enroll in a Medicaid managed care program without receiving a waiver from CMS.

Chapter 3: National Environmental Scan

- **Arizona:** Mandatory, statewide risk-based managed care programs for more than 90 percent of its Medicaid enrollees, including ABD populations, dual eligibles and long-term care recipients.¹⁰¹
- **Indiana:** Mandatory, statewide risk-based managed care only for TANF populations, while other populations receive services through FFS or PCCM arrangements.
- **Pennsylvania:** Mandatory risk-based managed care for TANF and ABD populations in 25 counties; voluntary risk-based managed care in 25 additional counties where a PCCM program also operates.

Many states are currently considering or are in the process of implementing reforms to make their programs more cost-effective while improving quality, access and outcomes. As many states consider reform, expanding managed care programs to “non-traditional” populations that are highest risk and highest need is an option to which they are turning. Several states are proposing or currently implementing significant changes to their programs, which include both expansions to non-traditional populations as well as geographic expansions:

- **Florida:** Florida is seeking an amendment to its 1115 research and demonstration waiver to expand it beyond its pilot counties, Broward, Duval and Nassau. The expansion, referred to as the Statewide Medical Managed Assistance Program, would be statewide, cover all acute care physical and behavioral health services and be mandatory for almost all populations, including those that are voluntary in the pilot program (Medicaid, dual eligibles, children with chronic conditions, children in foster care and adoption subsidy). An evaluation of the Medicaid pilot project concluded that PMPM expenditures in Broward and Duval counties were lower in the first two years after the pilot was implemented than would have been the case without the pilot.¹⁰² To provide adequate choice, the state will competitively procure a minimum of two MCOs, as well as a Provider Service Network, to serve each of the 11 regions. Together with the acute care managed care, the state has applied for 1915(b)/(c) approval to implement a long-term managed care program that will cover both institutional and community-based services. Enrollees in the long-term

¹⁰¹Stateline State Health Policy, Managed care explained: Why a Medicaid innovation is spreading. May 2011. Available at: <http://www.stateline.org/live/details/story?contentId=577819>

¹⁰² The Department of Health Services Research, Management and Policy, University of Florida. An Analysis of Medicaid Expenditures Before and After Implementation of Florida’s Medicaid Reform Pilot Demonstration. June 2009.

care program would receive acute care medical and behavioral services through the Statewide Medical Managed Assistance Program. The state indicates it is implementing these changes partially for cost containment purposes, but also to help simplify the Medicaid program, which is currently a complicated mix of delivery systems.

- **New Jersey:** submitted an 1115 waiver application to CMS that proposes consolidating all existing state plan services, five home and community-based services waiver programs, a managed care waiver program, two earlier section 1115 waiver programs, and multiple contracts into a managed care delivery system. Although New Jersey is waiting for approval of this new waiver, the state is currently moving forward with many managed care initiatives under other federal authorities. Beginning July 1, 2011, the state moved ABD populations and dual eligibles into managed care.¹⁰³ Behavioral health is carved out of the managed care program and will be administered and managed through a non-risk-based vendor. If the waiver is approved, the state will implement managed long-term care. Managed long-term care MCOs would be responsible for providing all acute and long-term care services.
- **Texas:** expanded the STAR and STAR+PLUS Medicaid managed care programs to new counties starting on September 1, 2011, and will add more counties on March 1, 2012. Texas is not substantially changing the design of its current programs, but is expanding them regionally. STAR will be statewide by March 2012, while STAR+PLUS will be only in certain counties. Additionally, these changes bring dental services into managed care for the Medicaid population. Texas also recently received approval of an 1115 waiver to implement a new funding mechanism for coalitions of public and private hospitals.

Accountable Care Organizations (ACOs)

An Accountable Care Organization (ACO) is a payment and delivery model comprised of a network of doctors and hospitals that share responsibility for providing care to patients. ACOs aim to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. The structure of an ACO may vary (a hospital with employed physicians, a health system consisting of several hospitals and employed physicians,

¹⁰³ The state did not need waiver approval for this expansion because the populations are included under an existing waiver.

Chapter 3: National Environmental Scan

physician joint ventures, or multi-provider networks). However, have some common features, including a focus on primary care and promoting integrated, organized processes for delivering coordinated services that meet the highest quality and efficiency standards; payment reform; and performance measurements that rely on timely and accurate data to promote organizational accountability for quality and costs of care for a defined population.¹⁰⁴

Proponents of the ACO model believe that ACOs will lead to a more coordinated health care system while providing higher quality care to patients at a lower cost to providers and payers. ACOs would make providers jointly accountable for the health of their patients, giving them strong incentives to cooperate and save money by avoiding unnecessary tests and procedures. Those that save money while also meeting quality targets would keep a portion of the savings.

The ACA presents a variety of options for ACO development for Medicare and Medicaid programs. It provides Medicaid programs with options to develop pediatric ACOs using shared savings incentives. Also, the ACA establishes the Center for Medicare and Medicaid Innovation to test innovative models for health care payment and delivery, so development of ACO delivery systems may be considered by that Center.¹⁰⁵

Some state Medicaid agencies are considering the ACO model as a method to improve health care for some of their higher cost population groups with more complex problems (dual eligibles, ABD population). Through a state plan amendment or federal waiver, states may make payments to an ACO by building off models (managed care, PCCM, Prepaid Health Plan [PHP], disease management, and pay-for-performance) which already exist in their programs.¹⁰⁶ For example:¹⁰⁷

- **Colorado** is developing regional community care organizations, an ACO model, for Medicaid consumers.
- **New Jersey** passed legislation for a Medicaid ACO demonstration project in which community-based, non-profit coalitions could apply for recognition as a Medicaid ACO. Applicants would be required to have a geographic focus and include all of the acute care hospitals, 75 percent of the PCPs, two behavioral health providers and

¹⁰⁴ K. Purington, A. Gauthier, S. Patel, and C. Miller, *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, The Commonwealth Fund and the National Academy for State Health Policy, February 2011.

¹⁰⁵ K. Purington, A. Gauthier, S. Patel, and C. Miller, *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, The Commonwealth Fund and the National Academy for State Health Policy, February 2011.

¹⁰⁶ Ropes and Grey. ACOs and Medicaid: Challenges and Opportunities. March 2011

¹⁰⁷ K. Purington, A. Gauthier, S. Patel, and C. Miller, *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, The Commonwealth Fund and the National Academy for State Health Policy, February 2011

two community residents from that area on the board of the organization. Providers would continue to receive their usual Medicaid FFS payments and the ACO, if its providers meet quality benchmarks, would receive shared savings payments for distribution to its providers based on a gain sharing plan. This initiative is part of New Jersey's 1115 waiver application.

- **Illinois** is developing its Care Coordination Innovations Project for the ABD population in select regions of the state. The state is inviting hospitals and providers to organize into care delivery networks, or "care coordination entities", to facilitate the delivery of appropriate health care and other services, and improve care transitions. Illinois law defines care coordination as "delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, dental services, and rehabilitation and long-term care services." The law also specifically states that care coordination must include risk-based payment arrangements related to health care outcomes, the use of evidence-based practices and the use of electronic medical records.¹⁰⁸ Illinois will release its RFP for these organizations in January 2012. The Innovations project will run concurrently and be integrated with the state's PCCM program.
- Providers in **North Carolina** are considering the development of a pediatric ACO, which would contract with networks in the CCNC program. A pediatric ACO, which contracts with Medicaid MCOs, is operational in Ohio.
- Numerous other states are considering or implementing ACO-type initiatives, including **Oregon, New York, Washington** and **Massachusetts**, but details are limited in these early stages of development.¹⁰⁹

Populations and Services

As states consider reforming their Medicaid programs and CHIP programs to be more cost-effective programs focused on improving quality, access and health outcomes, they are beginning to focus more on their higher risk, higher cost populations. There is tremendous

¹⁰⁸ [Public Act 096-1501, State of Illinois](#)

¹⁰⁹ States may also participate in Medicaid pediatric ACO demonstration which will permit participating states to make incentive payments to pediatric medical providers organized as an ACO.

Chapter 3: National Environmental Scan

opportunity for states to control costs and improve outcomes by better managing high-cost populations and better coordinating services for those populations.

States have long used a variety of managed care models for certain populations, such as for the pregnant women, infants and healthy children group (or TANF) population. The TANF populations are not typically the most expensive or difficult to manage. Although the majority of the Medicaid population is enrolled in managed care, historically, they tend to be healthier, lower-risk, lower-cost populations.¹¹⁰ States have implemented various levels of care management (medical homes, health homes, ACOs, CCOs) within these managed care models, which have often focused on individuals within the enrolled population with complex high-cost medical needs.

Now that states have experience and some success with managed care for healthy populations, many are looking to expand to more care management for more expensive populations, such as the ABD, dual eligibles and children in foster care.¹¹¹ Figure 3.10 below shows the number of states enrolling different eligibility groups into managed care either voluntarily or mandatorily. There is significant potential for cost savings through better management of these populations.

¹¹⁰ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

¹¹¹ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

Figure 3.10: Mandatory and Voluntary Medicaid Managed Care and PCCM Enrollment by Eligibility Group^{*112}

Eligibility Group	No. of States Reporting that, for at least one Program and/or Geographic Area, Managed Care Enrollment is:		No. of States Reporting that Group is Always Excluded
	Mandatory	Voluntary	
SSI children	26	21	8
Children in foster care	21	21	14
Children with special health care needs	32	20	5
Medicaid-expansion CHIP children	34	8	0
All other children	46	12	0
Pregnant women	44	13	1
Parents/caretaker adults	44	12	2
Non-dual aged	29	15	10
Non-dual blind/disabled	33	14	8
Institutionalized beneficiaries	9	10	32
Home-and community-based care beneficiaries	18	15	22

*Children receiving SSI or in foster care, dual eligibles and Native Americans require waiver authority to be enrolled mandatorily in managed care.

Many of the options for structuring risk-based managed care programs are specific to the special needs of the populations served. Below we discuss several high-risk, high-cost populations as well as particular services where service coordination is needed.

Aged, Blind and Disabled Populations

The ABD Medicaid population includes those who are age 65 or over or those of any age who are blind or disabled. Federal law mandates minimum eligibility standards, but also provides states with the flexibility to enroll additional populations beyond the minimum. As a result, Medicaid eligibility policies vary among the states. Categories of ABD eligibility may include those eligible for SSI, institutionalized individuals and individuals who are eligible for both Medicare and Medicaid.

The ABD population generally has more complex medical needs than other Medicaid populations. Additionally, ABD enrollees tend to receive more costly services, such as long-

¹¹² Totals may add to more than 50 because states may have both mandatory and voluntary programs depending on the population. Source: Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey.

Chapter 3: National Environmental Scan

term care and inpatient hospitalizations, than other enrollees. As such, they are more expensive to cover. Nationally, in 2011, ABD enrollees accounted for 23 percent of the Medicaid population, but accounted for nearly 64 percent of the expenditures. Furthermore, Medicaid is the major payer for long-term care services and accounts for 48 percent of total spending on long-term care services.¹¹³ Nationally, Medicaid long-term care users accounted for six percent of the Medicaid population in 2007, but nearly half of total Medicaid spending.¹¹⁴

Traditionally, the ABD population has been served through FFS arrangements; however, recent trends indicate a shift toward managed care. States view managed care as an attractive option to contain costs or provide budget predictability and stability. The Kaiser Family Foundation's September 2011 fifty-state survey of Medicaid managed care practices found that states are increasingly using managed care for ABD populations. Only 10 states reported that non-dual eligible aged populations are excluded from risk-based managed care or PCCM, eight states reported that non-dual eligible blind and disabled populations are excluded and eight states reported that disabled children are excluded. The survey also indicated that 25 states enroll dual eligibles in managed care (either voluntary or mandatory). States have a wide range of experience in delivering services through managed care for this population. Some states have had managed care for the ABD population since the beginning of their managed care programs, while others have only recently implemented programs. Other states use different models to serve the population, even though risk-based managed care delivery systems may be in place for TANF populations.

States have developed a variety of approaches to delivering Medicaid services to the ABD population. In Michigan, approximately 90 percent of Medicaid consumers are enrolled in Medicaid managed care, and the state continues to make efforts to expand managed care enrollment. Michigan has maintained managed care coverage for the ABD population since the late 1990s, when it was less common for states to consider managed care for this population.

In Virginia, Medicaid managed care, including mandatory managed care for the ABD population, currently operates in select regions of the state, but the program will be extended to Roanoke and southwest regions of the state starting in January 2012. Currently, in Roanoke and southwest regions of the state, ABD populations have the option to enroll in the PCCM model or the managed care model. The default is a managed care option, and about 70 percent of the ABD population chooses to stay in this model. While Virginia's move to managed care is motivated by budgetary concerns and preparation for ACA provisions, the Commonwealth has

¹¹³ Medicaid and CHIP Payment Access Commission, Report to Congress on Medicaid and CHIP (March 2011).

¹¹⁴ Kaiser Commission on Medicaid and the Uninsured Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-based Settings (October 2011).

Chapter 3: National Environmental Scan

always had the intention of expanding managed care statewide. However, the expansion has not been possible until now because it was difficult to attract MCOs to these more rural regions of the state. Now, they have several health plans interested in bidding for the business. The ABD population in Virginia is thus prepared for and familiar with the managed care system, which may make for a smooth transition to mandatory managed care in 2012.

In 2008, Indiana created a care management program for its ABD population, Care Select. Care Select operates under an EPCCM model, covering ABD and HCBS waiver enrollees. Under this model, physicians and other primary medical providers have main care coordination responsibility. Indiana signed contracts with two vendors to provide medical homes, utilization management, prior authorization and care management services as appropriate to approximately 70,000 members.

Figure 3.11 displays a sample of various state models and initiatives from among the states interviewed as part of the national scan.

Chapter 3: National Environmental Scan

Figure 3.11: Summary of State Approaches to Managed Care for ABD Populations¹¹⁵

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>ABD Population Enrolled in Same MCOs as TANF Populations</p> <p>State Example: Michigan</p>	<p>Almost all ABD Medicaid recipients, excluding dual eligibles and children with special health care needs.</p>	<p>All medical services. Behavioral health services are carved out and administered through a different delivery system.</p>	<p>For the overall managed care program, Michigan notes that costs increased less than 20 percent from 1995 to 2005, while costs for FFS have more than doubled in that same time period.¹¹⁶</p> <p>Minimally, \$4.5 billion in total savings have been realized due to Medicaid managed care between FY 00 and FY 10 or nearly \$400 million each year. The savings (compared to FFS) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in partnership with the State¹¹⁷.</p>	<p>Michigan has a robust quality monitoring and improvement program including pay for performance. Michigan incents plans by:</p> <ol style="list-style-type: none"> 1. Giving plans with higher quality scores a greater proportion of auto-assigned enrollees 2. Withholding a small percentage of capitation rates for redistribution to plans based on clinical access, HEDIS® indicators, member satisfaction, CAHPS indicators, accreditation status and legislative criteria 	<p>Michigan experienced health plan failures, which disrupted care for Medicaid enrollees. To safeguard against this in the future, Michigan implemented contracting approach changes including setting the capitation rate, rather than having MCOs bid.</p>

¹¹⁵ Source: Information provided during state interviews, unless otherwise noted.

¹¹⁶ Michigan Department of Community Health, Presentation, “Michigan Medicaid Managed Care Program: A Brief History.” No date.

¹¹⁷ Performance, Value, Outcomes: Medicaid Managed Care FY 2011-2013 Medicaid White Paper: FY 12/FY 13 Michigan Association of Health Plans, 2011. Available online: <http://www.ma hp.org/resources/whitepapers/12MEDICAIDWHITE%20PAPER.pdf>

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>ABD Population Carved Out of Risk-Based Managed Care and Served in Non-Risk-Based Program</p> <p>State Example: Indiana</p>	<p>Care Select is a mandatory PCCM program for the ABD population, excluding dual eligibles.</p>	<p>Care management services are provided by non-risk based vendors.</p>	<p>An independent assessment of Care Select found that children enrolled in HCBS waivers and in Care Select and blind and disabled children have PMPM costs at \$2,522 and \$2,219 PMPM respectively. Adults who are also enrolled in a waiver are the most expensive subpopulation in Care Select (\$4,512 PMPM), but ABD adults (\$1,045 PMPM) are less expensive than ABD children.</p>	<p>The state pays its vendors about \$25 PMPM for care management and withholds about 20 percent of that fee contingent on vendor performance on quality measures. The vendors are required to invest a certain portion of these performance payments in enrollee or provider incentives.¹¹⁸</p>	<p>The program focuses the most intensive care management on those individuals with multiple chronic conditions.</p>
<p>Separate MCOs/Program for ABD Population: Regional Pilot Project</p> <p>State Example: Illinois</p>	<p>Illinois implemented a mandatory managed care pilot program for 40,000 adult ABD Medicaid on May 1, 2011 in certain regions of the state.</p>	<p>In the first phase of the program, the MCO is responsible for providing acute medical care services. As contractors build their familiarity with the needs of</p>	<p>Illinois estimates the new program will save the state \$200 million over the next five years compared to costs under the previous FFS system.</p>	<p>The state is testing out this managed care approach in the Chicago collar counties; it is testing other approaches to managing the ABD population in other, more rural, regions of the state.</p>	<p>The state received significant resistance from providers in contracting with MCOs. Providers cited concerns with payment and managed care administrative burden. The Medicaid Director and her Deputy made personal calls to hospital administrators to understand their hesitation,</p>

¹¹⁸ Center for Health Care Strategies. Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States. September 2009.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
		<p>the population and establish more robust provider networks, Phase II will include HCBS and developmental disabilities services.</p>			<p>dispel rumors, send message about the importance of the initiative.</p> <p>The state also notes that the current hospital payment system doesn't allow state to transition money to managed care easily, and doesn't incent hospitals to contract with MCOs. The state is in the process of developing new payment methodologies.</p>

Chapter 3: National Environmental Scan

Behavioral Health Services and Populations

A significant issue in the design of managed care programs is whether to carve-in behavioral health care as a responsibility of the MCO that delivers physical health.

Behavioral health problems include a broad range of illnesses that have affected nearly a third of adults and a fifth of children throughout the country yearly. Most behavioral health illnesses are treated as a short term or chronic illness in the community setting but 5 percent of adults and 10 percent of children require additional non-medical services such as income support or housing assistance to manage more severe behavioral health illness.¹¹⁹ Medical services for behavioral health illnesses include a continuum of psychosocial, pharmacological and addiction services, provided by both behavioral health specialists and PCPs.

Medicaid is the largest payer of behavioral health services in the United States. Most individuals with behavioral health needs who receive SSI are eligible for Medicaid coverage; it covers a broad range of benefits of both federally mandated and optional services; and its financing structure allows states to expand services with federal financial assistance. In 2007, Medicaid funding comprised 58 percent of State Mental Health Agency revenues for community mental health services.¹²⁰

While HCBS, prescription drug services and case management services are optional state Medicaid services; states often cover these services. States often finance HCBS through a federal waiver or less frequently through the state option which provides services in the community setting to those who would be otherwise institutionalized.¹²¹ Despite Medicaid's inclusive eligibility requirements, extensive service options and large financial contributions, there has been criticism that those in need of behavioral health services through Medicaid have problems coordinating care between multiple delivery systems resulting in difficulty accessing necessary services and fragmented care.

Traditionally, managed care delivery systems have been used as a way to better coordinate care and control costs. However, many states have not included behavioral health services in their

¹¹⁹ The Kaiser Commission on Medicaid and the Uninsured. Mental Health Financing in the United States. April 2011.

¹²⁰ Disabled and Elderly Health Programs Group, CMS. Medicaid and Behavioral Health. Presented July 2011.

¹²¹ The Kaiser Commission on Medicaid and the Uninsured. Mental Health Financing in the United States. April 2011.

Chapter 3: National Environmental Scan

managed care programs. There are two basic approaches states may take to provide behavioral health services:

- Carve-out behavioral health services: Exclude behavioral health care from Medicaid managed care contracts for physical health services. Behavioral health services are then provided through either a traditional FFS program or through separate MCO – either a single statewide vendor, or multiple contractors. Less commonly, states may carve out certain populations of those receiving behavioral health care.
- Carve-in behavioral health services to the MCO contract: Provide behavioral health services through the same MCO that provides general medical care either through its own provider network or by subcontracting with a behavioral health organization.

Both options present potential opportunities and concerns. Providing behavioral health services through a managed care model may lead to improved coordination, while reducing costs through a reduction in hospitalizations. However, there is concern that entering an MCO could force enrollees to change providers or treatment programs where there have been long standing relationships. Care coordination problems may continue to exist when behavioral health services are carved-out from physical health; on the other hand, there is concern that a comprehensive MCO network where behavioral health services are carved-in would not include the necessary services or expertise to address unique behavioral health needs.

States may have somewhat contentious relationships with behavioral health providers and advocacy groups regarding inclusion of behavioral health in Medicaid managed care programs. Since community mental health centers receive so much of their funding from Medicaid, they may perceive managed care as threatening to these revenue streams. Additionally, advocates may have concerns about access to care under managed care.

States have developed a variety of approaches to delivering Medicaid behavioral health services. Figure 3.12 displays a sample of various state behavioral health models from among the states interviewed as part of the national scan.

Chapter 3: National Environmental Scan

Figure 3.12: Summary of State Approaches to Managed Care Behavioral Health¹²²

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
Behavioral Health Services Carved in to MCO Contract, Statewide State Example: Indiana	TANF populations.	Behavioral and physical health services.	Not available	The MCO contract included extensive requirements for physical and behavioral health integration and provider communication and care management for members receiving behavioral health services. The state also developed a robust stakeholder feedback process and established regular behavioral health meetings to engage with community mental health centers and other important providers.	There was some concern from providers about payments, as initially, all MCOs sub-contracted behavioral health services to behavioral health MCOs (BH MCOs). Currently, some MCOs subcontract services to a BHMCO, while others administer the benefit directly. Those that administer the benefit directly may include care coordination between behavioral and physical health services.
Behavioral Health Services Carve-Out, Paid FFS State Example: New Jersey	TANF, ABD, dual eligibles, foster care and long-term care populations. ¹²³	All behavioral health services.	Not available	Under a recently submitted 1115 waiver, New Jersey plans to contract with a non-risk based vendor to administer and managed behavioral health services.	The state originally planned to carve-in behavioral health to managed care, but providers and advocates were resistant. To improve care coordination for individuals receiving behavioral health services, New Jersey will add contract requirements for both physical health MCOs and the behavioral health vendor for care coordination and data sharing.

¹²² Source: Information provided during state interviews, unless otherwise noted.

¹²³ Long-term care populations will be under managed care if the state’s 1115 waiver is approved by CMS.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
Behavioral Health Services Carved in to MCO Contract, Regional Variation State Example: Texas STAR, STAR PLUS and North STAR programs.	In Texas, behavioral health is carved in to the main Medicaid managed care STAR and STAR PLUS programs, except for in the Dallas region where it is carved out and managed through a separate program called NorthSTAR.	Inpatient/ outpatient behavioral health services.	The state estimates 15 percent savings for managed behavioral health services compared to FFS for the STAR and STAR PLUS programs. ¹²⁴	NorthStar started as a pilot and is now an established program for this geographic area. The state indicates the program has been successful in terms of costs and outcomes. However, it will likely not expand to other areas of the state, as the state perceives greater savings and efficiencies gained from carving in behavioral health into the STAR and STAR PLUS programs.	The State has indicated that relationships with behavioral health providers and other stakeholders are collegial, and there have been no major issues in the development of the carved-in program design for STAR and STAR PLUS.
Behavioral Health Population Carve-Out, Paid Through a Separate System State Example: Arizona Pilot	The pilot project in Maricopa county will provide integrated behavioral health and physical health services to Medicaid members with severe mental illness. This population has high utilization of behavioral health	Behavioral and physical health services.	The Maricopa Pilot is less of a cost savings initiative than it is a care coordination initiative, as the state expects utilization of physical health	The Regional Behavioral Health Authorities (RBHAs), not the medical/acute care MCOs, are responsible for providing and coordinating both physical and behavioral health care for this population.	The program eliminates the need for physical and behavioral MCOs to coordinate care and exchange data because individuals receive all care through one organization. Providers welcome the program because of administrative simplicity – there is no question of which organization to bill.

¹²⁴ Deloitte Consulting LLP. State of Texas Health and Human Services Commission Medicaid Managed Care STAR+PLUS Program Rate Setting, State Fiscal Year 2008. September 17, 2007.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
Project for individuals with severe mental illness (SMI) in Maricopa County	services, and some concern of underutilization of physical health services.		services may actually increase.		
Separate Physical and BH MCO Contracts State Example: Pennsylvania	TANF and ABD populations.	Services for mental health and substance abuse disorders are administered by the behavioral health plan, while medical services are administered by the physical health plan.	A study of inpatient utilization for alcohol-related treatment in found that costs per person decreased by approximately 26 percent at the managed care site, while costs per person increased by approximately 32 percent at the FFS site. ¹²⁵	Pennsylvania implemented a “medical home” pilot program for adults with SMI in selected regions to help better coordinated physical and behavioral health services. The program included information exchange, coordination of hospital discharge and follow-up, pharmacy management, appropriate use of the ED and co-location of resources. The state also established a shared incentives pool for the behavioral and physical health MCOs. ¹²⁶	System physical and behavioral health coordination, and coordination between the behavioral health and physical health MCOs is a longstanding challenge.
Behavioral	In Wisconsin, the	The program	Not Available.	The program is the first	Wisconsin is in the process of developing

¹²⁵ Medicaid Managed Care Study." The Pacific Health Policy Group. March 2010.

¹²⁶ Pennsylvania Department of Public Welfare, “Establishing Accountable Physical/Behavioral Health Homes: Pennsylvania’s Innovations Project”, October 2009.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>Health – Special Programs</p> <p>State Example - Wisconsin</p>	<p>WrapAround Milwaukee program serves children and adolescents in Wisconsin who have serious emotional disorders and who are identified by the Child Welfare of Juvenile Justice System as being at immediate risk of residential or correctional placement or psychiatric hospitalization.</p>	<p>contracts with nine community agencies which oversee about 72 care coordinators who facilitate the delivery of services and other supports to families.</p>		<p>government operated managed care service designed to treat emotionally disturbed youth in the home setting. The program has access to more information about children served than most public mental health systems and has far more flexibility as to what can be provided, largely as a result of blended funding and case rate and capitation financing arrangements.¹²⁷</p>	<p>several “medical home” initiatives for its Medicaid population, including integrating medical homes into the Wrap Around program.</p>

Behavioral Health Homes¹²⁷

Chapter 3: National Environmental Scan

Long-Term Care Services and Populations

Medicaid is the nation's primary payer for long-term care services. Long-term care covers a continuum of services ranging from HCBS, which allow persons to live independently in their own homes or in the community to institutional care provided in nursing facilities and intermediate care facilities. Medicaid finances nearly half (43 percent) of all spending on long-term care services. Medicaid consumers who rely on long-term care have a range of chronic conditions, disabilities and diseases and spending and enrollment patterns vary widely. Nationally, dual eligibles accounted for over two-thirds of Medicaid consumers who used long-term care. Sixteen percent of Medicaid long-term care consumers have disabilities.¹²⁸

Long-term care represents a potential area for cost savings for Medicaid. Medicaid long-term care users represented only 6 percent of the Medicaid population in 2007, but nearly half of total Medicaid spending. The average annual spending per Medicaid enrollee was \$43,296 for long-term care consumers compared to just \$3,694 for consumers who did not use long-term care services. There is also potential for cost savings in encouraging community-based services when appropriate. Even though more Medicaid consumers used community-based services, Medicaid consumers who used institutional services accounted for a larger share of total spending.¹²⁹

Community services are delivered through HCBS waivers, which waive the requirements of Section 1915(c) of the Social Security Act to enable states to develop programs to fund services not otherwise authorized by federal Medicaid requirements (e.g., respite care, home modifications), but which will allow consumers to remain in their homes. By waiving these requirements, states may also limit coverage of these services, offer different services to different populations, limit the services to certain geographic locations or allow more populations to become Medicaid eligible. The HCBS waiver program grew rapidly from its inception in 1981, but waivers were not able to stem the growth of institutional costs as Medicaid nursing home expenditures continued to grow as well. Through the 1990s, nursing home services continued to grow more rapidly than Medicaid expenditures generally, limiting states' fiscal capacity to expand HCBS options.¹³⁰

¹²⁸ Kaiser Commission on Medicaid and the Uninsured Spending Patterns Across Institutional and Community-based Settings October 2011.

¹²⁹ Kaiser Commission on Medicaid and the Uninsured Spending Patterns Across Institutional and Community-based Settings October 2011.

¹³⁰ U.S. Department of Health and Human Services. The Past, Present and Future of Managed Long-Term Care. April 2005.

Chapter 3: National Environmental Scan

Survey results released in October 2011 by the Kaiser Commission on Medicaid and the Uninsured, found that states are continuing to reorient their Medicaid long-term care delivery systems towards more community-based services.¹³¹ There are several reasons why states view HCBS favorably. They allow consumers to receive services in the least restrictive setting. Consumer demand for HCBS is high, as many consumers welcome the option to stay in the community. HCBS services are also less costly for the state than institutional care. In light of the current budget situation that state Medicaid agencies face - with Medicaid taking up a larger share of state budgets, and long-term care taking up a larger share of Medicaid budgets – reorienting services towards HCBS may provide cost savings.

Traditionally, states have provided long-term care services to enrollees through FFS delivery systems, and there has been little coordination between acute and long-term care services. However, there are several programs and managed care models that offer the potential for better coordination.

One option states have for providing managed long-term care services is the Program of All-Inclusive Care for the Elderly (PACE), which is a long-standing program for frail elders who need nursing home level of care that allows states to provide comprehensive Medicare and Medicaid medical and social services using an interdisciplinary team approach. States provide services through PACE Center, which operate as an adult day health care center. Payment is capitated and includes all preventive and primary care, acute medical care, pharmacy services, medical and assistive devices, mental and behavioral health services, and long-term services and supports.¹³² PACE is an integrated model (financially and clinically), but, by design, it targets small populations and so has not been used as a broad-based solution. In 2009, there were about 29 PACE programs nationwide and total enrollment was about 20,000.¹³³ Most PACE enrollees are dual eligibles, who have specific concerns as discussed in the next section of this Chapter.

Although PACE is seen as an effective program for the small number of Medicaid recipients it serves, it is not seen as a large-scale solution. Other states have implemented managed long-term care for their Medicaid populations. In the 1980s, the Arizona Long Term Care System (ALTCS) was the first mandatory managed long-term care program implemented. Through the 1990s, several states became interested in expanding their Medicaid managed acute care

¹³¹ Kaiser Commission on Medicaid and the Uninsured. Results from a 50 state Medicaid Budget Survey for FY 2011 and 2012. October 2011.

¹³² Kaiser Commission on Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey. September 2011.

¹³³ Kaiser Commission on Medicaid and the Uninsured. Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider. October 2011.

Chapter 3: National Environmental Scan

experience to include long-term care. Minnesota, Texas and Wisconsin were among the states that developed managed care models that borrowed concepts from PACE, ALTCS and others.¹³⁴

Minnesota was the first state to implement a fully integrated model that combines both Medicare and Medicaid financing, as will be discussed further in the next section of this chapter. Texas implemented its Star+Plus in 1998 in one county, which was the second mandatory program after ALTCS. In 1996, Wisconsin implemented the voluntary Partnership Program, which began operating as a partially capitated Medicaid managed care program and added capitated Medicare benefits in 1999.

Currently, 11 states – Arizona, Florida, Hawaii, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Washington and Wisconsin – operate managed long-term care programs. Appendix D lists these programs and key design features of each. In these programs, a risk-based MCO contracts with the state to provide a benefit package to enrollees on a capitated basis. The more services that the contractor is at risk for, the more potential for service coordination exists, as the contractor has the full picture of all the services their enrollees receive. Program design varies among these 11 programs, although all of the programs cover community based services and supports. In managed long-term care programs, the long-term care contractor may be at risk for:¹³⁵

- All long-term care (institutional and community-based) as well as all acute medical care
- All long-term care (institutional and community-based), but acute medical services are delivered through an acute care MCO or through FFS
- Home- and community-based services only, with institutional and acute medical services delivered through other delivery systems

Research to date indicates that relative to FFS programs, managed long-term care reduces the use of institutional services and increases access to HCBS, though there is limited definitive

¹³⁴ U.S. Department of Health and Human Services. The Past, Present and Future of Managed Long-Term Care. April 2005.

¹³⁵ Kaiser Commission on Medicaid and the Uninsured. Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider. October 2011.

Chapter 3: National Environmental Scan

evidence about whether the model saves money, or how it affects quality of care for consumers.¹³⁶

As states look to streamline services and balance budgets, several other states are implementing or considering managed long-term care. Appendix F includes a list of long-term care reforms under consideration by states. Program design for long-term care services is not a simple process and requires significant development, implementation and monitoring efforts. The extent to which managed long-term care programs interact with HCBS waivers, institutional services, acute and primary medical, and behavioral health services, affects MCOs' ability to coordinate care and manage costs effectively.

States have developed a variety of approaches to deliver Medicaid long-term care services. Figure 3.13 displays a sample of various state long-term care models from among the states interviewed as part of the national scan.

¹³⁶ Kaiser Commission on Medicaid and the Uninsured. Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider. October 2011.

Chapter 3: National Environmental Scan

Figure 3.13: Summary of State Approaches to Managed Care for Individuals Receiving Long-Term Care

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>All Acute and Long-term Care Services through one MCO</p> <p>State Example: Arizona Long-Term Care System (ALTCS)</p>	<p>For those who meet screening requirements, enrollment is mandatory for dual eligibles, most of the ABD population and HCBS waiver populations. Developmental disabilities populations are excluded.</p>	<p>This program is fully integrated (community-based and institutional LTC as well as physical and behavioral health services).</p>	<p>Between 1999 and 2005, average annual growth in HCBS expenditures was 15 percent, accounting for 75 percent of long-term care expenditures in 2005. Growth in overall long-term care expenditures grew 10 percent over the same period.</p>	<p>The state requires that care managers conduct in person visits and see consumers at least every 90 days.</p> <p>ALTCS has been able to support over 70 percent of its members in home or community-based resident facilities rather than placing members in nursing home settings.¹³⁷</p>	<p>Arizona reports challenges with appropriate settings for nursing home residents needing extensive behavioral health services.</p>
<p>Selected Acute and Long-term Care Services through one MCO</p> <p>State Example: Texas STAR+PLUS</p>	<p>STAR+PLUS operates in select urban areas of the state. It is mandatory for the ABD population, including dual eligibles and individuals with developmental disabilities, in the regions where it</p>	<p>Provides acute and long-term services and support, excluding inpatient hospitalizations and nursing home care. Behavioral health is carved in.</p>	<p>STAR+PLUS has proven successful and cost-effective for the state, and is well liked by Texas' legislature. The Texas STAR+PLUS program achieved PMPM savings of \$4 in the first waiver period and \$92 in the second waiver period with a total savings for the two year period at \$123 million.</p>	<p>Not available.</p>	<p>Texas is expanding the STAR+PLUS program to additional regions. Texas's recently submitted 1115 Waiver maintains the current STAR+PLUS program's structure, design and operation.</p>

¹³⁷ Kaiser Commission on Medicaid and the Uninsured. Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider October 2011.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
	operates.				
Separate MCO Contracts for Long-Term Care and Acute Care State Example: Florida (proposed)	Enrollment will be mandatory for those receiving nursing home or care under some waivers prior to or after program initiation.	The long-term care MCO will cover LTC services only such as, HCBS, nursing home care and limited medical care. Enrollees will receive all acute care services through another MCO.	The state expects to achieve long-term cost savings by moving members from nursing homes into community-based care.	Florida’s 1915(b) and (c) waivers expand Medicaid managed care to long-term care populations. The Legislature approved the statewide Medicaid long-term care managed care program which is to be implemented October 2013.	Since consumers will receive their LTC and acute care services through separate MCOs, care coordination and cost-effectiveness may be an issue.
LTC Services Carved Out of Managed Care, paid FFS State Example: Virginia	Medicaid enrollees requiring LTC services.	Institutional and HCBS LTC services are carved out of managed care.	Not Available	During FY 2012, Virginia plans to secure a vendor to provide “managed care like” coordination services for individuals receiving services through HCBS waivers. ¹³⁸	Coordinating care between providers can be an area of concern in FFS long-term care arrangements.
Acute and Long-Term Care Managed Care, Regional Variation State Example: Wisconsin FamilyCare and FamilyCare Partnership	Programs are voluntary for all populations. Serve people with physical disabilities, people with developmental disabilities and frail elders who require long-term care services. Includes	Family Care provides HCBS, institutional care, Medicaid personal care, home health and other services. Family Care does not pay for acute/medical services.	Not Available	Counties serve as the managed care contractor, accepting financial risk for meeting the needs of all persons requiring long-term care services in the county.	The majority of frail elderly and adults with developmental and/or physical disabilities in these programs have chosen to stay in their own homes or other community-based settings, rather than entering nursing homes. ¹³⁹ Wisconsin, effective July 1,

¹³⁸ Virginia Division of Health care Services. Virginia Medicaid Managed Care Overview July 2011.

¹³⁹ Wisconsin Department of Health Services. Long-Term Care in Motion: 2009 Annual Report of Wisconsin’s Long-Term Care Programs. 2009.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
	dual eligibles.	Family Care Partnership integrates long-term care services, acute medical services, and prescription medications.			2011, capped enrollment in Family Care and its related programs (the Family Care Partnership Program and the Program for All-Inclusive Care for the Elderly (PACE)). Enrollment was re-instated in December 2012.

Dual Eligible Populations

A key design issue for states is deciding whether individuals who are dually eligible for Medicare and Medicaid (dual eligibles) should be included in managed care programs. Dual eligibles are individuals who qualify for both Medicare and Medicaid services, including low income seniors and those who qualify for Medicare under the age of 65 (including children with disabilities)¹⁴⁰. This population often suffers from multiple chronic conditions; which results in multiple hospitalizations and emergency department visits and may require behavioral health services, nursing home care and long-term living services.¹⁴¹ Coordinating care, service delivery and payment is a main concern for this population who may be receiving services from numerous providers throughout the health care system and under both the Medicaid and Medicare system.

Compared to the general Medicare population, dual eligibles are poorer, less educated and sicker. They are more likely to have less than a high school level of education, more likely to be disabled, have a behavioral health disorder, have diabetes and reside in a long-term care facility.¹⁴² Health care costs for dual eligibles are nearly five times higher than costs for other Medicare recipients. Due to the higher utilization of services compared to other Medicaid or Medicare enrollees, Medicaid and Medicare spending for dual eligibles is disproportionately high. For example, dual eligibles comprise 15 percent of Medicaid enrollees but 39 percent of total Medicaid spending.¹⁴³ Similarly, they represent 21 percent of Medicare enrollees but 36 percent of total Medicare expenditures.¹⁴⁴ Therefore, states are looking for ways to provide cost-efficient, high quality, appropriate coordinated care for this population.

There are several types of dual eligible eligibility categories, which have varying levels of Medicare and Medicaid coverage, premiums and cost sharing. Some dual eligibles may receive full Medicaid benefits, as well as assistance with premiums and cost sharing, while other dual

¹⁴⁰ Full benefit dual eligibles qualify for full Medicaid benefits including both institutional and community based long-term care and prescription drug coverage and Medicaid may pay Medicare premiums and cost sharing for full benefit dual eligibles. While partially eligible duals may not receive full Medicaid benefits but may receive assistance from Medicaid with some or all for their Medicaid premiums and cost sharing.

¹⁴¹ Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011.

¹⁴² Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011.

¹⁴³ Note: Statistics include all dual eligibles.

Source: Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011.

¹⁴⁴ Kaiser Family Foundation Program on Medicare Policy. The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011.

Chapter 3: National Environmental Scan

eligibles receive only assistance with premiums. Each dual eligibility category and the various levels of assistance is displayed in Figure 3.12.

Figure 3.12: Categories of Dual Eligibles¹⁴⁵

Dual Eligible Category	Type of Medicaid Benefit			
	Part A Premium	Part B Premium	Medicare cost-sharing	Full Medicaid Benefits
Medicaid Only	No	Yes	No	Yes
Qualified Medicare Beneficiary (QMB)	Yes	Yes	Yes	No
QMB Plus	Yes	Yes	Yes	Yes
Specified Low Income Medicare Beneficiary (SLMB)	No	Yes	No	No
SLMB Plus	No	Yes	No	Yes
Qualifying Individual (QI)	No	Yes	No	No
Qualified Disabled and Working Individual (QDWI)	Yes	No	No	No

Medicare is the primary payer for most dual eligibles, covering most acute care services and prescription drugs; while Medicaid fills the gap, covering services such as transportation, vision, dental and nursing home care beyond Medicare’s limit of 100 days. Adding to the complexity, Medicare beneficiaries receive their prescription drug coverage through a Medicare Part D drug plan, although states are required to contribute to the funding of this benefit. As a result, coordinating services and payments between payers is a challenge, as each payer only has a partial view of the dual eligible’s utilization and claims history.

Dual eligibles are a challenging population to manage because of the difficulty in coordinating Medicaid and Medicare funding and services, as well as the difficulty in coordinating their care. Dual eligibles’ health needs are significant, and they may be seeing multiple providers and taking multiple medications. In the past, dual eligibles have typically received their Medicaid services through a traditional FFS delivery system. Because of their complicated health needs, FFS service delivery can be fragmented and uncoordinated without care management. In her recent testimony before the House Energy and Commerce Committee, Director of the CMS Medicare–Medicaid Coordination Office Melanie Bella said,

¹⁴⁵ Centers for Medicare and Medicaid Services. Dual Eligible categories.

Chapter 3: National Environmental Scan

“Too often, the care journey for these individuals is fragmented and uncoordinated...Over the years, a lack of coordination for this population has led to fragmented and episodic care, which can lead to lower quality and higher costs for this population.... Too often, the current approach to financing care for those eligible for Medicare and Medicaid provides a financial incentive to push costs back and forth between the States and the Federal government. Better coordination and partnerships between the two levels of government will eliminate these incentives and focus on finding the care setting that is most appropriate for the beneficiary, independent of who is paying for it.”¹⁴⁶

Over the years, there have been several attempts to address the lack of coordination for dual eligibles' care and funding. There have been several demonstration projects, but no large-scale coordinated care initiatives. One of these demonstration projects, the Minnesota Senior Health Options, started in the 1990s. The program was the first initiative that integrated Medicare and Medicaid financing, acute and long-term care service delivery, for dually eligible and Medicaid eligible physically disabled adults and elderly in a ten county area in Minnesota, including the Twin Cities. To operate the program, Minnesota obtained approval under a combined Section 1115 Medicaid demonstration waiver and Section 222 Medicare payment waiver. A key design feature of MSHO is the employment of a single contract between the state and the MSHO plans for both Medicare and Medicaid terms and conditions.¹⁴⁷ Although Minnesota's program was successful, the demonstration projects were not able to translate into changes on the national level, as the challenges of implementing such programs were too great for many states. In the 2000s, Special Needs Plans (SNPs) were introduced as a means of providing more coordinated care for dual eligibles and other Medicare beneficiaries. SNPs were created in the Medicare Modernization Act of 2003 as a special type of capitated Medicare Advantage managed care plan focused on improving care coordination and continuity of care for institutionalized, dual-eligibles and consumers with severe or disabling chronic conditions.^{148,149,150} The dual eligible SNPs cover those individuals eligible for both Medicare

¹⁴⁶ United States Department of Health and Human Services, Statement of Melanie Bella on Dual Eligibles: Understanding this Vulnerable Population and how to Improve their Care before the U.S. House Committee on Energy and Finance, Subcommittee on Health. June 21, 2011. Available at: <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/062111%20Dual%20Eligibles/Bella.pdf>

¹⁴⁷ U.S. Department of Health and Human Services. The Past, Present and Future of Managed Long-Term Care. April 2005.

¹⁴⁸ Medicare Advantage is the Medicare managed care program.

¹⁴⁹ Centers for Medicare and Medicaid Services. Special Needs Plans Overview.

¹⁵⁰ Chronic condition SNPs enroll Medicare beneficiaries with one of 15 specified severe or disabling chronic conditions. Institutional SNPs cover Medicare beneficiaries who require, for 90 days or longer, the level of services provided in a long-term care skilled nursing facility.

Chapter 3: National Environmental Scan

and Medicaid and offer an opportunity to combine the funding for both Medicaid and Medicare services.

A fully integrated dual eligible SNP must provide enrollees access to all Medicare and Medicaid benefits, including long-term care, under a single MCO and coordinate delivery of those benefits using aligned care management. SNPs must also provide required Medicare Part D prescription drug coverage. As of February 2011, there were 298 dual eligible SNPs serving 1.3 million dual eligibles.¹⁵¹

The Medicare Improvements and Patients and Providers Act of 2008 (MIPPA) facilitated further SNP integration by:

- Requiring plans or those that are expanding into new service areas to contract with state Medicaid Agencies
- Establishing new standards for provision of care, i.e., evidence-based models of care, interdisciplinary care teams, and individual care plan identifying goals, objectives, measurable outcomes, and specific benefits

Despite the efforts of dual eligible SNPs, true coordination between Medicaid and Medicare services has been limited; most dual eligibles are not enrolled in SNPs. Even in states that require or encourage their MCO to be SNPs, dual eligibles may receive their Medicare benefits through the same MCO as Medicaid, a different Medicare Advantage plan or Medicare FFS. Enrollment in dual eligible SNPs is limited to just 11 percent of dual eligibles.¹⁵² Only 14 states have fully integrated managed care programs that include the full range of Medicare and Medicaid primary, acute and long-term supports and services in operation or development.¹⁵³

States have taken a variety of approaches in providing services and designing managed care programs for dual eligibles to address the challenges that this population presents. Many MCOs that serve the dual eligibles population are certified as SNPs.

Hawaii's program, QUEST Expanded Access (QExA) was implemented in 2007 (post-SNP legislation) and is a fully integrated managed care program, where MCOs are at risk for the management of all long-term services (community-based and institutional) as well as for

¹⁵¹ MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*. Coordinating Care for Dual Eligibles. June 2011.

¹⁵² MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*. Coordinating Care for Dual Eligibles. June 2011.

¹⁵³ Center for Health Care Strategies, Inc. States with Fully Integrated Care Programs for Dual Eligibles. September 2010.

Chapter 3: National Environmental Scan

medical services, for the ABD population including dual eligibles. Contracted plans are not required to have SNP status, but QExA contractors have SNP agreements in place or in process.¹⁵⁴

Some long-standing programs were developed before the SNP legislation, but currently use SNPs as contractors in some capacity. Arizona requires contractors in its managed long-term care program to either be SNPs or have a connection to a SNP about half of its long-term care MCOs are SNPs. Texas does not require its long-term care MCOs to be SNPs, but all current contractors are SNPs and Texas will require future contractors in expansion counties to be SNPs. Minnesota has two well-established managed care program that includes dual eligibles – Minnesota Senior Health Options for dual eligibles age 65 and over and Minnesota Senior Care Plus for all seniors. Enrollment in Senior Care Plus is mandatory for duals, unless individuals choose to enroll in the Senior Health Options program. Minnesota contracts with the same SNPs for both programs.¹⁵⁵

The PACE program, as discussed in the previous section on long-term care approaches, is used by 29 states as a means to coordinate Medicare and Medicaid payments, but enrollment in PACE is small.

Most other states, however, including Oklahoma, Virginia and Michigan and most of the states interviewed for this report, currently carve dual eligibles out of managed care, and deliver Medicaid services through FFS arrangements most dual eligibles. States use this approach for a number of reasons, including the level of maturity of the managed care program and the state's experience in managing the needs of this complex population.

Recognizing the issues faced by states in managing the care of dual eligibles, the federal government developed the Federal Coordinated Health Care Office, now known as the Medicare-Medicaid Coordination Office, in 2010. The Medicare-Medicaid Coordination Office is working with the Center for Medicare and Medicaid Innovation (CMMI), which awarded design contracts in April 2011 of up to \$1 million to 15 states to develop service delivery and payment models that integrate care for dual eligibles.¹⁵⁶ The states are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.

¹⁵⁴ Center for Health Care Strategies. Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles. November 2010.

¹⁵⁵ Mathematica Policy Research. Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans. June, 2011.

¹⁵⁶ CMS Office of Public Affairs. 15 States Win Contracts to Develop New Ways to Coordinate Care for People with Medicare and Medicaid. April 14, 2011.

Chapter 3: National Environmental Scan

The demonstration project states are in early stages of implementation. Many states have chosen service delivery models for the demonstration that align with their other Medicaid service delivery models. For example, some states, such as Michigan, have chosen a managed care model to meet the challenges of integrating care for dual eligibles. In the late 1990s, Michigan attempted to integrate coverage for dual eligibles under the standard Medicaid MCO contracts; however, the MCOs were not able to effectively meet the needs of the population and shifted dual eligibles to a fee for service model. The Michigan Demonstration Project aims to integrate Medicaid and Medicare care and financing under a single, separate vendor contract.

Other states, such as North Carolina, are implementing programs using different delivery system models. The North Carolina Demonstration project will build upon Community Care North Carolina (CCNC), which is the current statewide PCCM/medical home model. CCNC's strategy enhances the services surrounding the dual eligibles' living arrangements by providing enhanced care coordination and care management services in the community, in nursing homes and in assisted living settings.¹⁵⁷

Also, CMMI has a second demonstration to align financing between Medicare and Medicaid. This alignment will support improvements in quality and cost of care for dual eligibles through two models: a capitated managed care model and a managed FFS model.¹⁵⁸

- The capitated model builds on the experience of the Program of All Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Medicare Advantage Special Needs Plans, managed long-term care programs in Medicaid, and prior Medicare-Medicaid demonstrations provide important lessons. Under this model, CMS will test a new capitated payment model utilizing a three-way contract among a State, CMS and health plans to provide integrated benefits to Medicare-Medicaid enrollees. Plans will receive a blended capitated rate for the full continuum of benefits provided to Medicare-Medicaid enrollees across both programs. The capitated model will target aggregate savings through actuarially developed blended rates that will provide savings for both States and the Federal government. Plans will be required to meet established quality thresholds. The three-way contract among CMS, the State, and health plans will also test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless

¹⁵⁷ Kaiser Commission on Medicaid and the Uninsured. Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS. August 2011.

¹⁵⁸ State Medicaid Director Letter, July 2011 available at

https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

Chapter 3: National Environmental Scan

experience for Medicare-Medicaid enrollees utilizing a simplified and unified set of rules. Such flexibilities will vary by State and may include, but are not limited to: supplemental benefits; enrollment flexibilities; and a single set of appeals, auditing and marketing rules and procedures. Any flexibility will be coupled with specific beneficiary protections that will be included in the contract among the parties.

- The managed FFS model builds on the existing FFS delivery system. Many States have invested significant resources to organize their delivery system to provide coordinated care for Medicaid beneficiaries through a FFS model. In addition, new CMS programs focused on redesigning the primary care delivery system (e.g., Accountable Care Organizations, Medicaid health homes) offer opportunities for States to improve coordination of care within a managed FFS delivery model. Under this model, CMS will test the impact of establishing a retrospective performance payment to States based on Medicare savings achieved for Medicare-Medicaid enrollees. The State program will ensure seamless integration and access to all necessary services based on the individual's needs through coordination across the two programs. States would make the upfront investment in care coordination and would be eligible for a retrospective performance payment should a target level of savings result to Medicare. Savings determinations will be based on rigorous evaluation of Medicare and Medicaid spending in each State and must be certified by CMS Office of the Actuary. States meeting quality of care thresholds will be eligible for retrospective performance payments based on Medicare savings net of increased federal Medicaid costs.

In the current environment, states have been increasingly interested in transitioning their dually eligible populations to Medicaid managed care programs to increase cost-effectiveness and care coordination opportunities. While there has been some resistance to the idea of managed care for dual eligibles, due to the complexities around financing and concerns that programs may not be able to meet the unique needs of this population, the options made available to states through CMMI offer states new opportunities to overcome some of the challenges they have faced in the past. Programs can now be designed to address the unique concerns of the dual eligibles – for example, by developing appropriate MCO network requirements, requiring important services (such as enhanced transportation or social services), performance and quality incentives that are relevant to the population – while using provider and MCO financial arrangements that are aligned among both payers and that promote the delivery of coordinated and cost-effective care for the patient.

Chapter 3: National Environmental Scan

Examples of state approaches in covering the dual eligible populations from among the states interviewed are included in Figure 3.13.

Chapter 3: National Environmental Scan

Figure 3.15: Summary of State Approaches to Managed Care for Dual Eligibles¹⁵⁹

Approach Description	Population Covered	Services Covered	Payments	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
Dual Eligibles Carved in to Acute and Long-term Care MCO Contracts (Statewide, Mandatory) State Example: Arizona	Mandatory enrollment for duals.	Acute care, behavioral health, long-term care and case management.	Plans are rewarded for meeting standards regarding the percentage of members served in community settings. ¹⁶⁰	The state is contracting with SNPs that receive funding from both Medicaid and Medicare for duals, with the expectation that the savings associated with care coordination and management can reduce the state’s Medicaid expenditures for duals in SNPs.	Arizona implemented “passive enrollment” in dual eligible SNPs operated by the same company, if available.	Arizona encourages Medicaid/Medicare integration by requiring that its health plans to also become a Medicare SNP or to partner with a Medicare Advantage plan. However, even this approach has its limitations, as not all dual eligibles in Arizona are receiving care from the same Medicare/Medicaid health plan.

¹⁵⁹ Source: Information provided during state interviews, unless otherwise noted.

¹⁶⁰ Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans. June 2011.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Payments	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>Dual Eligibles Carved in to Acute and Long-term Care MCO Contracts (Regional, Voluntary)</p> <p>State Example: Wisconsin</p>	<p>The Family Care Partnership is available in selected areas of the state; Voluntary enrollment for all enrollees.</p>	<p>Acute care, behavioral health and long-term care.</p>	<p>Capitated.</p>	<p>Not Available</p>	<p>Wisconsin is also part of the Demonstration Program for Integrating Care. It proposes that the State would function as Medicare/Medicaid entity, similar to PACE authority, but not restricted to a specific physical site, and with broader authority than Medicare SNP. Goal would be for one entity to be responsible for all acute, primary and LTCS and provide care coordination.¹⁶¹</p>	<p>Contractors are required to be SNPs.¹⁶²</p>
<p>Medicare-Medicaid Coordination Office and Center for</p>	<p>Dual eligibles are currently carved out of the state's managed care programs. This</p>	<p>All Medicare benefits, including those currently provided under</p>	<p>State Medicaid program would serve as a designated entity assuming complete</p>	<p>Not Available</p>	<p>The contractors will not initially be at risk, but will eventually assume full risk. The</p>	<p>Community mental health centers are concerned about the demonstration project, as they perceive it as</p>

¹⁶¹ Center for Medicare and Medicaid Services. State Demonstrations to Integrate Care for Dual Eligible Individuals Design Contracts Summary of State's Initial Design Concepts – Wisconsin. May 2011.

¹⁶² Center for Health Care Strategies, Inc. States with Fully Integrated Care Programs for Dual Eligibles. September 2010.

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Payments	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>Medicare and Medicaid Innovation Demonstration Program for Integrating Care</p> <p>State Example: Michigan</p>	<p>demonstration program targets all dual eligibles, enrollment is mandatory – estimated 220,050 eligible enrollees by April 2012.</p>	<p>parts A, B and D. Behavioral health is carved in.</p>	<p>financial responsibility over Medicare and Medicaid funds and services for duals.</p>		<p>contractor will be responsible for developing programs that focus on robust care coordination and include health homes with a single care coordinator and comprehensive provider network and integrate physical health with hospitals, Medicare and mental health.¹⁶³</p>	<p>threatening to their funding. The state has developed a robust stakeholder participation and feedback process and has received input from behavioral health providers and recipient advocates.</p>
<p>Dual Eligibles Carved Out, Paid FFS</p> <p>State Example: Virginia</p>	<p>All dual eligibles covered in FFS</p>	<p>All Medicaid covered services for duals are carved out of managed care.</p>	<p>FFS</p>	<p>Not Available</p>	<p>Virginia is one of 38 states to introduce a new pilot for the dual eligible population. They plan to fully integrate all services for the population – acute, primary, behavioral</p>	<p>Care coordination may be even more difficult for dual eligibles in a FFS arrangement.</p>

¹⁶³ Kaiser Commission on Medicaid and the Uninsured, Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS, August 2011.

Chapter 3: National Environmental Scan

Foster Care Populations

As of FY 2010, there were 408,000 children in foster care across the United States¹⁶⁴. Children in foster care include those under the age of 18 who are placed in out-of-home foster care, kinship care or other residential programs. Most children in the foster care system receive health care services through Medicaid. Children in foster care have difficult personal histories. Many have been removed from abusive or neglectful homes and may have suffered traumatic events. Many children in foster care require care for chronic physical problems. Additionally, they tend to have more behavioral health problems and require more psychosocial services than other children receiving Medicaid services. Providing the necessary services and coordinating care between service provider and state agencies is challenging and often more expensive for the foster care population than for their counterparts in the TANF population.

In December 2011, the United States Government Accountability Office (GAO) released a report indicating that children in foster care in the five states the GAO studied were prescribed psychotropic drugs at higher rates than other children in Medicaid during 2008. The report notes that the greater utilization could be due in part to greater behavioral health needs of children in foster care and the challenges of coordinating their care. However, the GAO notes that some of this difference in utilization may be inappropriate. The study found that many children were on treatment regimens that have little or no evidence to support them. For example, hundreds of children were receiving five or more psychotropic drugs concomitantly. Thousands of children were prescribed doses higher than the maximum levels cited in guidelines and children under one-year old were prescribed psychotropic drugs. The results of this study have important implications for states as they contemplate design options that minimize the risks of poor care coordination and inappropriate utilization.

One of the larger challenges of managing this population is their environmental instability. Care may be disjointed and sporadic because children in foster care are often moved throughout a state and are in a variety of custody arrangements. Shifting guardianship from birth parents, foster parents, guardians or adoptive family makes it difficult to coordinate necessary health care services, screenings and follow-ups. Lack of coordination between physical health and behavioral health providers as well as state agencies intensifies these issues. Some states use managed care programs as a way to coordinate continuous care for this population. Children in foster care may mandatorily be enrolled in managed care under a

¹⁶⁴ Trends in Foster Care and Adoption—FY 2002-FY 2010 (Based on data submitted by states as of June, 2011. Source: AFCARS data, U.S. Children's Bureau, Administration for Children, Youth and Families Discussion of. US Department of Health and Human Services Child

Chapter 3: National Environmental Scan

federal waiver, or voluntarily enrolled through a state plan amendment. Typically, foster care children enrolled in managed care are served under a population carve out from the general managed care program. Managed care programs designed specifically for children in foster care help to ensure that their unique needs are addressed. For example, children in foster care require coordination of social services from various state agencies but this requirement may not be included in standard Medicaid managed care contracts.¹⁶⁵

Keeping these design issues in mind, states have structured managed care for children in foster care in various ways. Figure 3.16 displays a sample of various models for the foster care population from among the states interviewed as part of the national scan.

¹⁶⁵ Center for Health Care Strategies, Medicaid Managed Care for Children in Child Welfare. April 2008.

Chapter 3: National Environmental Scan

Figure 3.16: Summary of State Approaches to Managed Care for Foster Care

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>Foster Care Populations Carved in to MCO Contracts</p> <p>State Example: Florida (Proposed)</p>	<p>Mandatory enrollment for children in foster care in the Florida Managed Medical Assistance Program</p>	<p>All physical and behavioral health services.</p>	<p>Not Available.</p>	<p>Not Available.</p>	<p>Children in foster care are a difficult population to manage because of their intense social service needs and how frequently they move. It is hard to provide consistent care management because of this.</p>
<p>Separate MCO Contract for Foster Care Populations</p> <p>State Example: Texas-STAR Health</p>	<p>Separate program and MCO contract for children in foster care</p>	<p>All physical and behavioral health services.</p>	<p>Although the state notes that operating a separate program may not be as cost-effective as other models, they state it is necessary to address the special care coordination needs of this population.</p>	<p>Through a medical home model, the plan coordinates physical, behavioral, dental, vision and disease management services between caregivers, state staff, guardian, attorneys, etc. for the best interest of the child. The plan uses electronic health records (EHRs) so that multiple providers may easily follow medical histories and coordinate services when care may be sporadic.¹⁶⁶</p>	<p>Texas Health and Human Service Commission believes the population’s specific needs are better met through this program design because the state is able to create programs and contract requirements specifically for this population.</p> <p>The state has decided to maintain only one MCO for this program at this time. Because foster care populations have so many various social needs, it is difficult to coordinate with other state agencies and the MCO. Adding additional MCOs could increase difficulty.</p>

¹⁶⁶ Texas STAR Health Presentation. Available at: <http://www.fosteringconnections.org/tools/assets/files/STAR.pdf>

Chapter 3: National Environmental Scan

Approach Description	Population Covered	Services Covered	Budget Implications	Innovative Aspects	Implementation or Operational Concerns
<p>Foster Care Populations Carved Out of Managed Care, Paid FFS; Statewide</p> <p>State Example: Indiana</p>	<p>Most children in foster care are in the FFS delivery system, except for those with serious mental illness, who are in CareSelect, Indiana's PCCM for the ABD population.</p>	<p>All physical and behavioral health services.</p>	<p>Not Available.</p>	<p>Not Available.</p>	<p>Children in foster care are currently in FFS; however, the state would like to transition this population to managed care.</p>
<p>Foster Care Populations Carved Out of Managed Care, Paid FFS; Regional Variation</p> <p>State Example: Virginia</p>	<p>Children in foster care are in the FFS delivery system, except for a pilot managed care program in the Richmond area.</p>	<p>The Richmond pilot does not include coverage for inpatient psychiatric services or community mental health rehabilitation services.¹⁶⁷</p>	<p>Not Available.</p>	<p>Not Available.</p>	<p>Foster care populations were included originally in managed care but because managed care was not yet statewide, it was difficult to manage when children moved in and out of managed care areas. Because Virginia is in the process of expanding managed care statewide, it positions the Commonwealth to eventually expand the Richmond pilot statewide.</p>

¹⁶⁷ Commonwealth of Virginia Department of Medical Assistance Services. Data Book and Capitation Rates Fiscal Year 2012.

E. *Other Emerging Models*

Although Medicaid is sometimes the innovator when it comes to health care delivery system models, the commercial sector also provides information on best practices and emerging trends that could potentially be considered. Challenges specific to Medicaid may limit innovation in certain respects. The National Association of Medicaid Directors (NAMMD) issued a statement in November 2011 indicating that the current structure of the federal-state relationship, in terms of lengthy approval processes and inflexible programs, limits the climate for Medicaid innovation.¹⁶⁸ The statement notes that the current health care environment is rapidly changing, and in its current form, Medicaid has limited ability to adapt. Given the constraints on Medicaid, this report looks outside of state Medicaid initiatives to gather innovative ideas from the commercial sector that may translate to the Medicaid environment.

Commercial Trends Applicable to Medicaid

Some of the approaches discussed in this section have already been in use by commercial health plans. As part of the national scan, we have reviewed commercial sector trends to identify leading practices and innovations in non-Medicaid programs. Navigant also received several documents and proposals from both contracted and non-contracted vendors, which were reviewed as part of our environmental scan.

In summary, the health care industry is moving toward the following trends to effectively manage their population, and provide high quality of care, while maintaining administrative efficiencies:

- **Increasing total population health and integration across the continuum of care.** This is being achieved through partnership and collaborations focused on helping individuals achieve and maintain their health goals.¹⁶⁹ Examples of these include:
 - Health improvement programs and offerings – these programs focus on supporting prevention, healthful lifestyles, and chronic care support. The federal government is looking at incentives to boost wellness program participation. The ACA includes a provision that increases premium discounts or other rewards to 30 percent of total employee health care costs—up from a

¹⁶⁸ National Association of Medicaid Directors. NAMMD calls for Pathway to Innovation in Medicaid. Press Release. November 2011.

¹⁶⁹ Outcomes Guidelines Report, Volume 5, Care Continuum Alliance

Chapter 3: National Environmental Scan

maximum 20 percent—for employees who participate in outcome-based wellness programs.¹⁷⁰

- Collaborative physician-led models for patient-centered care – these include PCMHs and ACOs
- Care Transitions for at-risk populations – this involves managing the transition from acute care to the home for patients
- Tools for health support in the home – examples of this include electronic health records (EHR), personal health records (PHR), biometric monitoring, diagnostic devices, and smartphone applications
- Expansion of HIT and Health Information Exchanges (HIEs)
- Participant engagement, incentives and personalization
- **Developing aggressive approaches for cost containment** – Health plans are taking aggressive approaches to curb inappropriate use and make sure patients receive competitively priced services that actually produce better health outcomes. Advanced diagnostic imaging is one major cost-growth area, as is cancer treatment and services related to back pain.
- **Providing wellness tools to support members in proactively managing their health**
These include tools such as the following:
 - Health risk assessments
 - Pharmacy drug comparisons
 - Treatment cost estimators
 - Self serve clinical support
 - Online symptom checker
 - Drug and treatment options

¹⁷⁰ Managed Health care Executive Modern Medicine, Use keen judgment with wellness programs

Chapter 3: National Environmental Scan

- Syndicated health content and health reference content
 - Interactive tools
 - Graphic surgery
 - Questions to ask your doctor, etc
 - Pharmacy drug comparison tools

Significant progress over the last several years has been made in the areas identified above, and this will continue as more individuals continue to focus on proactively managing their health. Figure 3.17 provides examples of leading practices in the following areas: health, wellness and education; care management; infrastructure, payment and benefit models; and other.

Chapter 3: National Environmental Scan

Figure 3.17: Examples of Leading Practices in Health Plan Innovations

Topic	Leading Practices in the Industry
Health Wellness and Education	
Preventive Services	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Plans have increased utilization of preventive service by tangible amounts through prevention outreach and incentives. Immunizations, screenings and checkups can be increased by as much as 25 percent in certain populations. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> Wellpoint implemented a remote technology program for heart failure.¹⁷¹ The program uses remote monitoring technology to help members with heart failure manage their illness while minimizing hospital readmissions. It allows patients to monitor weight and blood pressure, which can be indicators of potential heart failure. UnitedHealthcare implemented a HealthImpact program, which helps predict and prevent disease by pinpointing at risk individuals before an illness develops.¹⁷² It uses historical medical data and identifies underlying precursors to disease with high accuracy among at risk patients.
Mobile Health	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Some plans are “gamifying” mobile apps in health care so enrollees can compete with your friends for health and wellness points. Many plans including Wellpoint are using mobile technology for remote monitoring of weight and blood pressure for patients with heart failure and coronary artery disease ¹⁷³. The program has proven to be effective in reducing readmissions. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> CIGNA DailyFeats allows users to earn points in exchange for discounts and gift certificates at local businesses and national brands.¹⁷⁴ United Healthcare developed the first smartphone application which allows members to quickly and easily find physicians, hospitals, and clinics using global positioning system location technology.¹⁷⁵ OptumRx is the first pharmacy benefit management company to develop an application for prescription medication management.¹⁷⁶ Users get daily reminders to take medications and the ability to order refill prescriptions directly from their phone.

¹⁷¹ Wellpoint Annual Report (<http://www.annualreports.com/HostedData/AnnualReports/PDFArchive/wlp2010.pdf>)

¹⁷² United Health Annual Report (<http://www.unitedhealthgroup.com/2010-annual-report/content/assets/documents/2010-Annual-Report.pdf>)

¹⁷³ Wellpoint Annual Report (<http://www.annualreports.com/HostedData/AnnualReports/PDFArchive/wlp2010.pdf>)

¹⁷⁴ CIGNA Individual and Family Plan Customers Use “DailyFeatsTM” to Improve Health and Well-being (<http://healthplaninnovation.com/2011/07/cigna-individual-and-family-plan-customers-use-%e2%80%9cdailyfeatstm%e2%80%9d-to-improve-health-and-well-being/>)

¹⁷⁵ United Health Annual Report (<http://www.unitedhealthgroup.com/2010-annual-report/content/assets/documents/2010-Annual-Report.pdf>)

¹⁷⁶ United Health Annual Report (<http://www.unitedhealthgroup.com/2010-annual-report/content/assets/documents/2010-Annual-Report.pdf>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Social Networking	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Fifty percent of health plans use a Twitter feed to deliver health facts and incentive opportunities to members. • Doctors are using social media to tweet when appointments are running behind so patients do not rush to appointments and post flu shot clinic hours.¹⁷⁷ • Many leading plans including United, Aetna, and Wellpoint use Facebook to distribute health and wellness opportunities, encourage prevention services, and collaborate on health tips with other members. • Industry analysts see opportunities for improved member outreach and education through social networking tools. • Areas of application include wellness and prevention opportunities, disease management and case management recruitment and hospital and physician rating / selection. • Some plans are partnering with social networking sites such as MedHelp and PatientsLikeMe to allow members to upload detailed health information about their conditions and receive info from other patients who have had similar experiences. • Some plans have social networking tools where members can share tips, seek support, explore health topics. Examples include: physician and member blogs; healthy recipes; health events; walking/running races, etc. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • Aetna implemented a student health program which distributes health and wellness information to college students through Facebook, You Tube, Twitter and a free mobile application.¹⁷⁸ The mobile application allows the user to track calorie intake, download fitness programs, and download nutrition tips. • Wellpoint implemented a 10-day Facebook boost campaign that helps users track towards their health and fitness goals.¹⁷⁹ The program gives daily health tips from Bob Harper, a contestant on <i>The Biggest Loser</i>.

¹⁷⁷ More physicians tap into social media to engage patients (<http://www.fiercehealthit.com/story/health-insurers-try-humanize-themselves-facebook-twitter/2011-01-27>)

¹⁷⁸ Aetna Student Health (<http://www.aetnastudenthealth.com/>)

¹⁷⁹ Wellpoint Annual Report (<http://www.annualreports.com/HostedData/AnnualReports/PDFArchive/wlp2010.pdf>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Wellness Tools	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Plans offer many wellness tools to help members proactively manage their health. These include: <ul style="list-style-type: none"> – Health Risk Assessments – some plans offer dollar incentives to complete the health risk assessment – Pharmacy drug comparisons – Treatment cost estimators – Self serve clinical support (e.g., online symptom checker, drug and treatment options, etc.) – Syndicated health content and health reference content (e.g., interactive tools, graphic surgery, questions to ask your doctor, pharmacy drug comparison tools) – Second Opinion Service - Online medical second opinion and consultations from specialists <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • Wellpoint and BCBS FEP offer graphic surgery tools where a member can see a graphic video of the surgery that will be performed. In addition, questions are provided for what to ask your doctor pre and post surgery • CIGNA offers employees and dependents of a select group of its employer clients access to online second medical opinions from physician specialists, from the world-renowned Cleveland Clinic’s MyConsult service 180
Education / Outreach	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Many plans are implementing various outreach programs on health, wellness and managing their condition. • Many plans have demonstrated tangible success in preventing readmissions and reducing emergency room visits through member outreach. Emergency room visits declined as much as 20 percent when compared with the control group in some demonstrations. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • CIGNA implemented a mobile learning lab which consists of an 18 wheeler that is on tour to teach consumers how stress, portion control, etc. impacts health.¹⁸¹ Tools on board include stress IQ test, examples of portion distortion and a weight test. • Centene created children’s books to educate children about their diseases so they can be a part of managing and preventing disease conditions.¹⁸² They make learning about diseases fun through author and mascot visits to schools. Books include “smokey yuckpack” on smoking, a book on obesity and a DVD on asthma. • Regence Life and Health launched myStro, which allows members to take tours of their benefits plan, education around each product, and applications customized for each employee.¹⁸³ It also includes web-based, real-time enrollment features with educators walking the user through benefit options. • Aetna had a healthy food fight with a 10-city cooking contest that gave people the opportunity to showcase their healthy, low-cost recipes and educated them that delicious food can also be healthy.¹⁸⁴

¹⁸⁰ redOrbit (<http://s.tt/14HJr>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Wellness programs/ Behavior change campaigns	<p><i>TRENDS</i></p> <ul style="list-style-type: none"> • In 2009, 91 percent of health plans offered a wellness program. The biggest success factors in wellness: 1) member engagement; 2 and 3) behavioral change component and member incentives. • Data integration is a must for health plans seeking Wellness / disease management services (77 percent required in procurement). • Most popular types of wellness programs in health plans: cholesterol screening and counseling, fitness and exercise, coronary risk screening, weight loss control / nutrition. In 2010, Harvard researchers found that medical costs decreased \$3.72 for every dollar spent on wellness incentive programs. • Campaigns/programs to promote behavior changes around various conditions. • On-line coaching sessions. • Chronic condition management tools. • Education and incentives around various conditions/programs. Plans will provide dollar incentives for enrolling in and/or graduating from programs such as: Smoking cessation, weight loss, diet and nutrition, stress reduction, exercise and fitness programs, ergonomic programs, safety (both at the workplace and home), sleep hygiene, health advocacy, disease screening and immunization. • Proactive outreach to members to engage them in health and wellness programs and education: phone outreach; utilization of member data to trigger outreach programs (i.e., screenings); email notifications and alerts; wellness site notifications and alerts. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • United offers a personal rewards wellness program that offers financial incentives to people who pursue healthy lifestyles and receive regular care.¹⁸⁵ Each participant has a customized personal rewards scorecard that serves as a guide to his or her goals for better health, including annual physical exams, regular cancer screenings, weight management, smoking cessation programs and disease management. The more goals a person meets, the greater the rewards for the participant.
Care Management	

¹⁸¹ Cigna Mobile Learning Lab Takes to the Streets (<http://healthplaninnovation.com/2011/09/cigna-mobile-learning-lab-takes-to-the-streets/>)

¹⁸² Health Literacy and America's Health Insurance Plans (<http://www.ahipresearch.org/pdfs/HealthLitAHIPBookOct2011.pdf>)

¹⁸³ Regence Life and Health Keeps it Simple With Launch of myStro (<http://healthplaninnovation.com/2011/07/regence-life-and-health-keeps-it-simple-with-launch-of-mystro/>)

¹⁸⁴ Aetna Annual Report (<http://www.aetna.com/2010annualreport/>)

¹⁸⁵ United Health Annual Report (<http://www.unitedhealthgroup.com/2010-annual-report/content/assets/documents/2010-Annual-Report.pdf>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Embedded Care Management	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Health plans have found success in Care Management by embedding care management professionals directly into primary care practices. These nurses, behavior specialists, and social workers are employed by the health plan to encourage care management practices and establish relationships with patients before patients are discharged. This practice moves care management from anonymous phone conversations to face-to-face interaction with patients and clinician staff. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> Group Health, Fallon and Security Health plan saved over \$2.5 million, \$2.3 million and \$1 million respectively in embedded care management, while Tufts Health Plan saved \$1.90 for every dollar spent in embedded care management. Embedding care managers in the primary care sites is worthwhile not only because face-to-face patient care has more of an impact, but because the physicians benefit from the consultations, participation in "huddles" and discussion of the treatment plans. That also has led to a greater level of trust between the physicians and the nurses.¹⁸⁶
Latest in Disease Management	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Six out of the leading 10 plans insource disease management. Technology is playing a bigger role than ever (e.g. Aetna's disease management decision support engine CareEngine). Key to success in disease management is identification of members: new analytics and tools are making this possible. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> Powered by ActiveHealth's Patented CareEngine([R]) System, Aetna's Personal Health Record provides personalized alerts to members and physicians about opportunities to improve care around specific disease conditions.¹⁸⁷

¹⁸⁶ <http://diseasemanagementcareblog.blogspot.com/2011/12/building-care-management-program.html>

¹⁸⁷ http://findarticles.com/p/articles/mi_m0EIN/is_2006_Oct_3/ai_n27048798/

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Latest in Utilization Management	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Plans can reduce radiology / imaging expenditures by as much as 20 percent by introducing utilization management into populations. Industry appears to have matured in radiology; many plans exploring utilization management programs for pain management, radiation oncology and sleep disorders. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> CareCentrix acquired SMS to expand its sleep services benefits management. SMS provides health plans with a comprehensive program focused on improving patient outcomes and reducing the cost of sleep services. The company provides Home Sleep Testing (HST) technology to qualifying patients who conduct their prescribed sleep diagnostic test in their homes, enabling a more natural environment for testing at less cost than a facility. SMS also follows up with people who are approved for sleep therapy devices to ensure they are using the equipment properly and following their prescribed treatment.¹⁸⁸
Infrastructure/Payment and Benefit Models	
Shared Decision Making Centers	<p><i>TRENDS</i></p> <ul style="list-style-type: none"> Many studies have identified opportunities for shared decision-making to reduce cost and improve quality in health care. One study found that only 20 percent of patients considering breast cancer screening and only 49 percent considering blood pressure medication were properly educated about risks and potential drawbacks of the medications. Telephonic and web-based information distribution has been proven to reduce PMPM costs as much as 3.6 percent (in one study of 175,000 patients). Although implementation obstacles exist, industry analysts predict that shared decision-making will soon be an important part of benefit design for many health plans. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> MaineHealth has a shared decision-making program as core of its health system.¹⁸⁹ Its Learning Resource Centers are health education libraries that are staffed by health educators who provide educational opportunities for patients. The health plan provides outreach to patients who may benefit from the LRCs and allows patients to borrow materials for viewing at home.

¹⁸⁸ <http://www.sleepscholar.com/sleep-management-solutions-acquired-by-carecentrix/>

¹⁸⁹ Foundation for Informed Medical Decision Making: MaineHealth (<http://www.informedmedicaldecisions.org/maine-health.html>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Accountable Care Organizations	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • At least five major plans have already begun operating commercial ACOs including United Health care, Humana, CIGNA, Anthem BlueCross, and BCBS of Michigan. • Most commercial ACO arrangements have been established between major health plans such as those listed above and large multi-specialty provider groups or integrated delivery networks. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • CIGNA has made the most ACO progress, operating as many as eight programs with demonstrable success.
Expansion and Success of PCMH	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Many health plans have turned to technology to assist them with implementing PCMH models – from risk stratification, to developing patient registries and care opportunities, to creating provider incentive models. These models have shown that developing and implementing a PCMH model can provide successful outcomes.¹⁹⁰ Recent PCMH projects with integration of the payer have resulted in better coordination and more effective upstream care, leading to fewer hospitalizations and emergency room visits with corresponding reduction in costs. This is due to implementing data exchange processes between the hospital, the healthplan, and the PCP community, with the health plan driving the data exchange. The health plans were able to communicate real-time registries to the PCP as well as facilitate post ER discharge follow-up appointments and member engagement.¹⁹¹ • The PCMH model is gaining momentum on a national level, with many health plans looking for ways to improve their results by leveraging technology, partnering with providers, improving quality of care and delivering more cost-effective care...all of this in the wake of health care reform.¹⁹² <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • Geisinger Health System in Pennsylvania reduced hospital admissions by 20 percent and saved 7 percent in total medical costs by providing a PCMH model of care that included around the clock access to primary and specialty care along with physician and patient access to EHRs.¹⁹³ • Citing cost and quality improvements, BCBS of Tennessee plans to give 50 percent of its members access to a PCMH-focused practice. Practices are paid \$1 to \$3 per month for each PCMH-enrolled member. In the future there will be shared savings and performance bonus opportunities for practices with 1,000 or more PCMH members.

¹⁹⁰ <http://www.emdeon.com/resourcepdfs/EMDA1010318.pdf>

¹⁹¹ <http://www.emdeon.com/resourcepdfs/EMDA1010318.pdf>

¹⁹² <http://www.emdeon.com/resourcepdfs/EMDA1010318.pdf>

¹⁹³ <http://www.emdeon.com/resourcepdfs/EMDA1010318.pdf>

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Reliance on Non-traditional Providers	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Prominent health plans are relying more than ever on non-physician providers in care management as well as primary care <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> CVS Caremark’s MinuteClinic continues to grow a new retail model of primary care. MinuteClinic has entered into partnerships with major health delivery systems such as Emory in Georgia and Inova in Virginia as well as most leading health plans. Walmart, the nation's largest retailer and biggest private employer , now wants to dominate a growing part of the health care market, offering a range of medical services from basic prevention to management of chronic conditions like diabetes and heart disease¹⁹⁴
Other	
Cost Transparency	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> Many plans including prominent BCBSA plans are providing members direct access to on-line consumer-friendly health care cost information. The idea is to provide members with claims-based cost information for a range of providers and encourage more of a shopping experience for elective procedures. Members in high cost-sharing arrangements benefit. Some plans are offering a Health Expense Tracker - Online service that will help members manage their medical expenses: medical expense tracking; ability to pay balances online; and ability to find and fix errors <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> Five major BCBSA plans will provide real-time claims based cost information for 39 medical procedures performed at local hospitals, clinics, outpatient surgery clinics and radiology centers.

¹⁹⁴ Walmart Primary Care Medical Services (<http://www.kaiserhealthnews.org/Stories/2011/November/09/walmart-primary-care-medical-services.aspx>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Patient Safety	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Many plans are taking evidence-based approaches to reducing the occurrence of hospital-acquired conditions among their members. • Strategies employed by plans include grants, safety checklists, provider outreach strategies, safety scorecards, and pay-for-performance incentives to achieve tangible reductions in central line infections, urinary tract infections, MRSA (staphylococcus infections), and other hospital-acquired conditions. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • Aetna has created Partnership for Patients which brings together various stakeholders in the company to ensure patient care and lower readmissions¹⁹⁵. This program provides physical incentives for higher quality services, technology advances to better manage Aetna’s health care system and payment models that share cost savings and reward quality. Additionally, the company has several patient resources to improve the quality of care.¹⁹⁶ Aetna Pharmacy allows patients to research their medications and find out if they are at risk for harmful drug interactions. Similarly, Aetna Navigator allows patients to compare hospitals based on diagnosis, condition and procedure. • MedQuery reviews patient’s medical information automatically and alerts doctors if it determines opportunities to improve patient care.
Incenting Provider Quality	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Health plans reacting to the high-cost of poor performance started incenting provider quality. • By 2008, at least half of nation’s health plans had implemented provider pay-for-performance incentive programs, affecting 80 percent of the members in these plans. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • Aetna’s Pathways to Excellence incentivizes physicians and hospitals to improve quality and safety through the use of evidence-based measures and data by rewarding providers who have improved patient care.¹⁹⁷

¹⁹⁵ Aetna Pledges Support to Partnership for Patients Initiative (http://www.aetna.com/news/newsReleases/2011/0412_Partnership_for_Patients_Initiative.html)

¹⁹⁶ Patient safety – avoid medical mistakes and more (<http://www.aetna.com/health-wellness/patient-safety.html>)

¹⁹⁷ Aetna Pledges Support to Partnership for Patients Initiative (http://www.aetna.com/news/newsReleases/2011/0412_Partnership_for_Patients_Initiative.html)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Provider Satisfaction	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Maintaining strong relationships with providers through frequent and meaningful communications. • Introducing new technologies as tools to improve processes and diminish administrative burdens. • Implementing payment incentives, providing competitive contracting rates and processing claims in a timely fashion. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • Many health plans, such as Kaiser Permanente, have implemented programs to encourage provider retentions through favorable work environments. Kaiser aims to achieve this through the creation of a mentorship program, allowing providers to have perceived control over the work environment, recognition and rewards for achievement and reduction of stress in the work environment.¹⁹⁸

¹⁹⁸ Ten Evidence-Based Practices for Successful Physician Retention (<http://xnet.kp.org/permanentejournal/sum02/retention.html>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Investigations and Recovery	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Payers are implementing the following around investigations and recovery: <ul style="list-style-type: none"> – Developing alternative governance and operating models for the Fraud, Waste and Abuse program, including performing an outsourcing evaluation for executive consideration – Creating future state policies and procedures for monitoring and detecting fraudulent claims – Establishing procedures to refer appropriate cases to law enforcement – Providing analysis to ensure recommendations meet CMS guidelines – Documenting future state business process which delivers optimal operational efficiency to Citrus Health Care and PHC – Utilizing industry best practices to establish appropriate controls – Providing software evaluation on leading tools to identify aberrant billing practices – Creating a Future State Project Value Scorecard – Developing additional quick wins for immediate bottom-line improvements and cost savings – Developing Risk Management and Communication Plan • Health plans have their own fraud investigation departments that work alongside federal, state and local law enforcement agencies. These departments utilize data mining technology to identify potential instances of fraud and abuse. These advanced technologies reduce false positives and look for claims triggers that match the profiles of fraudulent activity. Some health plans also team up with other organizations that have advanced predictive technologies in order to better detect fraud. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • HealthMarkets, a health and supplemental insurance carrier covering lives in 44 states, has been reaping rewards from comprehensive fraud, waste and abuse prevention program by implementing a broad payment integrity solution. The organization has realized significant results through dedicated prepayment analysis efforts conducted over the last two years. After implementing a prepayment analytics solution in 2009, HealthMarkets achieved \$9.5 million in savings in the first year alone.¹⁹⁹

¹⁹⁹ <http://www.selffundingmagazine.com/article/driving-change-in-payers-fraud-waste.html>

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Information Technology Trends	<p><i>TRENDS:</i></p> <ul style="list-style-type: none"> • Plans are using HIT to:²⁰⁰ <ul style="list-style-type: none"> – Create easy-to-use tools to connect patients with physicians and make it possible to conduct business online. – Give health care practitioners evidence-based clinical information at the point of care. – Offer patients personalized, actionable information to improve their health, along with cost and quality data to help them make decisions. – Enable the secure exchange of health information among health plans, hospitals and physicians. • Digital pen technology is emerging in the health care industry, which records the pen strokes of doctors and converts this data into patient records. The technology is especially useful for doctors in hospitals who are very mobile and for emergency departments, specifically, use in ambulances. Shareable Ink is one of these vendors and is already being implemented in many emergency departments.²⁰¹ • On October 1, 2013, all providers and health plans must discontinue use of ICD-9 diagnosis codes and use ICD-10 codes. Some health plans will use this transition as an opportunity for improved claims and outcomes data analytics as well as better identification of candidates for disease management and case management. <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none"> • CIGNA has been offering patients the opportunity to participate in “virtual house calls” to discuss non-urgent health issues and obtain advice from doctors online, through structured interviews developed by RelayHealth. • BCBS of Massachusetts, Tufts and Neighborhood Health Plan developed eRx Collaborative, which offers e-prescribing. Participating prescribers use hand-held devices loaded with e-prescribing software. The system checks for drug-drug and drug allergy interactions; identifies generic alternatives to brand name drugs, checks health plan formularies for coverage information and offers a comprehensive prescription drug reference guide. • Kaiser members can use the health plan’s online My health manager PHR to: send e-mail messages to their doctors with medical questions and concerns and receive responses; view and learn more about their lab test results; schedule and cancel doctor’s appointments; and see information from past visits and medical histories. Members receive responses to physician e-mails within 48 hours.

²⁰⁰ AHIP, CPR Trends In Health IT

²⁰¹ Mobile solutions, new tech to play key roles at HIMSS (<http://www.fiercehealthit.com/story/mobile-solutions-new-tech-play-key-roles-himss/2011-02-14>)

Chapter 3: National Environmental Scan

Topic	Leading Practices in the Industry
Business Intelligence (BI)	<p><i>TRENDS:</i></p> <ul style="list-style-type: none">• Payers are focusing on Health care Business Intelligence, including predictive modeling and data mining to identify potential “high-cost” and “high-risk” members <p><i>EXAMPLES:</i></p> <ul style="list-style-type: none">• A subsidiary of national health care payer determined that traditional data warehousing approaches were not effective. The company created a BI platform to deliver time-sensitive, critical processes in minutes versus months. BI solutions now deliver reports, cubes, datasets, and dashboards, and are achieved without any reliance on the Information Technology department• Payer implemented multimedia program for increasing asthma knowledge of children and caregivers. The program covered basic pathophysiology of asthma, environmental triggers quick-relief and control medications and strategies. Results included reductions of asthma symptom days, emergency room visits and lower daily use of anti-inflammatory drugs²⁰²

²⁰² Christiansen & Remler 2007

Chapter 3: National Environmental Scan

Modified Benefit Packages and Consumer-directed Health Plans

Modified benefit packages and consumer-directed health plans (CDHPs) are an example of an approach used by the commercial sector that is just now emerging in the public sector. Modified benefit packages and CDHPs typically combine a high-deductible health plan with tax-advantage accounts, such as a health reimbursement arrangement, that enrollees can use to pay for health care expenses. CDHPs promote cost savings and personal health care management, and introduce questions regarding the consumer's role in his or her own health care and health care management. Modified benefit packages have yielded numerous initiatives including: "health savings accounts (HSAs)," "power accounts," "health opportunity accounts," "personal health records," "medical savings accounts," "healthy rewards accounts (HRAs)," etc. While CDHPs are appealing for their generally accepted cost savings, there are concerns that they dis-incent individuals from utilizing necessary health care.

Health reimbursement arrangements began appearing in employer benefit packages around 2001, with HSAs emerging in 2004. About 20 percent of large employers (>500 employees) offered either an health reimbursement arrangement or HSA plan in 2010, covering 21 million people or 12 percent of privately insured people in the United States. Of these 21 million people, there were 5.7 million accounts in 2010 containing \$7.7 billion.²⁰³

The Healthy Indiana Plan (HIP), which began in 2008, is the best known CDHP for its purported success and use of "power accounts" for low income adults. The HIP program covers parents of children covered by the state's CHIP program as well as childless adults. The state operates the plan under a federally-approved waiver, which allows it to waive specified federal Medicaid program requirements. The main benefit components of HIP include:

- High deductible coverage: After meeting a \$1,100 deductible, the state provides 100 percent coverage for medical services according to a basic benefit package
- Power Account: Used to cover the deductible and funded by the state, the enrollee and sometimes the employer. Enrollees contribute monthly payments, according to a sliding scale by family income and range from two percent to five percent of income.

²⁰³ The Health Care Blog, The Myth of Consumer Directed Health care 2011, Available online at: <http://thehealthcareblog.com/blog/2011/01/13/the-myth-of-consumer-directed-health-care/>

Chapter 3: National Environmental Scan

- Preventive Care: This is not subject to the deductible and does not draw from the Power Account²⁰⁴

Indiana reports that the state reached their enrollment capacity quickly and they have waiting list around 50,000 people. They have only limited enrollment available due to attrition. The state also noted that there was initially evidence of pent up demand, as the newly-insured sought services that had perhaps been delayed. However, Indiana notes that utilization started to fall by the second year. The vast majority of participants make their monthly payment as required. Only three percent of participants had been disenrolled because of missed payments.²⁰⁵

HIP is administered under an 1115 waiver, which requires budget neutrality, i.e., Indiana's Hoosier Healthwise program plus the HIP cannot cost more than it would cost the federal government to serve the HIP population through the Hoosier Healthwise program. However, an evaluation of the program indicates that although HIP has been meeting this requirement, projections indicate that costs for the Hoosier Healthwise population may be less than expected while costs for HIP members higher than expected.²⁰⁶

Indiana indicates that there are operational challenges in coordinating state and individual financial contributions; managing the logistics of the program requires information systems support. In the future, the state has received legislative approval to require a minimum contribution from all participants. Currently, some portion of participants who are also making payments to CHIP spend down their income to a level that does not require a HIP contribution.

Indiana also operates a HSA option for state employees. According to Governor Mitch Daniels, the HSA option has proven highly popular; in 2010, over 70 percent of 30,000 Indiana state workers chose it. Indiana and Mercer Consulting found that State employees enrolled in the CDHP will save more than \$8 million in 2010 compared to their coworkers in the preferred provider organization (PPO) alternative. They claim that workers are adding thousands of dollars to their take-home pay. Only 3 percent have opted to switch back to the PPO.²⁰⁷

²⁰⁴ IN.gov, What Services are Covered by the Healthy Indiana Plan? Available online at: http://iot.custhelp.com/app/answers/detail/a_id/212

²⁰⁵ Mathematica Policy Research, 'Healthy Indiana Plan: The First Two Years. July 15, 2010.

²⁰⁶ Mathematica Policy Research, 'Healthy Indiana Plan: The First Two Years. July 15, 2010.

²⁰⁷ WSJ.com. Hoosiers and Health Savings Accounts – An Indiana experiment that is reducing costs for the state and its employees, Mitch Daniels, March 1, 2010. Available online:

<http://online.wsj.com/article/SB10001424052748704231304575091600470293066.html>

Chapter 3: National Environmental Scan

The Rand Corporation released the largest study on CDHPs in March 2011. Rand found that CDHPs lead consumers to significantly restrain health spending, but also prompt cuts in preventative care (preventative care is not subject to the HSA or power account, under HIP). Researchers studied more than 800,000 U.S. families and found that for those who shifted into health insurance plans with deductibles of at least \$1,000 per person, health spending dropped an average of 14 percent when compared to families with lower deductibles. Additionally, families with high-deductible plans cut back on preventive services. Overall, Rand concluded that the people are cutting back on both necessary and unnecessary care.²⁰⁸

CIGNA released a report in 2009 highlighting a multi-year study of the health care claims experience of nearly 440,000 individuals enrolled in CIGNA CDHPs and traditional health maintenance organization (HMO) and PPO plans. CIGNA found that enrollees in the CDHPs continued to receive recommended care at the same or higher levels as when these individuals were enrolled in traditional plans in the previous year. Additionally, medical cost trends for the CIGNA CDHP were lower than that of CIGNA's HMO and PPO plans in both the first and renewal plan years, suggesting that cost reduction associated with CDHPs are sustainable and actually increase over time.²⁰⁹

In sum, the underlying premise of CDHPs is that health care costs can be better controlled if employees take more responsibility for decision-making about their health care. As the new health care reform law expands Medicaid to 16 million people, states will be looking for cost-efficient ways to meet the medical needs of this population. Models like Indiana's HIP plan will be highly scrutinized to determine if these consumer-driven models achieve long-term benefits in terms of high quality and cost-effective health care.

Block Grants, or other Non-traditional 1115 Waiver Programs

Under block grants, the federal government provides each state with a fixed dollar amount, usually based on a state's current expenditure levels, and that state would pay 100 percent of any costs that exceed these amounts. Debate over Medicaid block grants dates back to the Clinton-era, when there were discussions to convert both the welfare program and Medicaid to block grants.

²⁰⁸ Rand Corporation Largest Study of High-Deductible Health Plans Finds Substantial Cost Savings, but Less Preventive Care March, 2011 Available online: <http://www.rand.org/news/press/2011/03/25.html>

²⁰⁹ CIGNA Cigna Choice Fund Experience Study January 2009. Available online: http://newsroom.cigna.com/images/56/825638_ChoiceFund_Study.pdf

Chapter 3: National Environmental Scan

Today, some states have considered block grants as a means to gain more control over increasingly stressed Medicaid budgets. States' expenditures for Medicaid are expected to grow by 9.4 percent annually between 2010 and 2019.²¹⁰ Section 1115 Waivers give the Secretary of Health and Human Services (HHS) the authority to conduct Medicaid demonstration projects like block grants, and waive certain provisions of the Medicaid statute that otherwise would stand in the way of such initiatives.

Interest in block grants has grown for their perceived promotion of fiscal savings, cost-efficiency and increased state independence in Medicaid policymaking. However, they are criticized for the potential for capped enrollment, increased cost sharing which could hurt vulnerable populations and state financial risk as states may be unable to sustain coverage under fixed block amounts.

As states struggle to balance budgets and reduce deficits, program ideas like block grants will be considered as a way to make Medicaid more efficient. The capped financing of block grants make funding predictable, generate savings and provide for greater state autonomy. Though, these changes could mean shifting costs and risk to states, localities, providers and beneficiaries.

As Medicaid plays a larger role under health reform by expanding coverage, states may consider options like block grants as a way to effectively meet coverage while remaining cost-effective.

Rhode Island has often been highlighted as an example of a successful block grant initiative. In 2009, the state moved its entire Medicaid program under a block grant. The State agreed to operate the program under a \$12 billion budget through 2013. While reported results of the program vary, one of the conservative estimates made by Rhode Island Governor Chafee reports that the block grant program has saved at least \$44 million in general revenue costs.²¹¹

E. Health Reform

The Health Reform Law, the ACA, signed by President Obama on March 23, 2010, includes provisions to expand Medicaid and private health insurance coverage and reduce the number of uninsured. Depending on the Supreme Court's ruling about the constitutionality of the

²¹⁰ American Action Forum Sustainability of Medicaid February 2011 Available online: <http://americanactionforum.org/sites/default/files/Sustainability%20of%20Medicaid%20Action%20Steps%20for%20Governors%20to%20Achieve%20Meaningful%20Reform.pdf>

²¹¹ Chafee Administration, Frederick J. Sneesby, Communications Officer for the state Department of Health and Human Services, 2011.

Chapter 3: National Environmental Scan

ACA, the legislation may significantly change Medicaid financing and eligibility. In 2014, Medicaid eligibility may expand to all individuals under age 65 with incomes up to 133 percent of the Federal Poverty Level (FPL), which includes non-disabled adults without dependent children.

From 2014 to 2019, enrollment in Medicaid is projected by CBO to expand by at least 16 million individuals over baseline projections.²¹² States have already begun planning for the changes so that they are administratively and financially prepared for the newly eligible Medicaid population should they take place. While states would receive 100 percent federal funding from 2014 through 2016, federal support would gradually decrease. States would receive 95 percent federal financing in 2017, 94 percent federal financing in 2018, 93 percent federal financing in 2019 and 90 percent Federal financing for 2020 and subsequent years.²¹³

As states prepare for potential new eligibles in 2014, many indicate they are concerned about the cost of covering these additional populations as well as the stress these new eligibles will place on Medicaid processes, delivery systems and providers. Many states interviewed as part of the national scan have health care reform implementation in mind as they consider modifications to their existing Medicaid programs.

As discussed through the National Scan, the ACA provides states with many options to test new and innovative models. For example, the ACA provides planning grants and additional federal match for states that implement “health home” initiatives. Additionally, the ACA includes options for states to design alternative delivery system models such as ACOs. These options have encouraged some states to pursue innovative, cost-saving models that may assist in preparing for increased Medicaid enrollment.

Many states believe that full-risk, managed care models best position states to be able to handle the influx of new Medicaid enrollees in January 2014. Through contracting, states can leave the administration of delivering health services, including network development, to a contracted party and focus efforts instead on monitoring the MCOs. Since the ACA prevents states from currently cutting Medicaid enrollment, managed care is one of the options for states hoping to streamline costs in anticipation of the increased enrollment.

²¹² Kaiser Commission on Medicaid and the Uninsured. *State Medicaid Agencies Prepare for Health Care Reform While Continuing to Face Challenges from the Recession*. August 2010.

²¹³ Kaiser Family Foundation, *Summary of New Health Reform Law* (March 2010). Available online: <http://www.kff.org/healthreform/upload/8061.pdf>

Chapter 3: National Environmental Scan

Michigan believes that its managed care model can best deal with the significant enrollment changes coming in 2014. The state indicates that an MCO model will best handle the capacity change, and is therefore essential to handling the increased enrollment and providing access for enrollees. Michigan indicates that the MCOs have been successful in building provider networks and providing access, even in rural areas of the state. New Jersey has also indicated that the current expansion of managed care is essential for its ability to accept new Medicaid enrollees.

Indiana is considering a different approach and has considered using its public HSA program for low income adults to cover people who will become newly eligible for Medicaid under the federal health care law beginning in 2014. However, the federal government recently denied Indiana's request to use this approach as premature because the rules regarding the expansion have not yet been finalized.

For some states, like Oklahoma, potential access issues are a concern because of the rural nature of some areas of the state in which there are few providers. Oklahoma indicates that it will take a different approach and work with the state medical school to increase provider capacity in the state.

Other states, such as Georgia and Florida, are actively challenging the ACA and, as such, some states are not willing to discuss any plans for implementation of health care reform. Florida is challenging the ACA's Medicaid expansion provisions as well as the constitutionality of the individual mandate.

Another challenge that states will face is integrating enrollment and eligibility functions with the new Exchange. Some states already have infrastructure enhancements in place, which may position them well for the changes of health care reform. For example, the state of Oklahoma has invested significantly in technology to promote better, more efficient Medicaid systems. In the fall of 2011, the Oklahoma Health care Authority rolled out an internet-based enrollment system for most SoonerCare populations. The online enrollment process creates a single point of entry that determines whether an applicant is qualified for SoonerCare. The system also allows newborns to be enrolled in SoonerCare before they leave the hospital. The state is also taking an aggressive approach with federal grant funding to improve both quality and efficiency through the use of electronic health records. With such technological efforts underway, the state feels that it is well positioned to meet many federal requirements.

G. Conclusion

Although the Medicaid environment differs from state to state, several common themes emerged as part of the national scan. State budgets are stressed from the recession and recent increases in Medicaid enrollment, and many states are facing budget-cutting pressure from state legislature. Further, states are looking ahead to 2014 when new enrollees will be added to Medicaid. In this context, many states are moving toward risk-based managed care for non-traditional populations, expanding their existing managed care arrangement and testing additional innovative delivery system models. States express interest in expanding risk-based managed care not only for cost-saving and cost-predictability potential, but for care management, coordination and quality benefits as well.

Although recent Medicaid trends indicate that more states are moving towards expanded risk-based managed care, such changes are not without concerns. Implementing managed care may require restructuring Medicaid administration to place higher priority and focus more staffing resources on monitoring of contracted MCOs. Many states also cite concerns or resistance from stakeholders, including Medicaid recipients, their advocates and providers.

Success of these initiatives also depends on the availability of qualified vendors able to meet the challenging needs of the Medicaid population. In interviews, some states indicated that until the health insurance market was mature enough to accommodate the needs of the Medicaid population in all areas of a state, effort at expanding risk-based managed care were limited. According to a recent Consumer Reports, Georgia's commercial and Medicaid health plans scored 78 to 82 points out of a possible 100 points on based upon a NCQA scoring system. Only one commercial health plan in Georgia was ranked in the top 100 nationally.²¹⁴ This finding about the quality of the commercial and Medicaid managed care industry in Georgia may have implications for the state as it assesses delivery system options.²¹⁵ Further details about the Georgia health care environment are explained in Chapter 4: Georgia Specific Scan.

²¹⁴ See *Chapter 4, Georgia-specific Scan* for additional information about the Consumer Reports rankings.

²¹⁵ Consumer Reports, "Health Insurance: Which Plan to Pick?" November 2011.

Chapter 4: Georgia-specific Scan

In many regards, Georgia's health care profile mirrors that of the nation. Like many other states, Georgia's population is growing, state budget pressures are increasing each year, and the health care delivery system is pressured to care for increasing numbers of residents and faces a physician shortage that is expected to worsen.

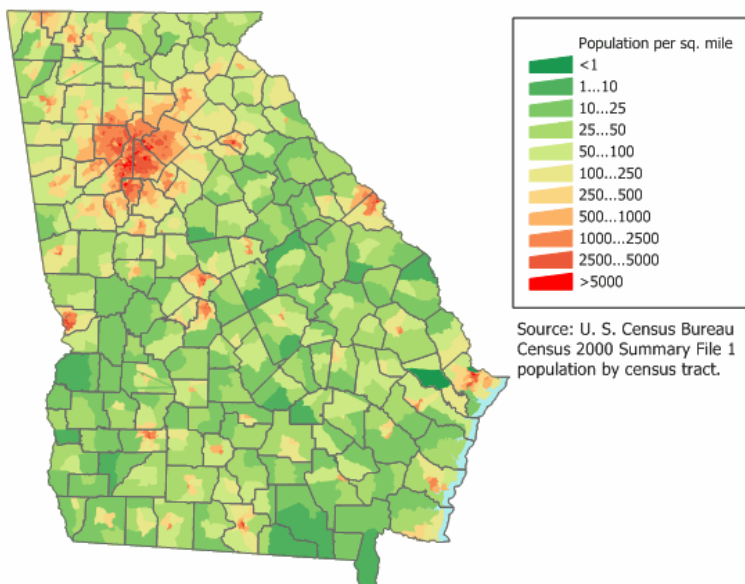
Although Georgia has achieved much, the State, like most states around the nation, must continually explore opportunities to improve access to and quality of care while also containing costs due to ongoing budget deficits – all while anticipating the potential impacts of federal health care reform.

A general understanding of some key aspects of Georgia's health care system and an understanding of the current Medicaid and PeachCare for Kids® programs are essential to the development of recommendations for redesign. The following sections of this report provide a brief overview of the State of Georgia, including a review of quality of care and access to physicians and other health professionals followed by detail about the Medicaid program.

A. Brief Overview of the State of Georgia

Georgia is the ninth most populous state in the nation and, of all states located east of the Mississippi River, has the largest land mass. As illustrated by Figure 4.1, Georgia is a largely rural state with a major urban center, Atlanta, in the north-central part of the State.

Figure 4.1: Population per Square Mile



Chapter 4: Georgia-specific Scan

Some key facts and figures related to Georgia's health care landscape are listed below.

- Georgia's total population in 2010 according to the U.S. Census Bureau was 9,687,653. The population has increased more than twice the national average increase from 2000 to 2010 – 18.3 percent compared to 9.7 percent.¹
- Compared to the national average, a greater percentage of Georgia residents are minorities.²
- Georgia's infant mortality rate is higher than the national average but lower than that of most geographically proximate states.³
- Twenty-one percent of the Georgia population is living in poverty compared to 20 percent of the total U.S. population.⁴
- As of October 2011, Georgia's unemployment rate was 10.2 percent compared to 9 percent nationally.⁵
- From 2000 to 2009, Georgia's share of the uninsured has outpaced national trends, rising nearly five percentage points compared with three percentage points for the United States.⁶
- In 2009, Georgia was ranked 5th highest of all states in terms of both the percentage of its population that is uninsured and the total number of uninsured.⁷
- Georgia has 159 counties, second only to Texas.⁸

There are more than 25 major government departments in Georgia's executive branch and hundreds of smaller agencies, boards and commissions. Among these, many are involved in

¹ U.S. Census Bureau. State & County QuickFacts. Available at <http://quickfacts.census.gov/qfd/states/13000.html>.

² U.S. Census Bureau. State & County QuickFacts. Available at <http://quickfacts.census.gov/qfd/states/13000.html>.

³ U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Health, United States, 2010. Available at [http://www.cdc.gov/nchs/data/10.pdf#077](http://www.cdc.gov/nchs/data/hus/10.pdf#077).

⁴ Kaiser Health state Facts.org

⁵ Kaiser Health state Facts.org

⁶ Trends in Health Insurance Coverage in Georgia, Georgia Health Policy Center, 12/2010

⁷ Trends in Health Insurance Coverage in Georgia, Georgia Health Policy Center, 12/2010

⁸ A Brief History of Georgia Counties, Ed Jackson, University of Georgia, <http://georgiainfo.galileo.usg.edu/countyhistory.htm>

Chapter 4: Georgia-specific Scan

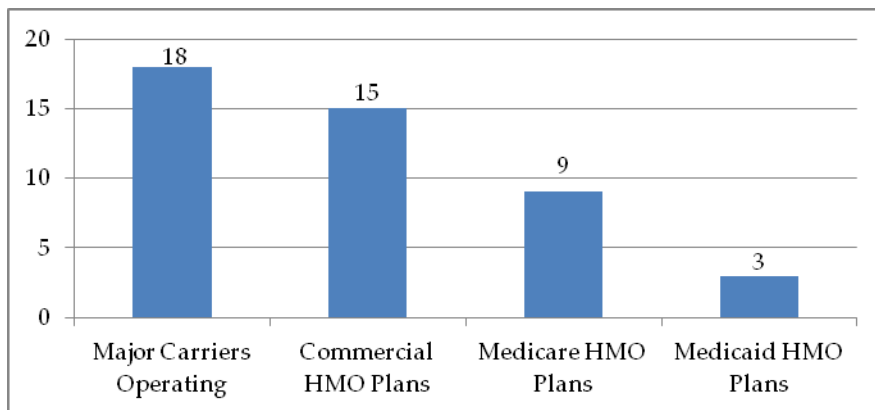
the provision of health care and health care-related services, including but by no means limited to:

- Department of Community Health (DCH)
- Department of Public Health
- Department of Behavioral Health and Developmental Disabilities

Georgia State government is the largest single purchaser of health insurance in Georgia, with Georgia's Medicaid program and State Health Benefit Plan (SHBP) being the largest state programs. In fiscal year (FY) 2010, the Division of Medicaid provided access to health care for 1.6 million Georgians at a cost of \$7.253 billion.⁹ The SHBP provides health insurance coverage to state employees, school system employees, retirees and their dependents. The Georgia Department of Community Health's SHBP Division is responsible for day-to-day operations for the Plan. The SHBP covered 691,016 people as of November 1, 2011.¹⁰

Eighteen major carriers operate health plans in Georgia. Of these, 15 offer health maintenance organization (HMO) plans, nine offer Medicare Advantage Plans and the three contracted care management organizations (CMOs) for the Medicaid program operate Medicaid HMOs, as shown in Figure 4.2.¹¹

Figure 4.2: Major Health Plan HMO Offerings in Georgia, 2011¹²



⁹http://dch.georgia.gov/vgn/images/portal/cit_1210/46/48/17750654710%20DCH%20Annual%20Report%20FINAL.pdf

¹⁰Georgia Department of Community Health, State Health Benefit Plan, http://www.georgia.gov/00/channel_title/0,2094,31446711_32021041,00.html

¹¹ Data includes the major commercial health insurers in the State of Georgia, and is not an exhaustive list of all health payers that operate in Georgia. Georgia Health Insurance. <http://www.georgia-health-insurance.org/index.php>

¹² Data includes the major commercial health insurers in the State of Georgia, and is not an exhaustive list of all health payers that operate in Georgia. Georgia Health Insurance. <http://www.georgia-health-insurance.org/index.php>

Chapter 4: Georgia-specific Scan

Like many states, Georgia faces population growth and, as outlined below, potential provider shortages. These trends, coupled with national health care reform, will impact the Georgia health care system in the coming years.

1. Quality of Care in Georgia

Like all states and payers, Georgia payers are concerned about quality and have pursued initiatives to improve quality of care delivered in Georgia. Recent studies evidence that while improvements have been made opportunities for further improvements exist. The Agency for Healthcare Research and Quality's (AHRQ's) National Healthcare Quality Report (NHQR) reports that Georgia's overall health care quality is "weak" when compared to all other states but is "average" when compared to other southeastern states.¹³ See *Appendix H* for additional information.

A November 2011 Consumer Reports article comparing commercial, Medicare and Medicaid plans across the nation notes somewhat similar trends.¹⁴ Using Healthcare Effectiveness Data and Information Set (HEDIS®) data from the National Committee for Quality Assurance (NCQA), this study ranks each of 830 health plans in one of three categories: 390 private plans in which people enroll through employers or on their own; 341 that serve Medicare beneficiaries in the Medicare Advantage program; and 99 that serve Medicaid members through states' Medicaid managed care programs. This study reveals some geographic patterns, for example, 18 of the 50 top ranked private plans are in the New England area. In contrast, just one of the 50 top ranked private plans and just three of the 100 top ranked private plans are in the Southeastern United States.¹⁵ The study also notes that while Aetna and the Blues had plans ranked in the top 100 in New England, many of the same insurers' plans in southern and western states ranked near the bottom of the list.¹⁶ One of the three Georgia Medicaid CMOs ranked in the top half of the 99 Medicaid plans nationwide.

¹³ Agency for Healthcare Research and Quality, Dashboard on Healthcare Quality Compared to Other States, <http://statesnapshots.ahrq.gov/snaps10/dashboard.jsp?menuId=4&state=GA&level=0> and <http://statesnapshots.ahrq.gov/snaps10/Methods.jsp?menuId=67&state=GA#scoring>

¹⁴ Consumer Reports, "Health Insurance: Which Plan to Pick?" November 2011, page 39. (Note: Results are published in three regional editions of *Consumer Reports*.)

¹⁵ Southeastern states include: Alabama, Arkansas, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee and West Virginia.

¹⁶ Consumer Reports, "Health Insurance: Which Plan to Pick?" November 2011, page 39. (Note: Results are published in three regional editions of *Consumer Reports*.)

Figure 4.3: Health Plan Quality Rankings for Georgia^{17,18}

	Overall Score	Consumer Satisfaction	Prevention	Treatment	National Rank
Georgia Medicaid CMOs (Out of 99 Ranked Nationally)					
Peach State	82	3	3	3	43
Amerigroup	81	3	3	3	52
Wellcare	78	2	3	2	72
Georgia Medicare HMOs (Out of 341 Ranked Nationally)					
Kaiser	86	4	5	4	31
Aetna	82	3	4	3	107
United	78	3	2	2	161
BCBS of GA	65	2	3	3	278
Wellcare	62	1	3	2	316
Arcadian	59	1	1	1	339
Georgia Commercial HMOs (Out of 390 Ranked Nationally)					
Kaiser	86	4	5	3	52
Cigna	83	4	3	3	126
Aetna	82	3	3	3	163
BCBS of GA	82	2	4	3	172
United	81	3	3	2	217
Humana	80	2	2	3	250

Note:

- Overall Score on a scale of 1 – 100 (higher is better) is based on performance on dozens of measures encompassing consumer satisfaction, treatment and prevention.
- National rank shows where each plan stands among all plans nationwide: 99 Medicaid plans, 341 Medicare plans (includes preferred provider organizations [PPOs] and HMOs) and 390 commercial plans (includes PPOs and HMOs). Performance ratings were scored from 1 to 5 with 1 as worse than average and 5 as better than average.

The studies referenced above have some limitations. For example, they do not control for confounding factors, such as demographics, when making comparisons across states, and the average results for Georgia mask a wide degree of variation across providers, geographies, subpopulations and services within the State. The studies also point toward a potential opportunity for Georgia: Georgia appears to have opportunities to improve quality of care – for both its Medicaid and PeachCare for Kids® members, as well as for its commercial population. With a covered population of over 1.6 million today – and possibly exceeding 2 million in 2014

¹⁷ Consumer Reports, “Health Insurance: Which Plan to Pick?” November 2011, page 39. (Note: Results are published in three regional editions of *Consumer Reports*.)

¹⁸ Data was obtained from NCQA based on data collected in 2010 and 2011.

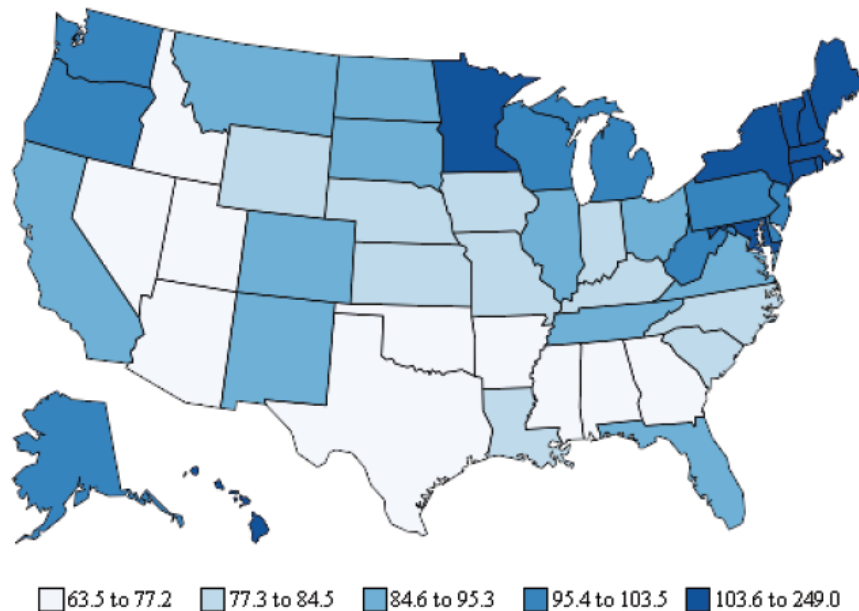
Chapter 4: Georgia-specific Scan

– Georgia Medicaid has the opportunity to drive improvements in quality, as highlighted in the sections relating to Medicaid and Georgia Families below. As the largest single purchaser of health insurance in Georgia, the State of Georgia is faced with an opportunity to align its priorities, negotiation strategies and outcomes targets to truly impact health care quality and outcomes in Georgia.

2. Access to Physicians and Other Health Professionals in Georgia

Like many states, Georgia faces some potential shortages and maldistribution of health care professionals. With 207.0 active physicians per 100,000 citizens, Georgia ranked 41st among the 50 states in 2010 and was 20 percent below the national rate of 258.7.¹⁹ As shown in *Appendix I, Figure I.4*, between 1998 and 2004, the number of physicians per 100,000 population grew somewhat, then remained fairly constant between 2004 and 2008, and grew again in 2010. Similar trends hold for Primary Care Physicians (PCPs). As of 2010, Georgia ranked 44th in the nation for active PCPs with 74.0 per 100,000 and was 18.2 percent lower than the all-state median of 90.5 physicians per 100,000. Figure 4.4 illustrates where Georgia stands in measuring PCPs per 10,000 persons.

Figure 4.4: Primary Care Physicians per 10,000 persons 2010²⁰



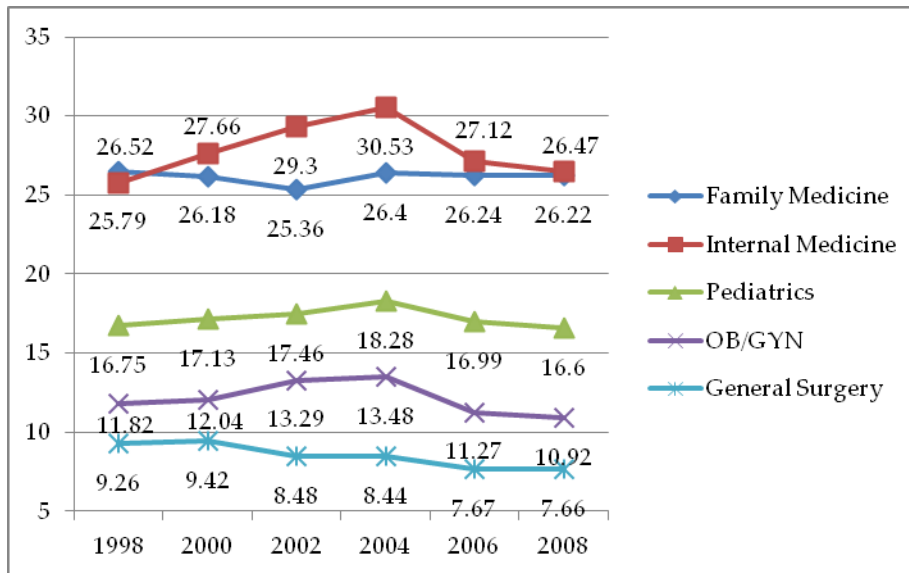
¹⁹ State Physician Workforce Data Book; Association of American Medical Colleges, November 2011. Figure includes MD and DO physicians

²⁰ State Physician Workforce Data Book; Association of American Medical Colleges, November 2011.

Chapter 4: Georgia-specific Scan

Looking at physician-to-population ratios by type of physician, Georgia experienced a decline in PCPs and growth in specialists, although these changes are very small for some specialties. This general trend of declines in PCPs and increases in specialists mirrors national trends. The specialties experiencing the largest declines over the last decade are General Surgery and Obstetrics/Gynecology (OB/GYN). Also of note is that the recent declines in the number of internal medicine physicians have completely offset gains made in the late 1990s, as illustrated in Figure 4.5. From 2004 to 2008, internal medicine and reproductive medicine have seen the greatest exodus of physicians out of Georgia practices.

Figure 4.5: Physicians per 100,000 Population by Type 1998-2008²¹



The Georgia Board for Physician Workforce groups counties into Primary Care Service Areas (PCSAs) based on the number of individuals who seek care in that county versus other counties.²² The Georgia Board for Physician Workforce categorized these 96 PCSAs based on whether they had a surplus, an adequate supply or a deficit of providers based on the rate of providers per 100,000 population for selected provider types.

Potential physician supply issues are most pronounced in rural areas. Fifty-two percent of Georgia’s physicians are located in five of the 96 PCSAs. These five service areas contain only

²¹ Georgia Board for Physician Workforce: State of Georgia July 2011. Available online: <http://www.files.georgia.gov/GBPWF/Files/2008%20Physician%20Profile-%20Final%208-8-11.pdf>

²² PCSAs™ are determined by examining health care utilization patterns of the citizens of individual counties. Ultimately, 96 areas were designated by applying two criteria to a review of data in the 1998 Georgia Hospital Questionnaire. A PCSA was designated if at least 30 percent of the patients received care in their county of residence or if a county received less than 30 percent of its residents as patients, it was assigned to the county where the majority of its residents go for primary care.²²

Chapter 4: Georgia-specific Scan

38.1 percent of the population, but more than half of the State's physicians practice. In contrast, in 2008, 22 PCSAs did not have a single practicing pediatrician. While this is a large number of PCSAs, these PCSAs represent a small proportion of Georgia's population: just 3.4 percent of Georgia's population resides in these 22 PCSAs, and all are considered rural areas or non-MSAs. Similar patterns are present for general surgery and obstetrics/gynecology. Figure 4.6 provides an overview of provider deficits within PCSAs in Georgia.

Figure 4.6: Georgia Primary Care Service Areas with a Provider Deficit, 2006 and 2008²³

Provider Type	Acceptable Range (providers / 100,000)	Deficit PCSAs 2006	Deficit PCSAs 2008
Family Medicine	13.1 – 39.9	3	3
Internal Medicine	16.4 – 36.0	27	33
Pediatrics	10.1 – 23.1	48	53
OB/GYN	5.7 – 16.1	42	40
General Surgery	3.1 – 12.3	27	25

Rural areas have been slightly more adversely affected by the physician exodus for key provider types. From 2006 to 2008,²⁴ declines of one percentage point or greater in the rate of physicians per 100,000 have occurred for pediatrics, internal medicine and family medicine exclusively in rural (non-MSA) while remaining relatively constant in urban (MSA) areas. These trends mirror national trends: when comparing the geographic distribution of physicians to the U.S. population at large, physicians were overrepresented in the Northeast and large metropolitan areas—likely reflecting in some cases patients traveling to urban areas for specialized services—and underrepresented in the South.²⁵

Figure 4.7 illustrates that the percent of Georgia's population living in a Health Professional Shortage Area mirrors the national average with regard to physicians and dentists and exceeds the national average with regard to mental health professionals.

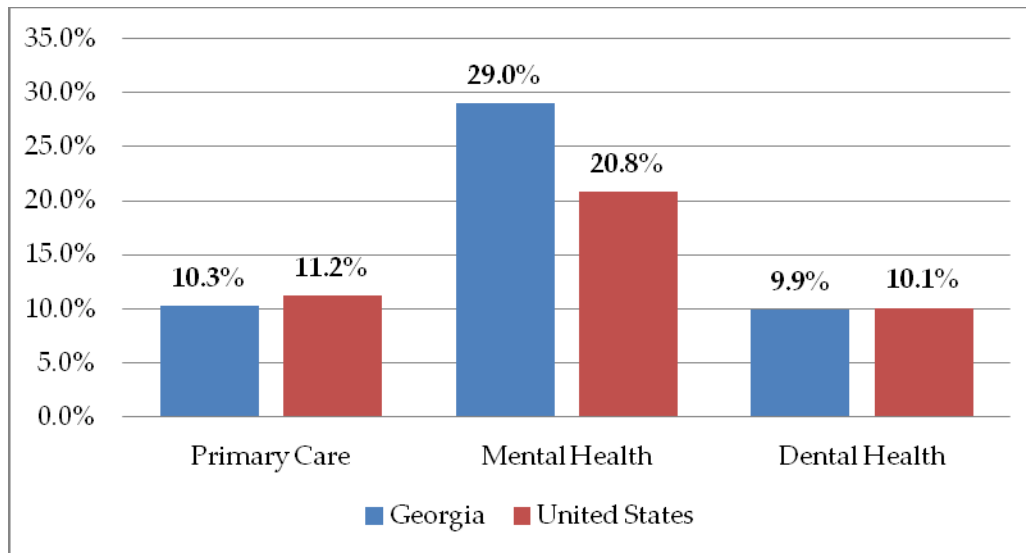
²³ Georgia Board for Physician Workforce: State of Georgia July 2011. Available online: <http://www.files.georgia.gov/GBPW/Files/2008%20Physician%20Profile-%20Final%208-8-11.pdf>

²⁴ Georgia Board for Physician Workforce: State of Georgia July 2011. Available online: <http://www.files.georgia.gov/GBPW/Files/2008%20Physician%20Profile-%20Final%208-8-11.pdf>

²⁵ A Snapshot of U.S. Physicians: Key Findings from the Health Tracking Physician Survey <http://hschange.org/CONTENT/1078/1078.pdf>

Chapter 4: Georgia-specific Scan

Figure 4.7: Estimate of Underserved Population Living in Health Professional Shortage Areas, 2011²⁶



Georgia Medicaid members represent approximately 18.8 percent of the total Georgia population, and, as shown in Figure 4.8, as of 2008 more than 65 percent of Georgia physicians were accepting new Medicaid patients and approximately 74 percent are currently serving Medicaid patients. These physician rates of Medicaid participation declined from 2000 to 2008,²⁷ and are slightly below the national average of 71.8 percent of physicians accepting new Medicaid patients.²⁸ Like all states, Georgia faces a potential expansion of Medicaid rolls if and when Affordable Care Act (ACA) provisions are implemented in 2014. The *New England Journal of Medicine* concluded that Georgia ranks second in the nation to Oklahoma in facing the greatest set of challenges to secure adequate access to primary care for post-2014 expanded Medicaid rolls.²⁹

²⁶ Kaiser State Health Facts. Available Online: <http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=156&rgn=12>

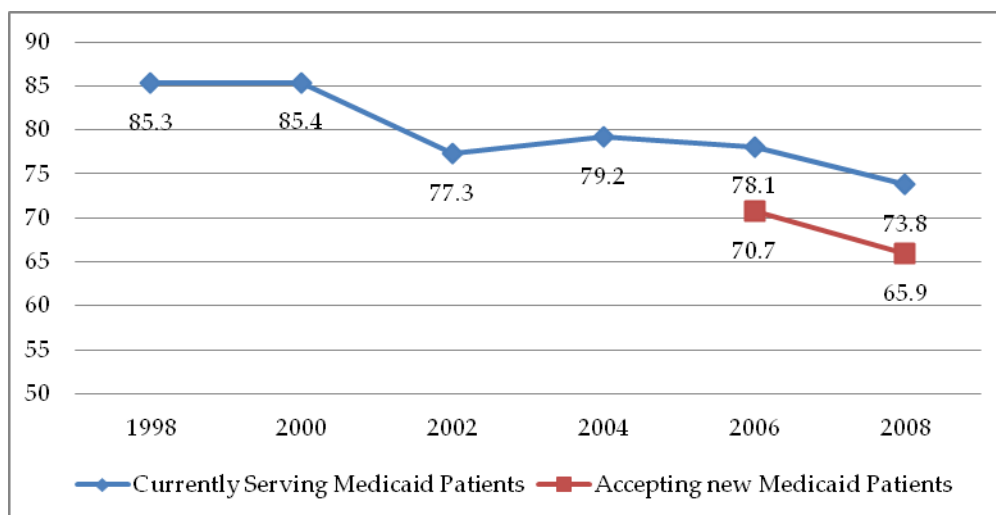
²⁷ Georgia Board for Physician Workforce: State of Georgia July 2011. Available online: <http://www.files.georgia.gov/GBPWF/Files/2008%20Physician%20Profile-%20Final%2008-8-11.pdf>

²⁸ Health System Change (HSC) Data Bulletin September 2009. Available Online: <http://hschange.org/CONTENT/1078/1078.pdf>

²⁹ Ku, Leighton et al. "The States' Next Challenge – Securing Primary Care for Expanded Medicaid Populations." *New England Journal of Medicine*. February 2011.

Chapter 4: Georgia-specific Scan

Figure 4.8: Percentage of Providers Serving and Accepting New Georgia Medicaid Patients 1998-2008³⁰



Physician supply issues impact every payer in Georgia including Medicaid, Medicare and commercial insurers. Therefore, redesigning the Medicaid and PeachCare for Kids® delivery systems alone will not fix any potential provider access issue. In recognition of this fact and like many other states, the State of Georgia has recently begun implementing several initiatives to impact the physician supply. Over the last several years, Georgia has also implemented several programs to allow alternative providers to practice and write prescriptions to ease the burden on physicians. For example, in July 2006, a law was implemented to allow nurse practitioners to write prescriptions.³¹

Efforts also include increasing recruiting efforts and working to increase medical school enrollment. Georgia ranked 40th among states in the number of students enrolled in medical or osteopathic schools during the 2010-2011 school year per 100,000 population.³² The Medical College of Georgia, Emory University School of Medicine, Mercer University School of Medicine and Morehouse School of Medicine are all increasing medical student enrollment in response to the need for more physicians.³³ Their efforts are reflected in the fact that Georgia has increased medical and osteopathic school enrollment by 48.4 percent between the years 2000-2010, which is 8th highest in the nation over that time period. These efforts are consistent with findings of recent studies, including one study which determined that generalist

³⁰ Georgia Board for Physician Workforce: State of Georgia July 2011. Available online: <http://www.files.georgia.gov/GBPWF/Files/2008%20Physician%20Profile-%20Final%208-11.pdf>

³¹ Georgia Nurses Association. Press Release. Available Online: http://www.georgianurses.org/media/RxPasses_28Mar.pdf

³² State Physician Workforce Data Book; Association of American Medical Colleges, November 2011.

³³ Georgia Board for Physician Workforce. Fact Sheet on Georgia's Medical Schools. January 2009. Available online: <http://www.files.georgia.gov/GBPWF/Files/Fact%20Sheet%20-%20GAs%20Medical%20Schools%202009.pdf>

Chapter 4: Georgia-specific Scan

physicians who benefit from state-based financial incentives are more likely than other generalist physicians to practice in needy areas and care for uninsured and Medicaid.³⁴ Georgia currently ranks 11th in the rate of physicians retained to practice in-state after completing public medical or osteopathic school with 51.1 percent actively practicing in Georgia. Additionally, Georgia ranks 17th in the nation in the rate of physicians retained to practice in-state after completing graduate medical education (i.e. residency) in Georgia at 49 percent.³⁵

Potential health care professional shortages must be considered in any redesign effort – both in terms of how the redesign itself can help to assure access for members despite the shortage and in terms of how the redesign might help to limit or reduce physician workloads and continue to incent physicians to participate in Medicaid and PeachCare for Kids®.

B. Medicaid and PeachCare for Kids® Programs

DCH serves as the lead agency for health care planning and purchasing in Georgia. The General Assembly created DCH in 1999 by consolidating four agencies involved in purchasing, planning and regulating health care. DCH's current mission statement is: The Georgia Department of Community Health will provide access to affordable, quality health care to Georgians through effective planning, purchasing and oversight. Georgia Medicaid has worked over the last two decades to improve quality of, access to and cost-effectiveness of care for Georgians.

As the largest division in DCH, Medicaid administers Georgia's Medicaid program, which provides health care for approximately 1.6 million low-income children, pregnant women and people who are aging, blind and disabled. DCH contracts with a variety of vendors, detailed in *Appendix I, Figure I.7*, to administer its programs.

DCH is responsible for PeachCare for Kids®, the State's Children's Health Insurance Program (CHIP), which is a comprehensive health care program that in 1998 began covering eligible uninsured children living in Georgia. The health benefits include primary, preventive, specialist, dental and vision care. PeachCare for Kids® also covers hospitalization, emergency room services, prescription medications and mental health care. An estimated 202,527³⁶ of the approximate 1.6 million covered lives managed by DCH are PeachCare for Kids® members.

³⁴ Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices? The Robert Graham Center: Policy Studies in Family Medicine and Primary Care. Available online: http://www.macyfoundation.org/docs/macy_pubs/pub_grahamcenterstudy.pdf.

³⁵ State Physician Workforce Data Book; Association of American Medical Colleges, November 2011.

³⁶ Georgia Department of Community Health Annual Report 2010; reflects 12 month average of 2010 membership

Chapter 4: Georgia-specific Scan

Additionally, DCH is expanding eligibility for PeachCare for Kids® in January 2012 to allow enrollment of eligible children who have parents with coverage through the State Employee's Health Plan. DCH estimates an additional 16,000 individuals will be eligible for the program.

In 1995, Georgia Medicaid created a voluntary capitated Medicaid managed care program. The goal of this program was to enroll nearly all of Georgia's Medicaid members into health plans and save 10 percent in Medicaid costs. However, enrollment lagged, and the large cost savings originally projected were not achieved. As of mid-1998, only 54,000 of 930,000 eligible Medicaid members were enrolled in HMOs.³⁷ Based on lack of enrollment, the program was later terminated. However, this program gave DCH insights into managed care, and it worked to incorporate some of its lessons learned into the later implementation of the current Medicaid managed care program, Georgia Families (described later in this Chapter).

In September 2006, Georgia transitioned many of its Medicaid and all of its PeachCare for Kids® members from a fee-for-service (FFS) delivery system to a full-risk mandatory managed care Medicaid delivery system.^{38,39} This full-risk delivery system, now called Georgia Families, enhanced the existing FFS Medicaid program by establishing medical homes, care management, provider networks and other features which are associated with improvements in quality of care and outcomes. Figure 4.9 provides enrollment information for both delivery systems.

³⁷ <http://www.urban.org/url.cfm?ID=310151&renderforprint=1>

³⁸ Individuals in the following Medicaid eligibility categories must enroll in Georgia Families: Low-Income Medicaid (LIM) program, Transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees and women with breast and cervical cancer.

³⁹ The Managed Care State Plan Amendment (SPA) identifies certain groups of members as those with "special health care needs". These members are exempt from enrolling in the Georgia Families program and include:

- Medicaid and PeachCare for Kids® members enrolled in the Children's Medical Services Program
- Children receiving services through the Georgia Pediatric Program (GAPP)
- Members residing in hospice or LTC facilities
- Individuals who are institutionalized
- Children 18 years of age or younger who are in foster care or another out-of-home placement
- Children 18 years of age or younger who are getting foster care or adoption assistance under Title IV-E of the Social Security Administration;
- Individuals enrolled in Medicaid who qualify for Medicare
- Individuals who qualify for Supplemental Security Income (SSI)

Chapter 4: Georgia-specific Scan

Figure 4.9: Georgia Medicaid and PeachCare for Kids® Enrollment, 2011⁴⁰

Delivery System	Medicaid	PeachCare for Kids®
Georgia Families	1,090,400	202,527
Fee-for-Service	357,465	Not Applicable

Georgia Medicaid has also implemented a variety of programs over the years to provide care coordination and care management for some individuals in the FFS delivery system.

- In 1993, Georgia Medicaid implemented Georgia Better Health Care (GBHC), a primary care case management (PCCM) program on a limited basis and expanded statewide in 1998. Through GBHC, Georgia Medicaid contracted with providers routinely providing primary care services and other entities such as rural health centers, public health departments and federally qualified health centers to deliver and coordinate health care services for Medicaid members. Individuals eligible for this program included low-income Medicaid adults, low-income Medicaid-related adults, Sixth Omnibus Budget Reconciliation Act (SOBRA) children and Supplemental Security Income (SSI) recipients ages 19 and over. The goals of the program were to: improve access to medical care, particularly primary care services; enhance continuity of care by creating a "medical home" through assignments to a PCP; and reduce unnecessary use of medical services. After implementation of Georgia Families in 2006, GBHC primarily served Medicaid members who were SSI recipients ages 19 and over. The GBHC program did not providing the additional level of case management services that DCH would have liked to have for members, and the State terminated the program DCH terminated the GBHC program in September 2011.⁴¹
- Georgia Medicaid implemented the Georgia Enhanced Care (GEC) program, a comprehensive disease management program, as an enhancement to GBHC in 2005 with the performance period beginning in 2006. The goals of GEC were to improve members' self management of their diseases and improve health outcomes for the enrolled population with a resultant decrease in medical costs to the State. DCH

⁴⁰ Georgia Department of Community Health Annual Report 2010. Available Online: http://dch.georgia.gov/vgn/images/portal/cit_1210/46/48/17750654710%20DCH%20Annual%20Report%20FINAL.pdf; Georgia Families figure reflects June 2010 enrollment total. Other figures reflect 12-month average.

⁴¹ Georgia Better Health Care. Available Online: http://www.workworld.org/wwwwebhelp/ga_georgia_better_health_care_gbhc_.htm

Chapter 4: Georgia-specific Scan

- contracted with two vendors who served all regions of the State.⁴² Georgia Medicaid's SSI recipients ages nineteen and over were mandatorily enrolled in the program while SSI children under age nineteen could voluntarily enroll. Individuals in nursing homes, personal care homes, mental health facilities and other domiciliary locations were excluded. The GEC program did not achieve the established self knowledge and health outcome goals based on the performance reports submitted by the contracted vendors, and the State terminated the program in October 2010.
- In 2007, DCH implemented Georgia Medicaid Management Program (GAMMP), a care coordination, disease management and case management program for individuals not enrolled in Georgia Families or Georgia Enhanced Care. Enrollees of Georgia Enhanced Care who disenrolled from the program were automatically enrolled in GAMMP during the program's existence. The State contracted with one vendor to operate this program statewide, and the vendor received tiered per member per month rates (PMPMs) for care coordination, disease management and case management. Performance outcomes reports for GAMMP submitted by the vendor did not meet the State's expectations, and the State terminated GAMMP in February 2010.

Due to the terminations of the GBHC, GEC and GAMMP programs, Georgia Medicaid members who are aged, blind and disabled (ABD) have reverted to the traditional FFS delivery system with no care management services – to a Georgia Medicaid delivery system that in many ways resembles that which was in place in the early 1990s.

Figure 4.10 shows Georgia's Medicaid cost growth compared to the national average from 2000 to 2009. This figure shows that Georgia has successfully decreased its annual growth in spending in Medicaid. The timing of the decrease might be associated with the State's transition to Georgia Families.

⁴² Each vendor served in different regions of the State.

Chapter 4: Georgia-specific Scan

Figure 4. 10: Georgia: Average Annual Growth in Medicaid Spending, FY 1990 – FY 2009⁴³

Federal Fiscal Year	Georgia	United States
FY 1990-2001	11.5%	10.9%
FY 2001-2004	21.2	9.4
FY 2004-2007	-8.7	3.6
FY2007-2009	4.8	7.1

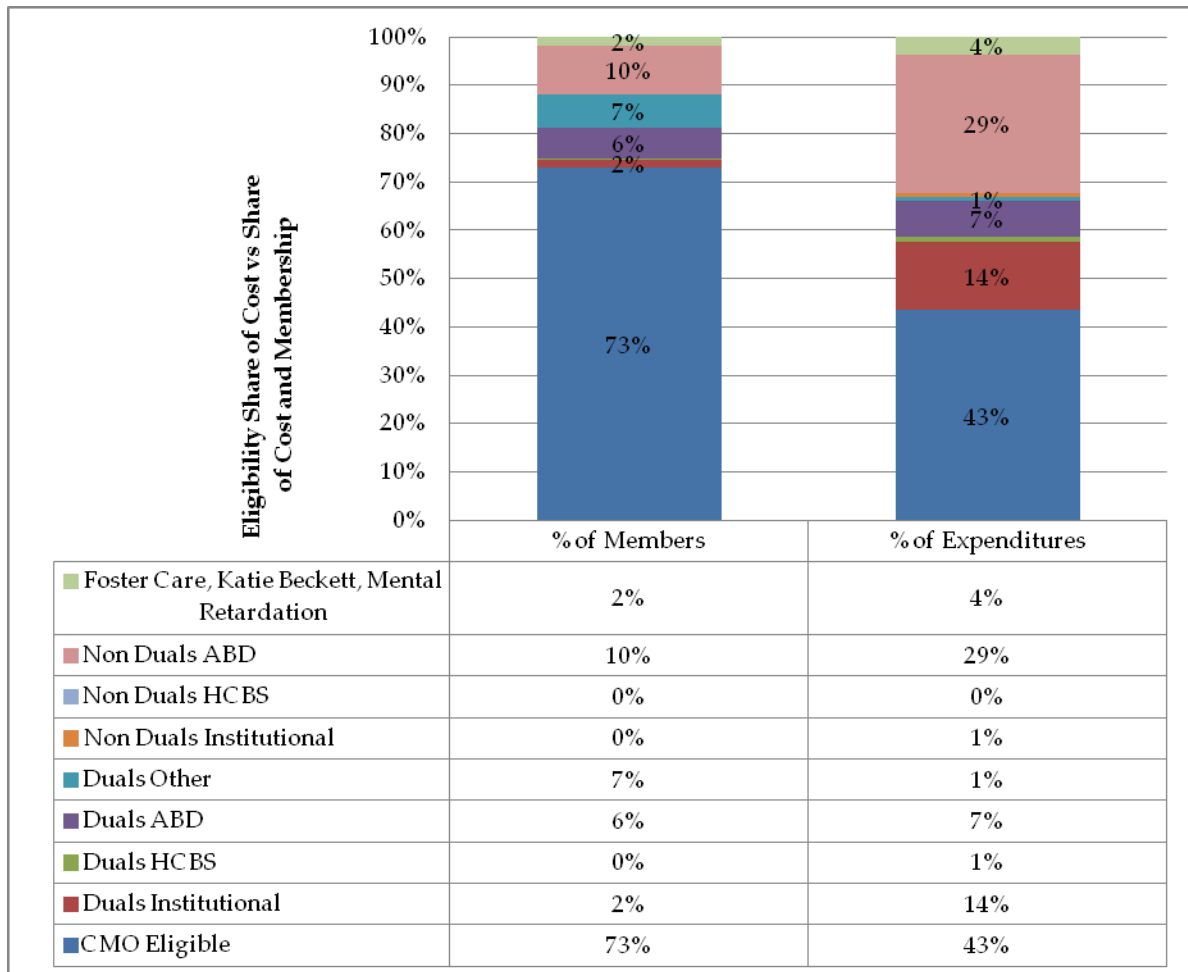
While the majority of Medicaid members participate in Georgia Families, the majority of Medicaid dollars are spent on members who are not enrolled in Georgia Families. Georgia's FFS delivery system serves Medicaid's most high-risk high-cost populations, including children in foster care, individuals who are dually eligible for Medicaid and Medicare (i.e., dual eligibles) and ABD populations. As illustrated in Figure 4.11, the FFS delivery system serves 23.8 percent of Medicaid members, but represents 54.9 percent of total costs. One of the questions national Medicaid agencies, including Georgia, face is whether the enrollment of ABD populations in a new delivery model (rather than FFS) might offer opportunities for improvements in access to, quality of and cost of care. In fact, as noted in *Chapter 3: National Scan*, many states are moving forward with delivery system reforms that involve ABD populations.

⁴³ Notes: All spending includes state and federal expenditures. Growth figures reflect increases in benefit payments and disproportionate share hospital payments; growth figures do not include administrative costs, accounting adjustments, or costs for the U.S. Territories.

Sources: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS-64 reports.

Chapter 4: Georgia-specific Scan

Figure 4.11: Medicaid Program Enrollment and Costs State Fiscal Year (SFY) 2010^{44,45}



Even with the changes DCH has made over the past several years, DCH is still facing increasing costs and a potentially significant number of new eligibles due to the potential Medicaid expansion in 2014. For example:

- Georgia Medicaid spending grew by 4.8 percent from FY 2007 to 2009, below the United States average of 7.1 percent during that same time period⁴⁶ (See Figure 4.11 above.)
- The total FFS system per person per month (PMPM) costs are projected to rise through 2017. The same trends are projected for Medicaid members who are dually eligible for Medicaid.⁴⁷

⁴⁴ Figures gathered from SFY 2010 Data and Thomson Reuters Commissioners Reports

⁴⁵ Managed Care figures are based on 2010 enrollment and PMPM cost projections.

⁴⁶ Kaiser Health state facts.org

⁴⁷ From Potential_MC_Opportunities_11112011.pdf

- With Medicaid expansion (based on 133 percent of Federal Poverty Level [FPL]), the estimated increase in enrollment and spending relative to the baseline by 2019 for Georgia is 40.4 percent versus the total United States figure of 27.4 percent.⁴⁸
- The potential membership increase due to the federally required eligibility expansion is projected to be 650,000 by 2020.
- The total cost of Georgia Medicaid due to expansion is expected to be \$25 billion over the period 2014 to 2020.⁴⁹

Like most Medicaid programs across the country, Georgia Medicaid is facing fiscal pressures and, as a result, is under tremendous pressure to explore options to deliver services in a more efficient manner and to control spending growth – all while maintaining quality of care and all within the context of potential physician shortages. Furthermore, with more than five years of experience operating Georgia Families, DCH is well positioned to evaluate the potential opportunities and challenges with this delivery system along with other types of delivery systems.

1. Georgia Families Program Features and Infrastructure

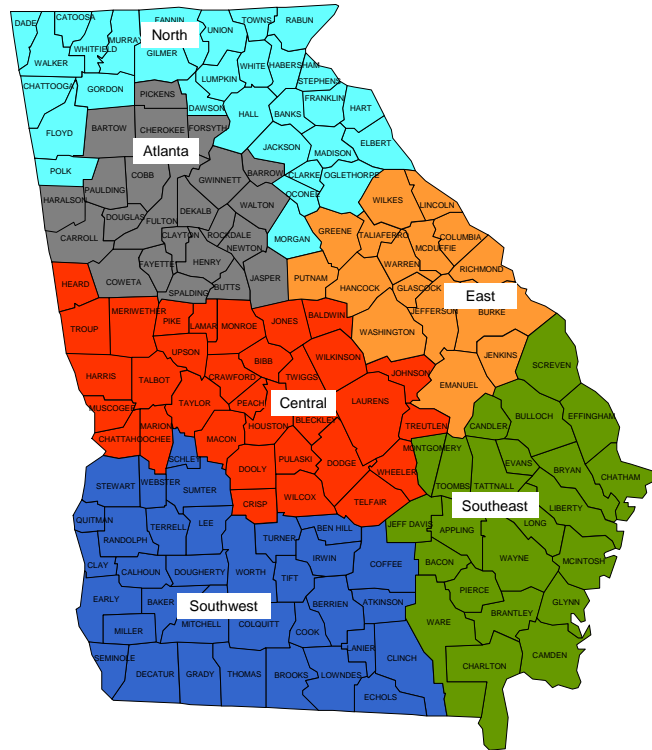
DCH contracts with three CMOs to serve approximately 1.1 million Georgia Families' members. The current CMO contracts are in effect through June 30, 2013, with an additional one year option. Figure 4.12 provides a map of the Georgia Families regions. Through 2011, all three CMOs operated in the Atlanta region while two CMOs operate in each of the five additional regions; however, as of January 2012, two health plans operate statewide. Non-emergency transportation is the only service carved out of this managed care program. DCH implemented Georgia Families through a State Plan Amendment.

⁴⁸ Kaiser Health state Facts.org

⁴⁹ Figures gathered from Commissioner's presentation to the AMCP 4/29/2011: AMCP JD April 2011 FINAL.ppt

Chapter 4: Georgia-specific Scan

Figure 4.12: Georgia Families Regions



Georgia Families Populations

Individuals in the following Medicaid eligibility categories must enroll in Georgia Families: Low-Income Medicaid (LIM) program, Transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees and women with breast and cervical cancer. Also, all PeachCare for Kids® members must enroll in Georgia Families.

Service Utilization and Quality of Care in Georgia Families

Like many Medicaid managed care programs across the nation, Georgia Families is designed to provide members assurances regarding access to and quality of care and an infrastructure to support members in accessing care. Some examples of these program design features are discussed briefly below.

- **Medical Home** – The CMOs are required to assure that every member has a designated PCP who will serve as his or her medical home. The medical home is intended to increase access to and continuity of care, increase early identification and treatment of chronic health conditions, and promote better care coordination.

Chapter 4: Georgia-specific Scan

- **Member Assessment** – To improve continuity and coordination of care, the CMOs must attempt to perform an initial screening and assessment for all enrollees within 90 days from the date of enrollment to identify pregnancy, chronic conditions, barriers to obtaining health care (such as transportation) and special or significant health care needs. The CMOs must also have procedures to coordinate services to prevent duplication of services.
- **Caring for People with Special Needs** – For Georgia Families’ members who have special medical needs, the CMOs have implemented mechanisms for identifying, assessing and ensuring the existence of a treatment plan for them. Mechanisms include outreach activities, evaluation of health risk assessments and review of historical claims data. The CMOs utilize case and disease management programs to target and improve the health outcomes for these members.
- **Provider Credentialing** – Each CMO is required to credential network providers in accordance with the standards of the NCQA, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or the Utilization Review Accreditation Commission (URAC).
- **Provider Network Composition** – DCH requires the CMOs to submit provider network adequacy and capacity reports demonstrating compliance with Georgia Families geographic access requirements (which are detailed in *Appendix I, Figure I.10*). The State reviews these reports to ensure the CMOs’ provider networks are sufficient in number, mix and geographic distribution to meet the contract requirements. CMOs are required to address network deficiencies by either contracting with existing providers in the region, making single case arrangements with non-participating providers or coordinating non-emergency transportation (NET) services to existing providers. Ninety-one percent of deficiencies are the result of no providers existing in the county, and the CMOs resolve these deficiencies by coordinating transportation to existing providers in other counties. DCH also requires the CMOs to meet established appointment timeliness standards, which are outlined in *Appendix I, Figure I.11*, and monitored regularly by the State.
- **CMO Accreditation** – The CMO contracts require each CMO to maintain accreditation with a managed care accrediting body. Each of the Georgia Families CMOs is accredited by NCQA and in 2011, each plan achieved commendable status

Chapter 4: Georgia-specific Scan

following their accreditation review. All three CMOs submit HEDIS® performance measures as a required component of the NCQA accreditation process.

- **Clinical Standards / Guidelines** – DCH requires the CMOs to establish, maintain and monitor compliance with Clinical Practice Guidelines (CPGs) among its contracted providers. Provider incentive strategies are used to encourage a 90 percent compliance rate with the CPGs. Figure 4.13 provides results reported by CMOs for FY 2010.

Figure 4.13: Compliance with Clinical Practice Guidelines, Monitoring Results by CMO, Fiscal Year 2010

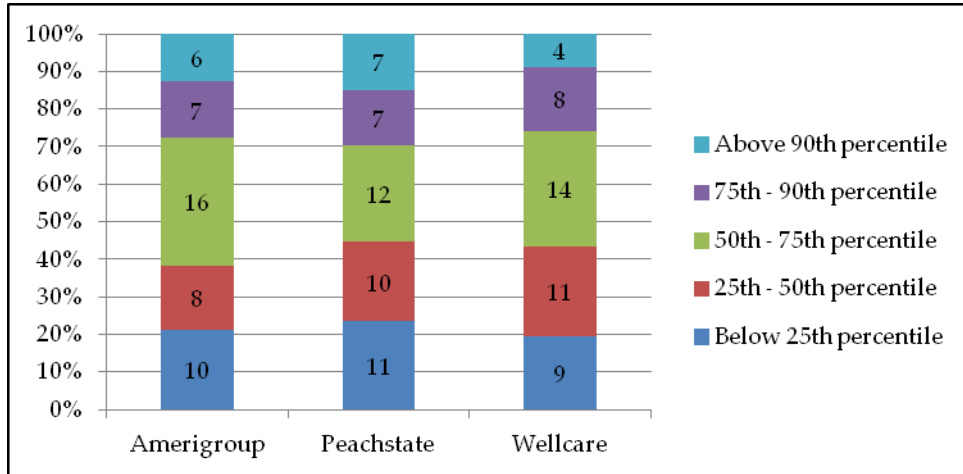
	Amerigroup	Peach State	WellCare
Percent Compliance with Guidelines	79	85	86
Percent of Providers Scoring 80 Percent or More	77	86	79
Total Number of Records Reviewed	450	450	327
Total Number of Providers Reviewed	90	90	52

- **Quality Measurement** – DCH’s tracking of quality metrics for Georgia Families has been an evolving process. In 2008, DCH implemented 6 HEDIS®-based metrics. In contrast to the early 2000s, today DCH tracks CMOs’ performance on 59 HEDIS® and HEDIS®-like measures. Compared nationally, the median number of measures that states require Medicaid managed care organizations (MCOs) to report is 32 measures (includes HEDIS® and state-specific measures). “Of the measures used by NCQA for accreditation of Medicaid MCOs, seven states required 10 measures or fewer, while 11 states required 30 or more. Twenty-nine states with MCOs responded in detail regarding their use of HEDIS® measures.”⁵⁰

For 40 of the 47 measures analyzed in 2009, the Georgia Families CMOs performed at or below the 50th percentile compared to other state Medicaid managed care programs. (See Appendix I, Figure I.12). Figure 4.14 summarizes the CMOs’ performance in the original 47 measures relative to NCQA median levels.

⁵⁰ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010: A Summary From a 50 State Survey. September 2011.

Figure 4.14. CMOs' Performance on 47 HEDIS® and HEDIS®-Like Measures⁵¹



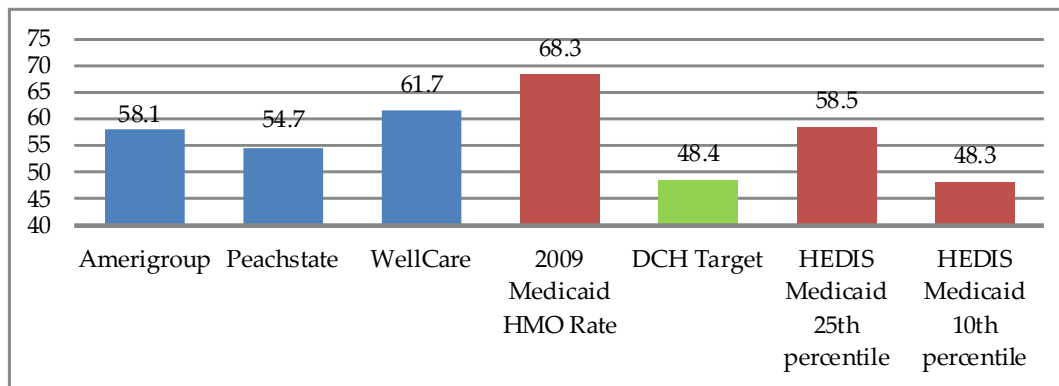
In addition to tracking of quality metrics, DCH requires the CMOs to implement Performance Improvement Projects and issues corrective action plans in areas where deficiencies are identified. For example, Georgia Families has had success in reducing utilization of the Emergency Department (ED) after DCH implemented corrective action plans.⁵² The CMOs and DCH collaborated to implement initiatives to achieve lower rates. Figure 4.15 shows 2010 ED utilization rates by CMO compared to the national average rate, as well as the DCH target. Two of the three CMOs experienced utilization lower than 75 percent of Medicaid plans reporting HEDIS® information in 2010 (between the 10th and 25th percentile). See *Appendix J* for DCH's Performance Measure Report for Georgia Medicaid and PeachCare for Kids® for 2008 through 2010.

⁵¹ Data gathered from DCH July 2011 Performance Measures Report

⁵²After initiating PIPs, all three CMOs experienced a statistically significant decline in ER Utilization between the baseline period (1/1/09 – 12/31/09) and the remeasurement period (1/1/10 – 12/31/10). See Performance Improvement Project Reports for SFY 2012 for each of the three CMOs.

Chapter 4: Georgia-specific Scan

Figure 4.15: Emergency Department Visits per 1,000 Member Months, 2010^{53, 54, 55}



Through the Georgia Families program, DCH is able to demonstrate measurable cost savings for the State on a PMPM basis when compared to the FFS delivery system, as illustrated in Figure 4.16. Depending on the methodology used to calculate savings, PMPM savings ranged from \$8 to \$29 in 2011, totaling a projected \$113 million to \$385 million depending on the calculation methodology.⁵⁶ The lower bound estimate (i.e., \$8 PMPM savings) includes only changes in acuity and utilization, while the upper bound estimate (i.e., \$29 PMPM savings) considers these factors and assumes FFS providers would have received periodic rate increases necessary to maintain access to care.

⁵³ Data gathered from DCH July 2011 Performance Measures Report.

⁵⁴ National figure reported in New Mexico Medicaid ER Visits Frequency, Diagnosis and Unit Costs. 2010 figure was not available. Available online:

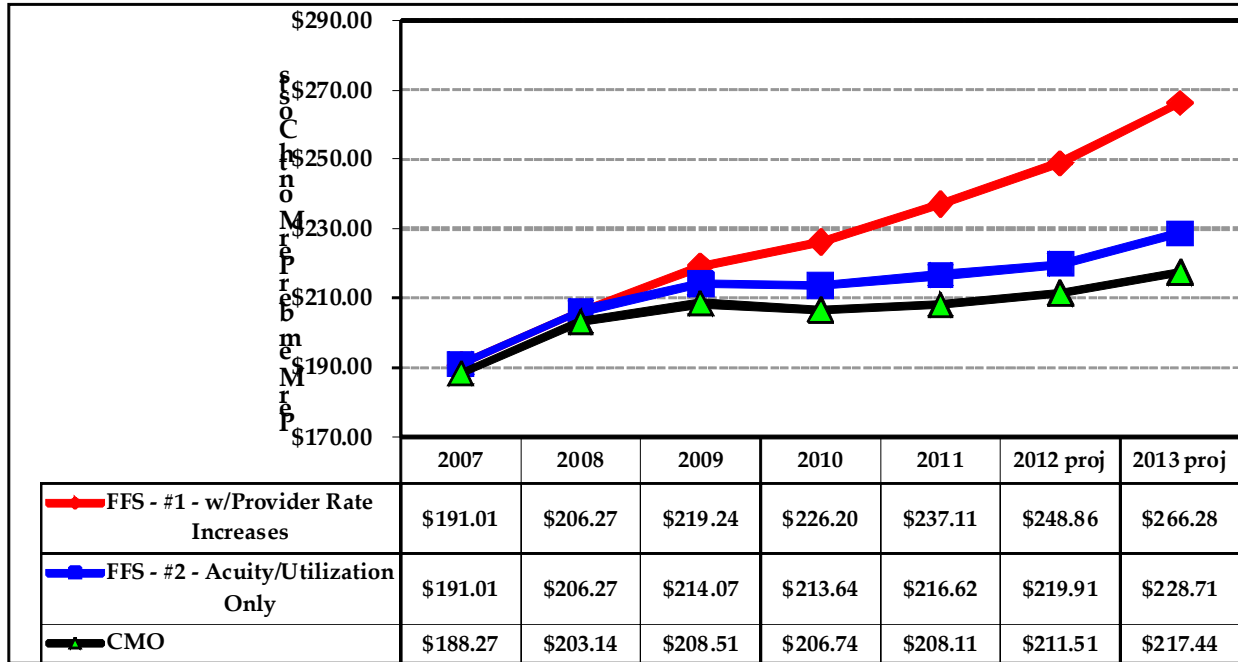
http://www.hsd.state.nm.us/mad/pdf_files/salud/ER%20report%2011%2023%2009%20Final.pdf.

⁵⁵ HEDIS® 2010 percentiles reported in SFY 2012 Performance Improvement Project Reports for each CMO.

⁵⁶ From CMO Savings January 2012.ppt

Chapter 4: Georgia-specific Scan

Figure 4.16: PMPM Payments for CMOs Versus FFS, Fiscal Years 2007-2013^{57,58,59}



⁵⁷ Georgia Department of Community Health., Georgia Families Financial Impact presentation. January 2012.

⁵⁸ Notes:

- Shows CMO actual and projected managed care savings against what would have been incurred under FFS. Uses two different methodologies for calculating FFS costs given historical FFS utilization trends.
- FFS #1 assumes providers in FFS would have received periodic rate increases necessary to maintain access to care. PMPM growth would also consider changes in utilization and acuity.
- FFS #2 assumes providers in FFS would not have received rate increases, and PMPM growth is solely related to changes in utilization and acuity.

⁵⁹ FY11 excludes hospital rate increase and health insurance premium tax were from the PMPM amounts since they are pass through amounts and are budget neutral to DCH

Chapter 4: Georgia-specific Scan

Quality Improvement

Often, Medicaid agencies evolve in their role as purchasers. In the early evolutionary phases, they focus on building infrastructure, designing and implementing new delivery systems, and the like – as DCH has done in recent years with Georgia Families. DCH has established an infrastructure and internal processes to support the collection and more meaningful use of quality performance and outcomes data; however, as described below, there are still limitations with this data:

- Performance measures the CMOs are required to meet have been modified annually, so performance cannot be meaningfully trended over time.
- Because of the methodology used to collect the data and, in some cases to define the measures, some of the data cannot easily be compared to national benchmarks.
- DCH is requiring the CMOs to work on nine Performance Improvement Projects (PIPs) and hundreds of network deficiency corrective action plans. Tracking such a large number of initiatives poses the risk that the CMOs will be unable to commit the necessary resources to implement the planned interventions and/or DCH will be unable to commit the necessary staff and other resources to effectively track progress and support the CMOs in their efforts. Furthermore, achievement of target rates is less likely when more targets are set and more interventions are required to achieve those targets – CMO and DCH resources are likely to be diluted as they are spread across many initiatives.

DCH is working to evolve the Georgia Families program from a start-up program to a more mature program. In general, DCH is working to transition from a system focused on operations such as paying claims and recruiting and retaining providers to a more sophisticated purchaser focusing on quality of care and member outcomes. Quality measurements and outcomes have been evolving over the past several years for Georgia's Medicaid program as a whole and, in particular, for Georgia Families. For example, DCH aligned HEDIS® and AHRQ performance measures for the FFS and Georgia Families populations. The availability and credibility of these metrics will allow the DCH to compare Georgia Medicaid to other states and identify areas for improvement.⁶⁰ Additionally, Georgia was recognized in the U.S. Department of Health and Human Services 2011 Annual Report on the Quality of Care for Children in Medicaid and

⁶⁰ Quality Strategy Report, Updated November 2011. (See Appendix K for DCH's prior Quality Strategy Report.)

Chapter 4: Georgia-specific Scan

CHIP. "Georgia reported 18 of the initial 24 Children's Health Insurance Program Reauthorization Act (CHIPRA) measures in FY 2010, more than any other state," the report said. "Moreover, the state actively uses the quality measures to assess managed care organizations' achievement against targets, develop performance improvement plans and enforce contractual provisions related to quality of care. Georgia has taken a proactive role in designing its data systems to support quality measurement at the state level." The report also gave the State credit for an eight percent increase in the number of children receiving preventive dental services from federal fiscal year 2000 to 2009.⁶¹

In short, DCH is just beginning to move into the next evolutionary phase, which is characterized by: consistently trending quality of care and outcomes data over time; implementing interventions to impact outcomes; frequently measuring outcome measures and the structure and process measures which might serve as interim measures of success; and implementing strategies to align incentives among the state agency, its vendors and providers so that all parties are working toward common goals.

Among the steps DCH has taken or is taking to improve quality in terms of access, transparency and performance are the following:

- Instituted quality measurement and performance improvement initiatives and established a transparent system which permits Medicaid and PeachCare for Kids® members and providers to view quality-related metrics on the Internet
- Established an auto-assignment methodology that assigns new membership to CMOs based on selected quality measures, which only nine additional states reported as also incorporating in their methodologies based on a recent study (see Figure 4.17 below)
- Established PIPs to monitor and improve quality of care through HEDIS®-based measurements
- Established various quality initiatives including the Planning for Healthy Babies™ and Know Your Numbers projects

⁶¹ U.S. Department of Health and Human Services. 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP. September 2011.

Chapter 4: Georgia-specific Scan

Opportunities exist for DCH to more effectively use data it is now gathering and planning to collect – to incentivize and encourage better quality or outcomes by linking performance to incentive payments or payment withholds. See Figure 4.17 below for information about states using these strategies in payment structures with MCOs. Additionally, three quarters of states contracting with MCOs reported in a recent study that they publicly report performance measures.⁶² We encourage DCH as it moves into its redesign to carefully consider what baseline data is necessary to use in monitoring ongoing success and how to establish that data.

Figure 4.17: Use of Quality Tools by State^{63,64}

State	Quality Factors Included in Auto-Assignment Algorithms		MCO Capitation Rate-Setting Methods and Pay-for-Performance Strategies				Public Reporting of MCO and PCCM Quality Reports
	Plan Quality Performance	Other Performance Measures	Capitation Withhold	Bonus	Shared Savings	Other	
Georgia	X	X					X
Arizona	X	X					X
Arkansas							X
California	X	X					X
Colorado							X
Connecticut							X
Washington, D.C.			X				X
Delaware							
Florida							X
Hawaii			X				X
Illinois			X	X			X
Indiana			X				
Iowa							X
Kansas							
Kentucky							
Maine							X
Massachusetts			X	X			X
Maryland			X	X			X
Michigan	X		X	X			X

⁶² Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

⁶³ Smith, Gifford and Ellis. Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012. Kaiser Commission on Medicaid and the Uninsured, October 2011.

⁶⁴ Thirty-six states contract with MCOs. All states did not respond to this question.

Chapter 4: Georgia-specific Scan

State	Quality Factors Included in Auto-Assignment Algorithms		MCO Capitation Rate-Setting Methods and Pay-for-Performance Strategies				Public Reporting of MCO and PCCM Quality Reports
	Plan Quality Performance	Other Performance Measures	Capitation Withhold	Bonus	Shared Savings	Other	
Minnesota			X	X			X
Missouri	X		X			X	X
Mississippi							
Nebraska	X						X
New Jersey							X
New Mexico			X				
Nevada							X
New York	X					X	X
North Carolina							X
Ohio	X	X		X			X
Oklahoma							X
Oregon							X
Pennsylvania	X			X			X
Rhode Island				X			X
South Carolina						X	X
Tennessee			X	X			X
Texas		X			X	X	X
Utah						X	X
Virginia							X
Vermont							X
Washington							X
Wisconsin			X	X		X	X
West Virginia							X
Total	9	5	12	10	1	6	36

2. Fee-for-Service Delivery System Program Features and Infrastructure

As noted above, some of Georgia’s Medicaid members who have the most complex needs receive care through the FFS delivery system. Among these are children in foster care, people who are dually eligible for Medicare and Medicaid, as well as people who are receiving long-term care (LTC) services (whether in an institution or in the community through a Home- and Community-based Services [HCBS] Waiver). These subpopulations are described briefly below.

Chapter 4: Georgia-specific Scan

Fee-for-Service Populations

Children in Foster Care

The Georgia Department of Human Services Division of Family and Children Services (DFCS) is responsible for assuring that children who cannot remain with their birth families be placed in safe and nurturing homes. DCH is responsible for coordinating the delivery of health care services for children in foster care. As of FY 2010, 26,845 children were in foster care in Georgia.⁶⁵

Children in foster care present unique challenges to Medicaid programs in delivering their health care services. Many children in foster care require care for chronic physical and behavioral health problems as well as psychosocial services. Providing the necessary services and coordinating care without duplicating services and efforts is challenging. Although they have these unique needs, they are managed through a delivery system that in many ways resembles that which was in place in the early 1990s – one in which they do not have access to care management.

Dual Eligibles

Dual eligibles are individuals who are eligible for and participating in both Medicaid and Medicare (i.e., dual eligibles). Medicare covers most of the acute care costs for dual eligibles; therefore, their average Medicaid PMPM costs are lower than that for non-dual eligibles who are aged, blind or disabled. (See Appendix I, Figures I.25 and I.26.)

Individuals Receiving Long-term Care and Home- and Community-based Services

At any given time, Georgia has approximately 26,000 individuals in a Skilled Nursing Facility (SNF). Reimbursement rates to SNFs have been held constant since 2006. However, SNFs are eligible for several add-on payments and, as a result, have been able to increase their revenues despite the constant rates. SNFs are eligible to receive add-on or incentive payments based on:

- Meeting minimum staffing requirements of 2.5 nurse hours per day per resident. Payment is based upon the SNF's self-reported data

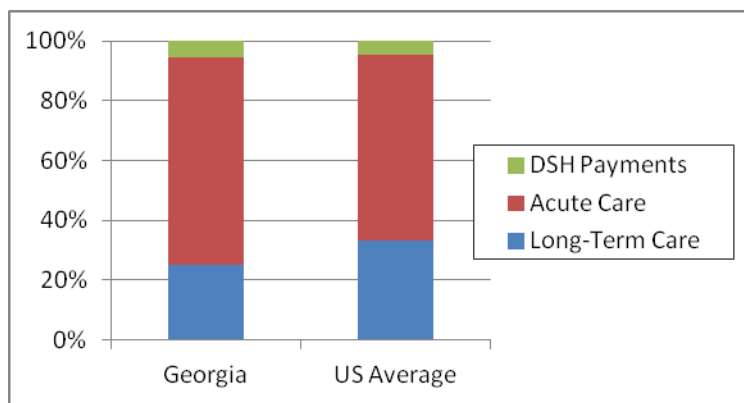
⁶⁵ SFY 2010 Data and Thomson Reuters Commissioners Reports.

Chapter 4: Georgia-specific Scan

- Having at least a minimum percentage of residents whose cognitive scores exceed an established level using a SNF-administered cognitive evaluation
- SNF-administered oral survey to seek residents' opinions regarding quality of care

Overall, Georgia already experiences lower-than-the-national-average Medicaid LTC expenditures despite the roughly equal elderly composition of the population as shown in Figure 4.18.

Figure 4.18: LTC as a percent of Total Medicaid Expenditure FY 2009⁶⁶



In FY 2009, Georgia spent 57 percent of total Medicaid LTC expenditures on nursing home care as compared to 42 percent for the United States. Also, Georgia spending for home and personal care was 37 percent of total spending, while the national average was 43 percent.

States have used HCBS waivers as an opportunity to move a greater portion of members needing LTC services into non-institutional settings as opposed to traditional nursing home facilities. Within the FFS delivery system, DCH provides administrative oversight of six HCBS waiver programs. Additionally, Service Options Using Resources in a Community Environment (SOURCE) is an enhanced primary care case management (EPCCM) program that provides services that are similar to HCBS waiver services. Figure 4.19 provides a high-level description of each of these programs.

⁶⁶ Kaiser State Health Facts.

Chapter 4: Georgia-specific Scan

Figure 4.19: Georgia’s HCBS Waiver Programs

HCBS Waiver	Description	No. of Members (SFY 2011) ⁶⁷
Community Care Service Programs (CCSP)	Provides services to people who are functionally impaired or disabled, helping members to remain in their own homes, the homes of caregivers or in other community settings as long as possible.	13,182
Georgia Pediatric Program (GAPP)	Provides services to medically fragile children with multiple system diagnoses. Services are provided in their homes and communities and in a ‘medical’ daycare setting as an alternative to placing children in a nursing care facility.	479
Independent Care Waiver Program	Offers services that help a limited number of adult Medicaid members with severe physical disabilities live in their own homes or in the community instead of a hospital or nursing facility.	1,767
Katie Beckett	Provides benefits to certain children 18 years of age or less who qualify as disabled individuals under §1614 of the Social Security Act and who live at home, rather than in an institution.	2,943
New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP)	Offers HCBS for people with mental retardation or developmental disabilities.	14,923
SOURCE	A program that utilizes selected features of an EPCCM program and serves individuals 65 years and older who have at least one chronic condition and are enrolled in Medicaid. Links primary medical care and case management with many referred providers of approved long-term health services in a person’s home or community to prevent hospital and nursing home care.	46,904

Based on interviews with DCH and sister agency staff, we identified a number of challenges with the current waiver delivery systems – challenges that are common to those identified in some other states. Georgia has multiple waiver programs, and the rules under which these programs operate vary. Some individuals could qualify for multiple waiver programs, which provide similar sets of services but that have differing service definitions. Each waiver may pay providers different rates for the same or similar service depending on the waiver under which treatment is being provided. Also, assessments are often provided by different agencies or

⁶⁷ All data, except KB, from SFY 2011 rpt for catherine.xlsx ; KB from 1- September 2011 Medicaid Sr Management Report.xls;

Chapter 4: Georgia-specific Scan

entities using or applying guidelines differently. Or, assessments may also be provided by the same agency that provides the waiver services. This is a practice that some states have begun to question due to the potential to introduce perverse incentives, particularly in the face of a downturned economy and fiscal pressures. Additionally, like many states, DCH relies on sister agencies to provide the day-to-day management of some of the waiver programs. This arrangement presents challenges, as DCH is the agency responsible for Medicaid program oversight and program funding; however, other agencies are managing and monitoring the programs.

Many studies have debated the cost-effectiveness of HCBS versus traditional nursing facilities; however, recent reports find that expansion of HCBS can cause a short-term increase in overall spending, followed by a reduction in institutional spending, netting long-term cost savings overall.⁶⁸ Traditional FFS delivery systems, like Georgia's, coupled with HCBS waiver programs that cap participation, typically offer little in the way of controls for reducing nursing home admission rates and the timeframe within which the member becomes eligible for nursing home care.

Georgia expanded member access to self-directed services via the Money Follows the Person program (MFP) which was implemented on September 1, 2008. Through partnerships with the Department of Human Services, the Department of Behavioral Health and Developmental Disabilities, the Department of Community Affairs and other state and local agencies and organizations, DCH's goal was to transition 1,558 individuals from institutional settings to the community. Based on data through June, 2011, the project has provided positive results. This includes Medicaid savings PMPM and happiness with living situations.⁶⁹ Georgia is currently developing a 1915(i) state plan amendment to provide community services to people with severe mental illness, which will allow MFP to add this group as a target population. Georgia is working to expand the availability of MFP-qualified housing options and has increased the number of rental vouchers.

Service Utilization and Quality of Care in the FFS Delivery System

As described above, Georgia Families is designed to provide members assurances regarding access to and quality of care and an infrastructure to support members in accessing care. Below, Georgia's FFS Medicaid delivery system is compared and contrasted to Georgia Families.

⁶⁸ <http://www.lhc.ca.gov/studies/activestudies/longtermcare/KayeAdditionalMay10.pdf>

⁶⁹ http://dch.georgia.gov/00/article/0,2086,31446711_131673936_158019816,00.html

Chapter 4: Georgia-specific Scan

- **Medical Home** – Members are not assured or required to have a medical home.
- **Member Assessment** – With the exception of individuals receiving LTC services, members are not subject to an assessment, nor is there a broad-based process for coordinating services to prevent duplication of services.
- **Provider Credentialing** – Every Medicaid provider is required to enroll with DCH, but Medicaid does not perform credentialing activities comparable to those required of the CMOs.
- **Provider Network Composition** – Any willing and qualified provider is permitted to participate in Medicaid, and Medicaid FFS members have the option to seek care with any of these providers. The federal Medicaid statute establishes a standard for access by requiring that Medicaid payments for covered care and services “are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area.”
- **Quality Measurement** – As with Georgia Families, DCH’s tracking of quality metrics for the FFS delivery system has been an evolving process. DCH has used its Georgia Families quality infrastructure as a foundation for building a more rigorous quality measurement process for FFS.⁷⁰

Based upon available data, there appears to be inappropriate utilization in the FFS delivery system and an opportunity for improvement. Cost savings achieved through reducing inpatient days are offset by the increasing trend in emergency department visits per member. While members have increased access to preventive services, quantifying the effects has been difficult using PMPM cost data. Utilization of preventive services has not yet been reflected in other utilization metrics such as emergency department visits.

DCH has experienced somewhat positive results in controlling avoidable admits and preventing readmissions among all Medicaid eligible members.⁷¹ Compared to 2009, avoidable

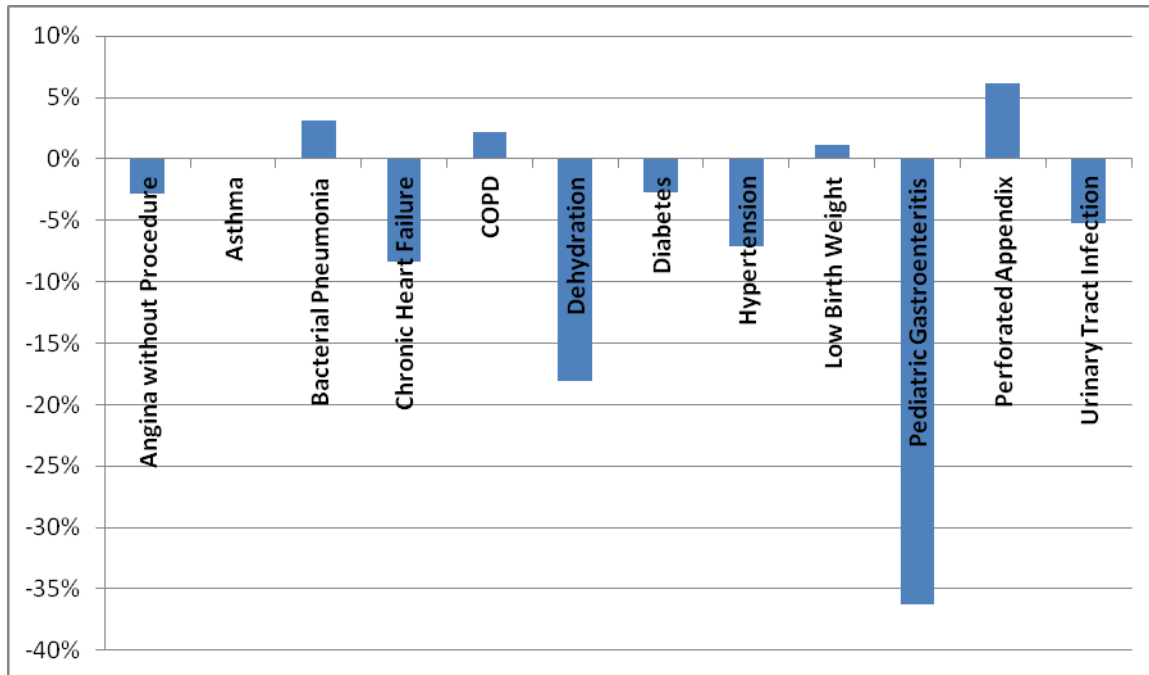
⁷⁰ In FFS, DCH’s chart reviews are conducted for an individual regardless of the duration for which that individual is continuously enrolled in the program. This differs from NCQA criteria, which require that an individual must be continuously enrolled in the health plan or program for at least a minimum number of months to be counted.

⁷¹ Note that the data source indicates “all eligible members”. Therefore, this data is not necessarily limited to the FFS population.

Chapter 4: Georgia-specific Scan

admissions in 2010 declined for 7 of the 12 conditions measured for avoidable admissions per 1,000 members. As a result, net expenditures on admissions considered avoidable declined by 4 percent year over year, saving \$5,900,000 versus 2009.⁷² Figure 20 shows the change in avoidable admissions per 1,000 members between 2009 and 2010.

Figure 4.20: Change in Avoidable Admits per 1,000 members between 2009 and 2010⁷³



DCH has taken a number of steps to try to improve the quality of care provided through the state Medicaid program, for example:

- Obtained Center for Medicare and Medicaid (CMS) approval for updates to Health Check (Georgia's Early Periodic Screening, Diagnosis, and Treatment [EPSDT] Program) to revise provider payment rates for screenings and immunizations.
- Aligned EPSDT periodicity schedules for the FFS populations with schedules for Georgia Families. Both programs' schedules now reflect industry standards using the American Academy of Pediatrics' 2008 Bright Futures Periodicity Schedules.

⁷² Avoidable Admissions Report Fiscal Year 2009 to 2011. Thomson Reuters provided this report to the Georgia DCH. Complete 2011 data was not available at the time of this report generation.

⁷³ Avoidable Admissions Report Fiscal Year 2009 to 2011. Thomson Reuters provided this report to the Georgia DCH. Complete 2011 data was not available at the time of this report generation.

Chapter 4: Georgia-specific Scan

Of the six core utilization measures the CMOs started reporting initially to DCH in 2008, overall improvements have been made in two of the six from 2008 to 2010 levels, while the results have been mixed for the other four. These utilization measures are HEDIS®-based performance measures reported annually and validated by DCH's External Quality Review Organization (EQRO). Positive patient behaviors related to these measures are known to have positive health effects in the long-term and lead to lower hospitalization rates and ED visits. While it is notable that DCH has, for these measures, compared FFS to Georgia Families experience, there are substantial data limitations that must also be noted:

- It is not possible to determine from the available data the extent to which Georgia Families led to increases or decreases in quality performance, or whether these rates were approximately the same for this population prior to the implementation of Georgia Families.
- A comparison of FFS to Georgia Families might, at first glance, appear to be useful. However, the dramatic differences in the underlying demographics and service needs of the Georgia Families and FFS populations make this comparison difficult to interpret. As HEDIS® rates are not risk-adjusted and we are unable to adjust for the higher risk of the FFS population and the resulting rates, we are not able to meaningfully compare the FFS rates to the CMO rates. The difference in the experience of these two delivery systems could be due to the underlying population differences, due to the different delivery systems, or due to a combination of the two. Unfortunately, there is no way to determine the precise cause with the data available.

Regardless of the limitations above, the slight increases in FFS performance on all of the measures seems to indicate that some improvements might have been achieved through DCH's recent efforts to improve quality of care for FFS members.

We encourage DCH to begin now to collect baseline data as it moves into its redesign, which will enable DCH to meaningfully assess the impacts of the selected design strategy.

Chapter 4: Georgia-specific Scan

3. Other Georgia Medicaid Initiatives

DCH has undertaken a variety of other initiatives to improve Medicaid program operations and quality. Some of the key initiatives are highlighted below.

- The DCH Medicaid Non-Emergency Transportation (NET) program provides transportation for eligible Medicaid members who need access to medical care or services. Starting in 1997, Georgia Medicaid contracted with a broker in each of five regions to administer and provide transportation services for eligible Medicaid members. The brokers are responsible for:
 1. Recruitment and contracts with transportation providers
 2. Payment administration
 3. Gatekeeping and verification of need
 4. Reservation and trip assignment
 5. Quality assurance
 6. Administration oversight and reporting
- Planning for Healthy Babies™ program, Georgia's family planning demonstration waiver created by the DCH, was developed to assist DCH in reducing the number of low birth weight and very low birth weight births in Georgia. This program offers family planning services for eligible women in Georgia and began in January 2011.
- DCH launched the Medicaid Electronic Health Record (EHR) incentive program in September 2011. This incentive program has paid out more than \$16.5 million to eligible Medicaid professionals and hospitals that have adopted EHRs.⁷⁴
- DCH implemented the Medicaid Management Information System (MMIS) on November 1, 2010 which is an integration of computer systems that work together to process Medicaid and PeachCare for Kids® claims and other pertinent information related to the management of the Medicaid and PeachCare for Kids® programs. DCH recently completed the certification process for the new MMIS and is expecting CMS approval.⁷⁵

⁷⁴ DCHNOW 12.5.11

⁷⁵ Medicaid Management Information System Implementation. Available Online: http://dch.georgia.gov/00/article/0,2086,31446711_152763481_152599191,00.html

Chapter 4: Georgia-specific Scan

- DCH also plans to launch an interagency Medicaid Eligibility system on January 1, 2014. The new system will provide more timely eligibility updates and more accurate information to vendors, providers and DCH staff. It will address identification verification, eligibility assessment and interagency information sharing.
- DCH has established its own quality enhancement group, known as the Performance, Quality and Outcomes (PQO) Unit. This unit has responsibility for oversight over many of the quality initiatives described above. Additionally, the PQO has coordinated a number of collaboration efforts with a variety of Georgia institutions, including the Georgia chapter of the American Academy of Pediatrics and the Georgia Academy of Family Physicians. Through these partnerships and others, the PQO has had the opportunity to gather best practices and unique insights related to eligibility issues for children, disability care practices and issues related to health care delivery in educational settings.
- DCH created the Strategic Quality Council, which had representation from various DCH business units including the Medicaid Division, the Office of Health Improvement, Public Health and the State Health Benefit Plan. This council spearheaded various quality improvement activities targeting statewide populations across payers. For example, in 2010, the group organized a statewide initiative to encourage blood pressure screening and education about the dangers of hypertension. Roughly 500 individuals participated in the “Know Your Numbers” Campaign.

4. Interview, Focus Group and Survey Findings

Navigant conducted 30 statewide focus groups in 12 locations throughout Georgia in addition to conducting interviews with DCH staff and sister agencies. Navigant also provided an online survey for completion by providers, consumers, advocates and vendors. In addition to the statewide focus groups listed in Figure 4.21, Navigant met with a Pediatric Task Force.

Chapter 4: Georgia-specific Scan

Figure 4.21: Focus Group Summary

Provider Type	No. of Focus Groups
Physicians	7*
Hospitals and EMS Providers	4
Behavioral Health Providers	3*
LTC, HCBS, Home Health Providers	4
Dentists	2
Pharmacy and Durable Medical Equipment (DME) Providers	2
Consumers and Consumer Advocates	4
Legislators	2
Georgia Families CMOs	1
Other Vendors Not Currently Contracted with DCH	1
TOTAL	30

* One focus group included both physicians and behavioral health professionals.

Common themes identified through interviews, focus groups and surveys are provided in Figure 4.22. Also, Figure 4.23 below outlines key findings that were specific to each provider type attending focus groups.

Chapter 4: Georgia-specific Scan

Figure 4.22: Common Themes Identified by Stakeholders

No.	Finding	DCH	Physician	Hospital	Behavioral Health	LTC, HCBS, Home Health	Rx/DME	Dental	Consumer/ Advocate
1	Patient non-compliance. This is a critical issue which has financial consequences for providers. It is hard to capture and win over this population due to multiple factors, such as reading level and mobility. Medicaid members do not have a financial stake so they are not incented to comply with treatment plans. There are no penalties when members do not keep appointments or do not comply with treatment protocols.	√	√	√		√	√	√	√
2	Standards of Care. CMOs do not follow the Medicaid FFS standards of care and sometimes use outdated guidelines (e.g., EPSDT for child screening). In addition, the delivery systems each use different standards of care resulting in procedures allowed under one CMO and disallowed under another CMO. There is not uniformity in the services/procedures that each CMO covers. Some CMOs also do not update coverage or pricing on drugs in a timely manner.		√	√	√	√	√	√	√
3	Inconsistency and lack of uniformity across different Medicaid delivery systems. The FFS system and each of the CMOs have their own policies and procedures leading to administrative burdens for providers. There is no consistency in credentialing, formularies, standards of care and prior authorization processes.	√	√	√	√	√	√	√	√
4	Pre-Authorization. Providers need pre-authorization for a large number of procedures and medications as pre-authorizations differ from CMO to CMO. Process is paper intensive and sometimes approval/denial decision takes a long time.		√	√	√	√	√	√	
5	Transportation. Transportation services are not dependable. There is no guarantee the patient will be picked up on time. Provider staff often spends 30 to 40 minutes on the phone to schedule transportation for a patient to ensure the patient will keep his/her scheduled appointment. Transportation is not available to behavioral health patients.	√	√	√	√	√	√		√

Chapter 4: Georgia-specific Scan

No.	Finding	DCH	Physician	Hospital	Behavioral Health	LTC, HCBS, Home Health	Rx/DME	Dental	Consumer/ Advocate
6	<p>Eligibility Determination and Re-certification.</p> <ul style="list-style-type: none"> Different eligibility periods – one month (Peachcare for Kids®), three months, six months – associated with different Medicaid programs cause confusion for Medicaid members and havoc for providers. Providers have difficulty receiving accurate member eligibility information. Establishing eligibility is time-consuming and frustrating for providers. On occasion, providers incorrectly receive notice that a Member is eligible and then claims are denied because the member was not eligible 	√	√	√	√	√	√	√	√
7	<p>Low Reimbursement Rates. Medicaid reimbursement rates are unreasonably low and declining. Low reimbursement rates and slow payments are significant disincentives to providers to accept Medicaid patients. Reimbursement rates vary across the different Medicaid systems.</p>		√	√	√	√	√	√	√
8	<p>Vendor Contracts and DCH Oversight.</p> <ul style="list-style-type: none"> DCH employees need to more effectively monitor vendor contracts and hold vendors accountable for meeting contract requirements and performance targets. Contract language is at times not as detailed as necessary making it more difficult for DCH to hold vendors accountable for performance. 		√	√	√	√	√	√	√
9	<p>Communications. Hewlett-Packard and CMO customer service are not responsive to providers’ and members’ questions and information needs. Providers and members are unclear which vendor to contact for specific information.</p>	√	√	√		√	√	√	√
10	<p>Provider Credentialing Process. Both DCH and CMOs are duplicating efforts related to provider credentialing and prior authorization processes. The process is not streamlined. It is cumbersome, varies from CMO, and is slow.</p>	√	√	√	√	√	√	√	

Chapter 4: Georgia-specific Scan

Figure 4.23: Key Findings by Provider Type

Focus Group	Finding
Physician	Assignment to a Primary Care Provider (PCP). Assigning Medicaid members to PCPs has helped but has not been implemented consistently or reasonably.
	Copayments. The copayment system that was scheduled to start in November 2011 and that is based on the cost of the visit is unreasonable because the provider’s office may not always know the cost of the visit ahead of time. <i>(Note: This copayment system is specific to PeachCare for Kids® and implementation is targeted for April 2012.)</i>
	Claims resolution/appeals process. Claim denial and repeal is common.
	Paperwork. Paperwork involved in system is overwhelming and costly. Practices have to hire more staff just to handle the paperwork.
	Coordination of care. No mechanism or process for coordination of care at the state system level. There is also no care management system for chronic conditions.
	Quality reviews. The quality review methodology CMOs use could be enhanced. It is currently based on the volume of prescriptions written without consideration of the disparity among providers in the number of Medicaid patients they see.
	Fraud and abuse. The Medicaid system is fraught with fraud and abuse on the part of Medicaid members. Some Medicaid members abuse the system by over utilization of the ER because it is easier for them as it does not require scheduling an appointment.
	Practice management. Practice management is highly complicated and costly because of the different procedures and fee schedules that need to be followed for each delivery system.
	CMO data completeness and quality. CMOs keep their own data and are unwilling to share it.
Hospitals / EMS providers	Access to care. There is limited or no access to services in areas where there was no access problem before implementing Georgia Families. Medicaid does not have enough specialists who participate in the program.
	Assignment to PCPs. Medicaid members do not always know their PCP.
	Claims resolution/appeals process. Among all insurers, Medicaid issues the highest percentage of denials
	Coordination of care. Coordination of care through case management is not being implemented, although it is a CMO requirement.
	Fraud and abuse. Current system does not focus on waste in the program. Some medical services that are covered are unnecessary.
	Burdensome and unnecessary provider requirements. Providers believe the following are burdensome – outlier process requires a lot of documentation, back transporting process, crossover payments and crossover audits.
	Audits. Larger hospitals can sustain a payback resulting from audits, but not small facilities.
	Current system outcomes. Providers have not seen any outcome reports or outcome data.

Chapter 4: Georgia-specific Scan

Focus Group	Finding
	CMO data completeness and quality. Reports CMOs provide are not accurate and therefore not reliable.
Behavioral Health	Limiting access to services. Fewer providers agree to participate in Medicaid because of low reimbursement rates, inconsistencies, etc.
	Coordination of care. Moving children from acute to residential facilities is a complicated and lengthy process that is not sensitive to the needed level of care.
	Transition of care. CMOs cover youth until the age of 19 but there is no plan of care after that age. After the age of 19 youth have to find services and coverage.
	Current system outcomes. It is difficult to measure outcomes because mental health services have multiple funding streams (DCH and DBHDD)
LTC, HCBS, Home Health	Communications and coordination with DFCS. No coordination between DCH and DFCS regarding co-insurance issues
	Quality of providers. Georgia has a large number of HCBS providers. However, the quality of some of these providers is questionable. The GACCP asked for a moratorium on enrolling new providers but federal regulations require open enrollment.
	Medicaid billing system. The Medicaid billing system is not user friendly and the vendor portal is very limited in what is reported in it.
Pharmacy/ DME	Inability to track DME. Computer systems do not track across providers for DME items or other equipment. Consequently, DME providers cannot check to see what type of DME was already provided to Medicaid members. Retrieving equipment given to Medicaid members on a long-term rental basis is typically not feasible in cases where eligibility was not renewed.
	Generic and brand name drug costs. The Medicaid system is not cost-efficient in the drugs it covers. According to a pharmacy provider, only 66 percent of drugs dispensed to Medicaid members are generic. Since 2006, the CMOs increased the use of brand name drugs. Some of the drugs that are approved for Medicaid members are the most expensive drugs because of arrangements that CMOs have with PBM companies.
	Auditing. The audits performed by DCH and the CMOs require an inordinate amount of time on the part of the pharmacy providers.
Dental	Limiting access to dental services. In 2007, the CMOs closed the dental networks except for specialists. The CMOs closed dentists' panels and terminated many dental providers from their networks. By closing networks and causing dental practices to close, many practices were flooded by Medicaid members and were losing money due to low reimbursement rates. Since the establishment of the Georgia Families, Georgia has fallen below the national average in the number of children receiving dental services.
	Copayments. Associating copayments with the amount charged for a procedure is burdensome because it results in copayments such as \$2.38, requiring providers to have change.
	Dental mobile vans versus brick and mortar practices. The operations of the dental vans, which increased their radius of operation, cause further confusion and duplication of services under the current delivery system. The dental mobile vans provide basic, mostly on-time treatment to Medicaid members and submit claims to the CMOs. When brick and mortar practices follow-up or treat Medicaid members that were seen by dental vans, the CMOs tend to refuse payments. Having patients being treated by multiple dental providers also makes it difficult to track the treatments that were already given and causes duplication of services.

Chapter 4: Georgia-specific Scan

Focus Group	Finding
Consumer/ Consumer Advocate	Communications between families and Medicaid. The communication between families and Medicaid is poor. Medicaid does not provide any information on what is available, how to get services, or about policy and program changes.
	Assignment to a PCP. It is not easy to find a PCP, especially in rural areas, who wants to treat Medicaid patients.
	Transition of care. There is no transition of care for children with developmental disabilities after they complete high school.

Chapter 4: Georgia-specific Scan

Navigant also conducted focus groups with vendors that are contracted with DCH and other organizations to determine what works well today with members they serve and what leading practices and innovative programs they believe would enhance the Georgia Medicaid program. Key themes raised by these focus group participants include the following:

- **Member eligibility redetermination process** should be extended from 6 months to 12 months. CMOs have difficulty delivering the quality of care if members are disenrolling within 6 months.
- **Transportation** is a major issue in Georgia, especially within rural areas, and needs to be addressed in the new model.
- **Member Incentives** should be incorporated into the redesign to incent and disincent certain member behaviors. Consider over the counter (OTC) benefits, completing health risk assessments, etc. as incentives.
- **Communication** to members needs to be enhanced. Currently, CMOs receive large amounts of returned mail. (One CMO has a 34 percent return mail rate).
- **Provider Incentives** (e.g., enhanced payments) should be incorporated in the new model to provide after hours care and handling urgent care.
- **Predictive modeling tools** should be considered in the new model. This enables CMOs to view the entire population to see what disease states need attention and appropriate interventions.
- **Data systems** should be evaluated. In a survey of 4,000 members, 78 percent said they receive their primary information through mobile phone and 95 percent of members said their primary contact was the Smart phone. Many health plans have similar results.⁷⁶
- **Performance Measures** need more predictability in terms of changes to measures, goals, performance targets and auto-assignments for CMOs.
- **Community outreach and education** needs to occur on an ongoing and continuous basis for the various programs. Other states have been outreaching to communities

⁷⁶ Contracted Vendor Focus Group, November, 2011

Chapter 4: Georgia-specific Scan

about what managed care is, the various programs, etc. This is especially important with the high turnover in the population.

- **Member satisfaction surveys** should be conducted at least two times per year to engage members and to find out what is working well and not working well. Incentives should be given to complete the surveys.
- **Standardization of forms**, as providers complain about the different forms from CMOs. Other states have standardized forms, and vendors are willing to adjust.
- **Reimbursement structures** that vary by geographic area should be considered.

C. Conclusions

The Georgia Medicaid program has made significant strides over the last decade. It has:

- Successfully implemented and then operated Georgia Families for five years, assuring a medical home, care coordination and other features that promote quality health care services for its members
- Developed its quality measurement infrastructure and is working to evolve its quality measurement and performance improvement processes
- Enhanced oversight and monitoring of CMOs' performance through the expansion and accreditation of HEDIS®-based performance measurement, demonstrated improvement through PIPs, and cross-state agency collaboration initiatives
- Planned for an eligibility system update which will address many of the current provider and member frustrations related to eligibility determination, program enrollment and service authorizations
- Progressed in its monitoring of vendors and sister agencies to make improvements in the administration of its HCBS waiver programs and to terminate vendors who were contracted to provide care management and disease management but which were not in compliance with their contract

As a purchaser, DCH has progressed by building infrastructure for quality management and contract monitoring. In other words, it has been establishing the building blocks to become a

Chapter 4: Georgia-specific Scan

more sophisticated purchaser. Often, Medicaid agencies evolve in this way. In the early evolutionary phases, they focus on building infrastructure, bringing up new programs and the like. For example, as most states do when they build a Medicaid managed care program for the first time, Georgia used a somewhat prescriptive approach to health plan contracting and monitoring, focusing primarily on how the CMOs are permitted to operate and not on member outcomes.

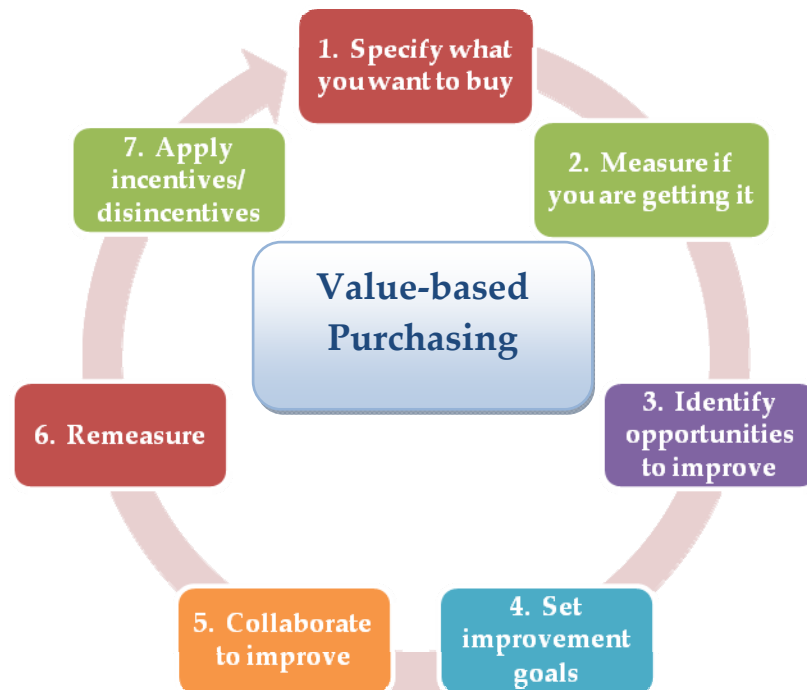
DCH is now primed to transition to the next evolutionary phase: becoming a **value-based purchaser**. Under a value-based purchasing model, the purchaser (i.e., DCH) stipulates what value the contractor would deliver in return for the purchaser's payment, and used in procurement establishes a firm foundation for contract monitoring. Used alone, clear contractual requirements and incentives are often not enough to obtain desired performance. Value-based purchasing is more than pay-for-performance (P4P), and requires active, ongoing purchaser oversight. Monitoring contracts under a value-based purchasing model shifts the focus from monitoring structures and processes to monitoring outcomes – or measuring the value of the services the State has purchased. We provide a graphical description of the Value-Based Purchasing Cycle™ in Figure 4.24 below.

Texas is an example of a state using value-based purchasing methods. MCO contracts include a provision that allows the State to withhold up to one percent of an MCO's performance-based at-risk capitation payments if the MCO does not meet performance measure targets. The State reallocates withheld funds to each of its managed care program's Quality Challenge Award to annually reward MCOs that demonstrate superior clinical, quality, service delivery, access to care and/or member satisfaction.⁷⁷

Collection, analysis and comparison of data about CMO performance supports value-based purchasing. Georgia has taken an initial step in implementation of value-based purchasing in Georgia Families by linking auto-assignment of members to the CMOs based on CMOs' performance on selected quality measures. In order for Georgia to progress to the next stage of evolution, it will need to employ more rigor around contract monitoring, oversight and accountability to achieve successful outcomes and assure value. Monitoring contracts under a value-based purchasing model shifts the focus from monitoring structures and processes to monitoring outcomes – or measuring the value of the services that Georgia has purchased.

⁷⁷Texas Health and Human Services. Managed Care Quality. http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/Medicaid/QualityBasedPaymentDocs/ManagedCareQualitySummary.pdf.

Figure 4.24: The Value-Based Purchasing Cycle⁷⁸



DCH is now ready to “take stock” and consider options for redesign. There are opportunities to improve quality of care for members, contain costs, and make budgets more predictable. When designing the new Medicaid programs and services, there are opportunities for Georgia to address some of the current provider and member frustrations. These include:

- Increasing communication among all stakeholders
- Reducing the administrative complexities and burdens for providers and members
- Standardizing, centralizing or streamlining appropriate processes and forms across the CMOs
- Increasing patient compliance through incentives and disincentives
- Increasing focus on health and wellness programs and preventive medicine

⁷⁸Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans: A Purchaser Guide, Joshua Slen, Michael Bailit and Marge Houy, *Published April 2010* http://www.bailit-health.com/articles/042810_bhp_scivaluebased_report.pdf

Chapter 4: Georgia-specific Scan

Other opportunities for improvement include:

- Tracking progress over time in achieving quality of care improvements using HEDIS® and HEDIS®-like measures, now that the infrastructure for doing so has been established
- Considering an approach to manage care for Georgia’s most expensive Medicaid members: those who are dually eligible and those who are aged, blind and disabled
- Considering short- and long-term plans for the use of technology including EHRs and telemedicine

Factors outside the control of DCH will also shape the future of Medicaid and PeachCare for Kids®. Health care reform may create significant change in the Georgia health care marketplace and in Georgia Medicaid and Georgia potentially faces major growth in Medicaid enrollment.

The physician shortage must also be considered in any redesign effort – both in terms of how the redesign itself can help to assure access for members despite the shortage and in terms of how the redesign might help to reduce physician workloads and incent physicians to participate in Medicaid and PeachCare for Kids®.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

This Chapter of the report presents redesign options and Navigant's recommendations for the future design strategy for the Medicaid and PeachCare for Kids® programs that offer the Georgia Department of Community Health (DCH) the greatest likelihood of achieving its goals and strategic requirements. We provide an overview of our approach to evaluating delivery system options below followed by a discussion of our evaluation of generic delivery system options, potential carve outs and carve ins for special populations and services and specific delivery system options. We end this Chapter with an overview of recommendations and next steps.

A. Overview of Approach to Evaluating Design Strategy Options

As addressed in prior Chapters, Georgia faces critical decisions regarding the shape of its planned Medicaid and PeachCare for Kids® design strategy. As evidenced by the discussion in the preceding Chapters, this decision cannot be made in a vacuum: it must account for a variety of factors (such as Georgia's health care market, DCH's experience and the resources it can bring to bear, the experiences of other states in implementing new delivery systems, etc.). Likewise, the decision must be based upon the relative likelihood that the redesign will enable Georgia to achieve its goals. Thus, a design strategy that is preferred by another state might not be the design strategy that is best suited for Georgia.

As also noted in prior Chapters, this Design Strategy Report is part of an extensive public process to evaluate options and select a Medicaid redesign approach for Georgia. Such a public process requires that the assessment of redesign options be conducted using an explicit approach, where redesign options are clearly described and evaluated and where the basis for the assessment's conclusions are detailed and clear to the reader.

Thus, for our evaluation, Navigant has used a modified version of the Kepner-Tregoe decision-making method. The Kepner-Tregoe decision-making method is a helpful tool in strategic decision-making. It is a conscious, step-by-step approach for systematically solving problems. It helps evaluators to maximize critical thinking skills, organize and prioritize information, set objectives, evaluate alternatives and analyze impact.¹ The Kepner-Tregoe method incorporates the following steps when approaching an analysis:

¹ Kepner-Tregoe Matrix, Decision-making Method Framework Tool. Available at http://www.valuebasedmanagement.net/methods_kepner-tregoe_matrix.html; Kepner-Tregoe Matrix. Available at http://www.12manage.com/methods_kepner-tregoe_matrix.html.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

- Establishes a decision statement which integrates both an action and a result component
- Defines requirements and/or goals
- Ranks requirements/goals and assigns a relative weight value to each
- Generates alternatives (i.e., options)
- Designates a relative score for each alternative on a goal-by-goal basis
- Calculates a weighted score for each alternative and identifies the top two or three alternatives
- Selects a final single choice from among the top alternatives

The Kepner-Tregoe analysis assists with unbiased decision-making by ranking all critical decision factors. As such, it limits conscious and unconscious biases that tend to result in decisions that may be out of line with established goals. The Kepner-Tregoe methodology comprehensively evaluates alternative courses of action to optimize the ultimate results based on explicit goals.²

The primary strength of this model is that it forces the decision-making and prioritization process. Moreover, this assessment approach is useful for evaluation of qualitative, or subjective, measures as well as quantitative measures. As illustrated later in this Chapter, the Kepner-Tregoe model presents the evaluation using a summary table which explicitly details the scores that form the basis of the evaluation.

The success of any assessment based on the Kepner-Tregoe methodology depends, however, upon the identification of the organization's goals. If the assessment relies upon a complete and accurate set of goals and weights are properly assigned to those goals, then a Kepner-Tregoe style assessment will be meaningful and will enable the organization to select the course of action that is most likely to enable the organization to achieve its goals. If, however, the goals are not complete and accurate with properly assigned weights, then the Kepner-Tregoe style assessment will not point the organization toward the "right" course of action. Likewise, changes to the goals or their weights will change the findings. For these reasons, it is essential

² Kepner-Tregoe Matrix. Available at http://www.12manage.com/methods_kepner-tregoe_matrix.html.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

that the organization spend sufficient effort considering the goals that it uses to build the Kepner-Tregoe model; to make sure that the goals reflected in the assessment clearly reflect the priorities of the organization.

B. The Department of Community Health’s Design Strategy Goals and Strategic Requirements

The goals for the future design strategy serve as the foundation for developing recommended redesign options: each delivery system option is evaluated based on the likelihood with which it would enable Georgia to achieve the goals. The redesign options vary in the degree to which they address each of the goals and represent a change from the status quo.

Navigant requested that DCH identify and achieve consensus regarding its goals for the future design strategy. In addition to the goals, DCH identified strategic requirements that must be employed for achieving the identified goals. DCH vetted its proposed goals and strategic requirements internally and with the DCH Board and with Governor Nathan Deal, followed by a public input process through posting of the goals and strategic requirements on the DCH website and discussion at other key provider and stakeholder forums. We requested that DCH assign each goal and strategic requirement a relative weight, depending on its relative importance and priority, as determined by DCH. DCH weighted the goals and strategic requirements separately. Each goal and strategic requirement, including the related assigned weights, is presented in Figures 5.1 and 5.2 below:

Figure 5.1: DCH Program Goals for the Future Design Strategy

Goal	Weight	Rationale
1. Enhance appropriate use of services by members	33%	Appropriate use of services will decrease inappropriate utilization, improve outcomes and decrease costs.
2. Achieve long-term sustainable savings in services	33%	Medicaid is one of the most expensive public programs in Georgia. Given limited budgets in a challenging economy, the State must have a Design Solution that is cost-efficient and has budget predictability.
3. Improve health care outcomes for members	34%	Improving health care outcomes for members is part of DCH’s mission for the Medicaid program. Healthier individuals will have more productive lives and may lead to decreased program costs.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.2: DCH Strategic Requirements for the Future Design Strategy

Strategic Requirement	Weight	Rationale
1. Gain administrative efficiencies to become a more attractive payer for providers	20%	Developing a program that decreases administrative burden for providers may help to attract more provider participation and increase access.
2. Ensure timely and appropriate access to care for members within a reasonable geographic area	20%	Access to care for members will help to improve health outcomes.
3. Ensure operational feasibility from a fiscal and administrative oversight perspective	20%	Given limited budgets in a challenging economy, the State must have a design strategy that is cost-efficient and has budget predictability. Additionally, the design strategy must be one for which DCH can appropriately operate and provide a sufficient level of oversight.
4. Align reimbursement with patient outcomes and quality versus volume of services	18%	Given limited budgets in a challenging economy, the State must have a design strategy that incorporates payment reform so as to be cost-efficient and have budget predictability while also improving outcomes and quality.
5. Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%	Implementing a design strategy that incorporates member responsibility may help to decrease inappropriate utilization, improve outcomes and decrease costs.
6. Develop a scalable solution to accommodate potential changes in member populations, as well as potential changes in legislative and regulatory policies	4%	Given potential implementation of the Affordable Care Act (ACA) and the significant number of new lives Georgia would cover due to Medicaid expansion, the design strategy must be able to accommodate new membership.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Assigning weights is a critical component of our evaluation. Higher priority goals and strategic requirements carry more weight in the overall rating of an option. Re-weighting of the goals and strategic requirements may result in a different set of scores for each option and thus, the selection of different options.

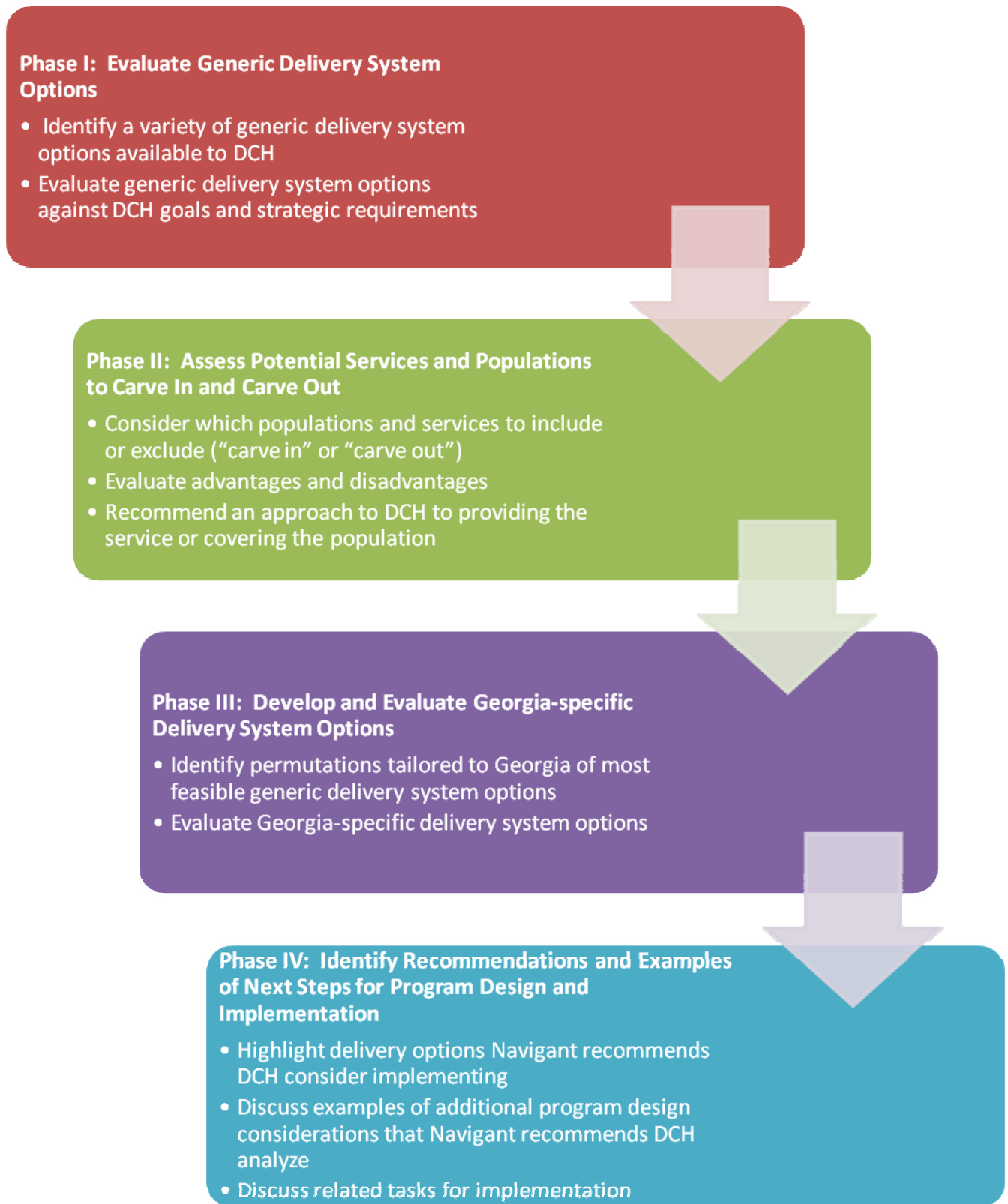
C. Multi-phased Evaluation

As noted above, the assessment of redesign options is complex and must account for many factors. It also must include a wide range of redesign options. As with any Medicaid program, many potential changes could be considered, some of which would have a far-reaching effect, and some of which are smaller in scale. The options considered in this report are focused on the macro level; they do not address every aspect of the Medicaid program. Furthermore, this report is deliberately focused on analysis of delivery system options that have a reasonable likelihood of effecting change given Georgia's and the nation's current economic and political environments. Because the scope of the assessment is so broad, Navigant has employed a multi-phased assessment to evaluate redesign options. These phases are outlined in Figure 5.3

This report is the first in a series of steps DCH must take to fully develop a new design strategy. Navigant's recommendations outline a general framework for the redesign. Once DCH selects a delivery system option to implement and decides which populations and services to carve in or carve out, DCH will then need to conduct a planning process to further define all key design and programmatic features of the design strategy, such as the specification of any vendor responsibilities, provider network requirements, etc. During this planning process, DCH should consider its approaches to developing a federal waiver application, if needed, procurement of key vendors and modification of other vendors' contracts to accommodate the design strategy.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.3. Overview of Multi-Phased Process to Evaluate Potential Redesign Options



Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Phase I: Evaluate Generic Delivery System Options

The first step in our analysis was to identify for consideration a range of generic delivery system options that vary in terms of how comprehensively they are managed. As introduced and described in detail in *Chapter 3, National Environmental Scan*, delivery systems can be placed on a spectrum in terms of the degree to which they comprehensively manage care. Figure 5.4 provides a spectrum of commonly discussed delivery systems for Medicaid programs.

At the left side, traditional fee-for-service (FFS) implies low or no care management or care coordination and potentially more unnecessary service utilization and lower potential cost savings. Members may see any provider willing to accept Medicaid patients, and there is no explicit mechanism for measuring or ensuring access to care, quality care or containing costs.³ Moving across the continuum, states have more options for monitoring and improving key cost, quality and access indicators.

At the right side, full risk-based managed care implies a higher level of care management and care coordination, as well as potential for improved quality of care, reduced inappropriate utilization and cost savings. Through contracts, states can mandate that providers and contractors meet certain requirements designed to ensure access to care or to meet certain quality indicators. Contracts also allow for holding contractors and providers accountable for meeting performance standards and providing data sufficient to evaluate performance.⁴ States also have the added benefit of the incentives that capitation payments provide. Because of the structure of payments, MCOs have an incentive to control costs through better managing utilization of high-cost services. As a result, mandatory managed care has led to less reliance on emergency rooms and hospitals for patient care and to an increased reliance on primary care providers (PCPs).⁵ Additionally, more options are available for monitoring and improving quality of care. Federal rules require quality management for Medicaid managed care plans. Medicaid managed care plans are required to monitor service delivery and improve quality of services, state Medicaid agencies are required to monitor care and the Centers for Medicare and Medicaid Services (CMS) must monitor states' quality strategies.

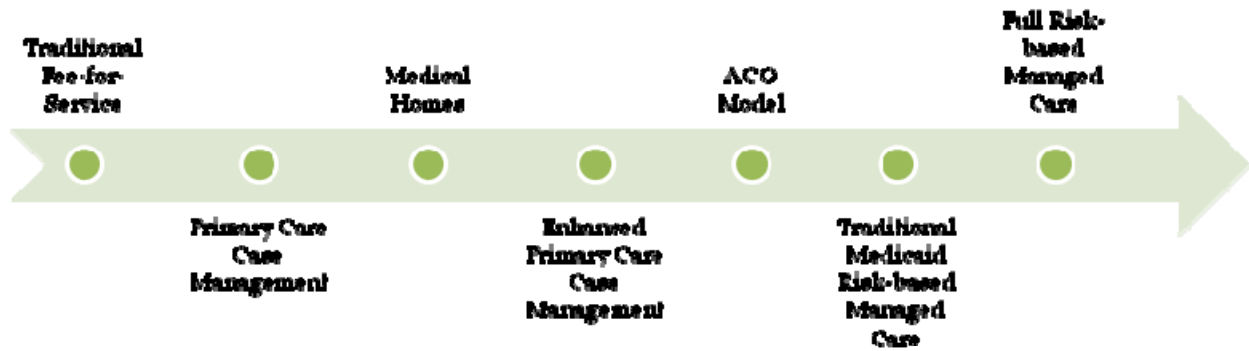
³ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010:A Summary From a 50 State Survey. September 2011.

⁴ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010:A Summary From a 50 State Survey. September 2011.

⁵ Stephen Zuckerman et al., Has Medicaid Managed Care Affected Beneficiary Access and Use?, 39 INQUIRY 221, 224, 234 (2002).

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.4: Spectrum of Delivery Systems – Least to Most Comprehensively Managed



For the Phase I evaluation, Navigant identified a variety of generic delivery system options that span the spectrum illustrated in Figure 5.4. Figure 5.5 provides a listing of the generic delivery system options that Navigant identified and evaluated, as well as a brief description and potential advantages and disadvantages of each option. Most of these options are described more extensively in *Chapter 3: National Environmental Scan*, along with examples of such programs operating in other states. Information about Georgia's current FFS and Georgia Families delivery systems can be found in *Chapter 4, Georgia-specific Environmental Scan*.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.5: Summary of Delivery System Options

Design Solution Option	Description	Key Advantages	Key Disadvantages
<p>Option 1: Current Delivery Systems: Fee-for-Service (FFS) and Georgia Families</p>	<ul style="list-style-type: none"> • Maintains the “status quo”: <ul style="list-style-type: none"> - Current FFS delivery system for currently-enrolled populations - Current mandatory risk-based managed care program, Georgia Families, for currently-enrolled populations • For Georgia Families, benefit package remains the same (i.e., transportation is carved out and all other services are carved in) 	<ul style="list-style-type: none"> • Infrastructure is already in place • Providers, members and other stakeholders are familiar with the current delivery systems • Georgia Families is a capitated program, therefore provides budget predictability • Georgia Families provides opportunity for comprehensive care management for its enrollees • Georgia Families provides opportunity to hold providers accountable for performance 	<ul style="list-style-type: none"> • FFS delivery system does not allow for budget predictability • Does not provide access to care management for many members in the current FFS delivery system • Does not address costs of long-term care (LTC) population • Requires DCH to support two sets of administrative resources and processes: one to manage the FFS delivery system and one to manage Georgia Families. This duplication limits DCH’s potential to achieve efficiencies via Georgia Families. • Is viewed by providers as administratively burdensome given two delivery systems and three care management organizations (CMOs) with differing policies and processes for prior authorization, credentialing and billing • Georgia Families transportation carve out limits CMOs’ ability to promote member access and appropriate service use • Limits tools available for controlling and identifying fraud, waste and abuse in the FFS system, particularly for LTC and other services that are heavily used by individuals who are aged, blind and disabled (ABD) and foster children

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
<p>Option 2: Traditional Fee-for-Service (FFS) Delivery System</p>	<ul style="list-style-type: none"> All populations are served in a traditional FFS delivery system, which provides little or no care management Members are not served under a Primary Care Case Management (PCCM) or similar model. (Such models are considered separately below.) 	<ul style="list-style-type: none"> Infrastructure is already in place One delivery system results in less administrative burden for DCH One set of coverage policies, prior authorization, credentialing and billing processes would be attractive to providers 	<ul style="list-style-type: none"> Does not provide access to care management for many members Does not allow for budget predictability, as providers are paid on a FFS basis Does not control costs of LTC population Perpetuates any existing inappropriate service utilization Limits DCH’s ability to influence and improve quality Places burden of provider monitoring on DCH Limits tools available for controlling and identifying fraud, waste and abuse
<p>Option 3: Patient-Centered Medical Home Model (PCMH)</p>	<ul style="list-style-type: none"> Provider groups must be certified and enrolled in Medicaid as PCMHs based on recognition by an accrediting entity such as the National Committee for Quality Assurance (NCQA)⁶ and/or meeting other standards as defined by DCH⁷ Members may choose a PCMH in which to enroll to serve as their medical homes and would be assigned if they don’t select one Providers are paid on a FFS basis 	<ul style="list-style-type: none"> Provides teams of health care providers to attend to the whole scope of members’ health care needs including hands-on case and disease management Provides potential for improved quality and improved outcomes due to dedicated providers organized within one group Addresses inappropriate service utilization, which may have a positive impact on costs Addresses some administrative burden for providers who are in a PCMH 	<ul style="list-style-type: none"> Shortage of statewide PCMHs may force DCH to operate a second delivery system to cover populations and/or areas that do not have access to or are not covered by a PCMH Increase in number of statewide PCMHs may be slow due to a number of issues (e.g., start up costs, lack of certain provider types in certain geographic areas, lack of provider interest, etc.) PCMHs do not develop a network of providers; therefore, do not assure access

⁶ NCQA, Patient-centered Medical Home. <http://www.ncqa.org/tabid/631/Default.aspx>

⁷ DCH may could establish standards that require PCMHs to provide or coordinate a broader range of services than those typically coordinated by PCMHs as defined by NCQA.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
	<p>with some shared savings requirements</p> <ul style="list-style-type: none"> • PCMHs would provide primary care that is patient-centered and focused on evidence-based medicine, wellness and prevention, care management and care integration so that the “whole person” is managed • PCMHs must use information technology to assist in managing care and access (e.g. electronic health records) • There is no prime vendor; therefore, State contracts with and pays PCMHs and other providers directly 	<ul style="list-style-type: none"> • Generates potential cost savings through improved care management and if shared savings are incorporated into the model 	<p>to all provider types</p> <ul style="list-style-type: none"> • Depending upon composition of PCMH and its linkages to other providers, may not address needs of LTC population • PCMHs are not able to provide all services (e.g., inpatient hospital) thereby requiring other delivery system options for those services • Offers limited budget predictability, as providers are paid based on FFS basis • Places substantial staffing needs and administrative burden within DCH to conduct PCMH certification if DCH develops and uses its own standards, initiate provider contracts and provide oversight and monitoring of contracts (Note that some efficiencies could be gained if DCH accepts certification from a national certifying entity such as NCQA.) • Limits tools available for controlling and identifying fraud, waste and abuse

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
<p>Option 4: Enhanced Primary Care Case Management (EPCCM) Model</p>	<ul style="list-style-type: none"> • All populations are served in an EPCCM model, whereby providers are paid on a FFS basis • One contracted vendor statewide administers program • Provides case and disease management for members who meet criteria established in the vendor agreement (e.g., members with diabetes, asthma) • Vendor is responsible for member and PCP education and outreach • Vendor develops and maintains PCP network and specialist referral listing • PCPs enroll with Medicaid agency as a Medicaid provider and sign a PCP agreement with the State • State pays providers directly • Vendor agreement sets forth savings for which the vendor guarantees a portion of the covered population will achieve via more appropriate use of services; if guaranteed savings are not met, vendor pays a penalty to the State • Members may choose a PCP in which 	<ul style="list-style-type: none"> • Addresses some administrative burden on providers (e.g., one set of prior authorization criteria to follow) • Provides option for care management for members, including LTC population and others with chronic illnesses • Provides opportunity for vendor to share savings with PCPs, depending upon structure of financial arrangement between vendor and State • Addresses inappropriate service utilization • Delegates monitoring of network providers, and provides option to require vendor to implement monitoring efforts specific to fraud, waste and abuse 	<ul style="list-style-type: none"> • May require a waiver to mandate enrollment of certain populations and to implement guaranteed savings, for which approval time could delay implementation timelines⁸ • Offers limited budget predictability, as services are paid on a FFS basis • Limited ability for vendor to hold providers accountable for performance, as vendor does not contract directly with PCPs or non-PCP providers and the PCP agreement with the State is limited in scope • Does not traditionally develop a specialist network nor a network of other types of providers • For many members, case and disease management is typically operated out of the corporate office and is not fully integrated with the PCP office or medical home • Does not provide all services thereby limiting care management options for the whole person and requiring other delivery system options (e.g., transportation) • Limits DCH’s ability to hold vendor

⁸ See Chapter 3: National Environmental Scan for an overview of federal waivers.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
	to enroll to serve as their medical homes and would be assigned if they don’t select one		accountable for meeting quality and financial goals if vendor is not at full-risk and because vendor does not hold contracts with providers
Option 5: Accountable Care Organization (ACO) Model	<ul style="list-style-type: none"> • Each participating ACO would develop a network of doctors and hospitals to share responsibility for patient care • An ACO could be a hospital with employed physicians, a health system consisting of several hospitals and employed physicians, physician joint ventures, or multi-provider networks • ACOs would provide primary care, care management and care coordination • DCH would pay ACOs on a capitated basis • Depending upon Georgia insurance laws regarding ACOs, which are yet to be developed, ACOs might need to obtain a license to operate as an insurer 	<ul style="list-style-type: none"> • Provides option for care management for all populations in need, and particularly for those with chronic illnesses • May be better able to focus on improving health outcomes than a health plan, since the health plan must spend substantial resources on network development and maintenance • Provides an opportunity to improve quality and decrease costs due to leverage with providers • May have opportunity to manage the “whole person” due to linked information systems with network hospitals and providers • Delegates risk to and allows DCH to hold ACOs accountable for meeting quality and financial goals • For services the ACO is responsible for, risk-contracts provide incentives for ACOs to monitor for and identify fraud, waste and abuse 	<ul style="list-style-type: none"> • May not be a feasible statewide option if at least two ACOs are not willing to serve in every region, requiring other delivery system options • May not be able to provide all services thereby requiring other delivery system options • Is likely not to offer member choice in rural areas sufficient to meet CMS member choice requirements and may not be sufficient to provide statewide coverage for all Medicaid populations • Members are free to seek care from providers or hospitals outside of the ACO in which their providers participate without paying more⁹ • May be limited in ability to serve LTC populations if the ACO is not horizontally or vertically integrated to provide skilled nursing, home care and other community-based services • May be administratively burdensome for

⁹ Gold, Jenny. Kaiser Health News. FAQs on ACOs, Accountable Care Organizations, Explained. October 21, 2011. Available online: <http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx>.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
			<p>DCH to monitor the number of ACOs that may be required statewide and for non-ACO providers to handle billing and other requirements</p> <ul style="list-style-type: none"> • Insurance requirements for ACOs are not yet developed, and development and debate surrounding these might cause delays • Start-up costs are significant, and some providers may request financial assistance from the State to develop infrastructure • Newly structured ACOs may be refining their infrastructure and processes which may impact outcomes • Industry concerns, including providers, specific to antitrust and anti-fraud laws¹⁰

¹⁰ Gold, Jenny. Kaiser Health News. FAQs on ACOs, Accountable Care Organizations, Explained. October 21, 2011. Available online: <http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx>.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
<p>Option 6: Georgia Families Plus</p>	<p>Expands upon the current Georgia Families program by:</p> <ul style="list-style-type: none"> • Incorporating extensive value-based purchasing¹¹ • Further encouraging use of medical homes, for example, through PCMHs • Reducing administrative complexities and burdens for providers and members¹² • Increasing patient compliance through incentives and disincentives beyond those currently used in Georgia Families • Increasing focus on health and wellness programs and preventive medicine • Continuing to build upon current efforts to focus on quality • Carving in more services (e.g., transportation) and populations (e.g., individuals who are aged, blind and disabled) 	<ul style="list-style-type: none"> • Is a statewide option • Can build upon existing Georgia Families infrastructure • Providers and members in Georgia Families are familiar with managed care • Provides option for care management for LTC population and others with chronic illnesses • Has a variety of tools available to addresses inappropriate service utilization • Delegates provider monitoring and oversight to CMOs • Provider contracts provide ability for vendors to hold providers accountable for performance • Allows for budget predictability • Allows DCH to hold CMOs accountable for quality and financial outcomes • Full-risk contracts provide incentives for CMOs to monitor for and identify fraud, waste and abuse 	<ul style="list-style-type: none"> • Will require a waiver to mandate enrollment of certain populations, for which approval time could delay implementation timelines¹³ • Initiatives to encourage appropriate patient behavior may not be enforceable • Stakeholders who oppose Georgia Families may view this as a “tweak” to the current program¹⁴ • Administrative burden on DCH may be high initially due to development and implementation of a new contracting and monitoring approach and infrastructure for value-based purchasing and related learning curve

¹¹ See Chapter 4: Georgia-Specific Scan for a discussion about valued-based purchasing.

¹² See Chapter 4: Georgia-Specific Scan for a discussion of administrative concerns and burdens identified by providers and members.

¹³ See Chapter 3: National Environmental Scan for an overview of federal waivers.

¹⁴To emphasize the substantial differences from Georgia Families, DCH might wish to consider using a different name for this delivery system option.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
<p>Option 7: Health Savings Accounts (HSAs) with a High Deductible Plan</p>	<ul style="list-style-type: none"> Contract with health plans to provide Medicaid benefit packages that include a high deductible plan, HSAs and Healthy Rewards Accounts (HRAs)¹⁵ Some individuals would be subject to deductibles and copayments On behalf of each member, DCH would: <ul style="list-style-type: none"> Pay health insurance premium for the high deductible plan Deposit funds in an HSA to cover deductibles and copayments Deposit rewards (e.g., incentive payments) in HRAs of members who meet goals for healthy behaviors Members could use HRAs funds to purchase certain health care related services or items Remaining balances in HRAs and HSAs could be used in a shared savings model whereby members, upon leaving Medicaid or reaching end of benefit year, have option to 	<ul style="list-style-type: none"> May allow for some budget predictability, since health insurance premiums are paid prospectively Encourages member involvement and holds members accountable for managing their health benefits Exposes members to commercial health insurance market, thereby easing their transition into the commercial market if and when they enter that market May address inappropriate utilization (e.g., using the emergency department for primary care services) May encourage members to appropriately use preventive care and dental care, as in Indiana 	<ul style="list-style-type: none"> Will require an 1115 waiver for which approval time could delay implementation timelines, particularly since this model is largely untested in Medicaid¹⁶ CMS may not be willing to grant approval of this model for all Medicaid populations Challenging for some populations to manage their own benefits and requires focused and ongoing outreach and education to members which may be challenging for DCH May create perverse incentives for members to not seek care and may discourage use of preventive care (depending upon design and member incentives), which in the long-term may lead to use of more expensive treatments when chronic conditions are not well-managed Unless waived by CMS, entitlement would still exist (i.e., DCH would be responsible for payment of services if member exhausts available HSA funds) May be challenging to address scenarios

¹⁵ See Chapter 3: National Environmental Scan for a discussion about Healthy Rewards Accounts/Power Accounts.

¹⁶ See Chapter 3: National Environmental Scan for an overview of federal waivers.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
	<p>spend a portion of remaining funds on pre-approved items such as commercial health insurance premiums</p>		<p>where members have exhausted HRAs and do not make copayments</p> <ul style="list-style-type: none"> • May be administratively burdensome for DCH (e.g., tracking of premium and rewards payments to make into each account) • May pose additional risks for and challenges with controlling and identifying fraud, waste and abuse
<p>Option 8: “Commercial Style” Managed Care Program</p>	<ul style="list-style-type: none"> • Expands upon Option 6, Georgia Families Plus program, a full risk-based managed care program with value-based purchasing¹⁷ • Employs all levers and innovations typically used in commercial market, including incentives and, for some members, deductibles and copayments, to encourage members to be active participants in their health care and to comply with treatment plans • Establishes HRAs for members where rewards (e.g., incentive payments) are deposited for members who meet goals for healthy behaviors • Members could use HRAs funds to 	<ul style="list-style-type: none"> • Is a statewide option • Encourages member involvement and holds members accountable for managing their health benefits • Exposes members to commercial health insurance market, thereby easing their transition into the commercial market if and when they enter that market • Relative to traditional Medicaid managed care delivery systems, provides substantially greater opportunity to reduce inappropriate utilization (e.g., using the emergency department for primary care services) • Provider contracts allow for vendor to hold providers accountable for performance 	<ul style="list-style-type: none"> • Will require an 1115 waiver for which approval time could delay implementation timelines, particularly since this model is largely untested in Medicaid¹⁸ • CMS may not be willing to grant approval for all populations • Challenging for some populations to manage and requires focused and ongoing outreach and education to members which may be challenging for DCH • May be challenging to address scenarios where members have exhausted HRAs and do not make copayments • Cost-sharing requirements may create perverse incentives for members to not seek care, which may lead to use of more

¹⁷ See Chapter 4: Georgia-Specific Scan for a discussion about valued-based purchasing.

¹⁸ See Chapter 3: National Environmental Scan for an overview of federal waivers.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Design Solution Option	Description	Key Advantages	Key Disadvantages
	<p>purchase certain preapproved health care related services or items</p> <ul style="list-style-type: none"> Balances in HRAs could be used in a shared savings model whereby members, upon leaving Medicaid or reaching the end of the benefit year, have the option to spend a portion of remaining funds on pre-approved items such as commercial insurance premiums or health club memberships 	<ul style="list-style-type: none"> Allows for budget predictability Allows DCH to hold CMOs accountable for quality and financial outcomes Full-risk contracts provide incentives for CMOs to monitor for and identify fraud, waste and abuse 	<p>expensive treatments when chronic conditions are not well-managed</p>
<p>Option 9: Free Market Health Insurance Purchasing</p>	<ul style="list-style-type: none"> DCH would provide a credit to members for purchase of insurance through the free market DCH would not contract directly with health plans and would not process claims DCH would partner with the Department of Insurance to define the standard Medicaid benefit packages participating health plans must offer and certification requirements specific to Medicaid (e.g., covered benefits, provider network composition and reporting) DCH would contract with or serve as a choice counselor, helping members to select a health plan 	<ul style="list-style-type: none"> Is a statewide option Allows for budget predictability Might increase members' choice of insurers Depending upon which health plans participate and approach they use for contracting and payment, may encourage provider willingness to participate, thereby improving access to care Exposes members to commercial health insurance market, thereby easing their transition into the commercial market if and when they enter that market Requires very limited Medicaid administrative role and costs 	<ul style="list-style-type: none"> Depending upon budgeting and financing approach, will require 1115 global or demonstration waiver for which approval time could delay implementation CMS may not be willing to grant approval for all populations Limited to no ability to provide oversight of health plans, and members may lose the direct advocacy provided by DCH DCH may lose economies of scale and negotiating leverage which may lead to large annual increases in premiums, unless DCH limits the number of insurers May limit provider willingness to participate, thereby decreasing access to providers, depending upon which health plans participate and the approach for contracting and payment

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®




Design Solution Option	Description	Key Advantages	Key Disadvantages
			<ul style="list-style-type: none"> • May be challenging for some populations to manage and requires focused and ongoing outreach and education to members, which may be challenging for DCH • Limits tools available for controlling and identifying fraud, waste and abuse • Commercial market might not be amenable to designing benefit packages as comprehensive as Medicaid's (e.g., including EPSDT services), and, so, DCH might need to cover wrap-around services • Approach to operationalizing this model is most simple in a Health Insurance Exchange infrastructure and will be more administratively burdensome if there is no Exchange

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Next, we evaluate the various generic delivery system options outlined in Figure 5.5. This evaluation assesses the relative likelihood that each option would enable DCH to achieve its identified goals and strategic requirements for the new design strategy for the Medicaid and PeachCare for Kids® programs. Scoring is based on our perspective and understanding of each generic delivery system. Each option must be a statewide solution that provides member choice and that DCH can begin to implement in 2014. This assessment is strictly limited to the generic delivery system options assuming they are effectively implemented and operated, and these options are defined at the macro level without consideration of some of the more intricate features of program design. We later evaluate some of those features for permutations of delivery system options determined to be most feasible for Georgia. Those options with the highest total scores have the greatest likelihood of enabling DCH to achieve its goals for the Medicaid and PeachCare for Kids® programs.

Figure 5.6 presents an assessment of generic delivery system options using a modified Kepner-Tregoe decision-making method. A weight, or percentage, is assigned to each goal and strategic requirement. For each goal and strategic requirement, a score ranging from 1 to 9 is given to each option, where 9 represents the greatest likelihood of the option achieving that goal and strategic requirement, relative to all other options, and 1 the lowest. A total score is then calculated for each option. Those options with the highest total scores have the greatest likelihood of enabling DCH to achieve its goals and strategic requirements for the Medicaid and PeachCare for Kids® programs.

For ease of use, the assessment in Figure 5.6 relies upon a stoplight model, whereby each option is rated based on the likelihood that it will enable DCH to achieve each of the goals and strategic requirements defined by DCH using the following color-coded format:

Key	
	High likelihood that the Option will meet Goals or Strategies (raw score 7-9)
	Moderate likelihood that the Option will meet Goals or Strategies (raw score 4-6)
	Low likelihood that the Option will meet Goals or Strategies (raw score 1-3)

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.6: Phase I Assessment of Generic Delivery System Options for the Medicaid and PeachCare for Kids® Design Strategy¹⁹

Likelihood that the Option will...	Wt.	Option 1: Current Delivery System	Option 2: FFS	Option 3: PCMH	Option 4: EPCCM	Option 5: ACO Model	Option 6: Georgia Families Plus	Option 7: HSA with High Deductible Plan	Option 8: "Commercial Style" Managed Care	Option 9: Free Market Purchasing
Goals										
Enhance appropriate use of services by members	33%	●	●	●	●	●	●	●	●	●
Achieve long-term sustainable savings in services for members	33%	●	●	●	●	●	●	●	●	●
Improve health care outcomes for members	34%	●	●	●	●	●	●	●	●	●
Strategies for Medicaid and PeachCare for Kids® Redesign										
Gain administrative efficiencies to become a more attractive payer for providers	20%	●	●	●	●	●	●	●	●	●
Ensure timely and appropriate access to care for members within a reasonable geographic area	20%	●	●	●	●	●	●	●	●	●
Ensure operational feasibility from a fiscal oversight and administrative perspective	20%	●	●	●	●	●	●	●	●	●
Align reimbursement with patient outcomes and quality versus volume of services delivered	18%	●	●	●	●	●	●	●	●	●
Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%	●	●	●	●	●	●	●	●	●
Develop a scalable solution to accommodate potential changes in member populations as well as potential changes in legislative and regulatory policies	4%	●	●	●	●	●	●	●	●	●
Weighted Average Score		3.8	2.0	4.8	4.7	4.8	7.2	4.6	8.2	6.0

¹⁹ As DCH refines the design strategy through ongoing planning, it may wish to revisit the individual scores. This initial scoring of options is a tool to help inform DCH's decision-making and provides a framework for conducting a rational decision-making process.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Based on the above assessment, the generic delivery system options that received the highest weighted evaluation scores and are most likely to enable DCH to achieve its goals and strategic requirements are:

- Option 6: Georgia Families Plus
- Option 8: "Commercial Style" Managed Care
- Option 9: Free Market Health Insurance Purchasing

The next phase in our analysis, Phase II, evaluates various populations and services which DCH should consider including in its selected delivery system. We follow that analysis with an assessment in Phase III of various permutations specific to Georgia of the generic delivery systems identified as having the most potential for achieving DCH's goals.

Phase II: Evaluation of Potential Carve Outs and Carve Ins for Special Populations and Services

Key to considering any design strategy for the Medicaid and PeachCare for Kids® programs is determining which populations and services to include or exclude in the selected delivery system. As outlined in *Chapter 3: National Environmental Scan*, states have employed a wide variety of approaches to handle special populations and services in Medicaid managed care and other Medicaid care management systems. For example, some states offer comprehensive benefit packages that cover most services while others carve out particular services, such as behavioral health, and provide those through other delivery systems. Similarly, populations may also be included or excluded.

More recent developments seem to indicate a trend toward including historically carved out populations and services in Medicaid managed care. This trend might be explained by increasing budgetary pressures and by states' collective wealth of experience designing and operating Medicaid managed care programs. For example, in a recent Kaiser study, 27 states reported plans to implement Medicaid managed care programs "to a greater extent." Six states report plans to mandate managed care enrollment for additional Medicaid populations, such as individuals who are aged, blind and disabled, and others, including New Jersey, Texas and West Virginia reported that they are considering carving in additional services (e.g., behavioral health services, dental benefits and pharmacy).²⁰

²⁰ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Phase II of our evaluation assesses special populations and services that we have identified as warranting particular consideration in the development of a new design strategy for Georgia.

Assessment of Special Populations and Services

Figure 5.7 below provides a listing of the special populations and services for which we assess the advantages and disadvantages of carving in or out of a new delivery system.

Figure 5.7. Special Populations and Services

Populations	Services
<ul style="list-style-type: none">• People using behavioral health services• People using LTC services• People using home- and community-based waiver services• People who are dually eligible for Medicaid and Medicare• Children who are in foster care	<ul style="list-style-type: none">• Behavioral health services• LTC services• Home- and community-based waiver services• Dental services• Transportation services• Pharmacy services

Navigant recommends that DCH carve in all of the above-identified populations and services. In the following narrative, we briefly discuss issues specific to each population and service, overarching themes that support carving in each and also opportunities identified specific to each. We encourage readers to see *Appendices L through Q* as part of their review of Phase II. In these appendices, we more fully discuss our rationale, including advantages and disadvantages of various approaches to carving each of these populations and services in or out of a new delivery system.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Behavioral Health

Over half of all Medicaid members with disabilities are diagnosed with a mental illness. People with a mental illness or addiction are likely to have co-occurring physical health problems, many with chronic conditions. Individuals with co-occurring mental illness and chronic conditions have more preventable hospital admissions due to non-compliance with medication and treatment plans resulting in significant costs that could be saved through better care coordination using a specialty team approach.²¹ Industry guidance confirms that behavioral health issues impact physical health outcomes and significantly increase cost of physical health care, especially for chronic diseases.

Given the high rates of co-occurrence, many efforts are underway to integrate provision of physical and behavioral health services. Various methods are being implemented to achieve this integration, for example, “co-locating physical and behavioral health services in a single clinic; linking clinical information systems; training providers in interdisciplinary practice; and restructuring financial incentives to include risk-sharing arrangements or cross-care. There are also many benefits to be considered in serving members through one delivery system so as to enhance care management opportunities for the whole person. Efforts to implement these strategies have met varying levels of success, stymied by difficulty navigating information-sharing regulations, cultural norms among providers and competing priorities.”²²

In many state Medicaid programs, physical health and behavioral health services are administered through separate delivery systems and by different offices, which has been found to present significant challenges in coordination of care and care management. Currently, behavioral health is carved in to Georgia Families, and DCH provides behavioral health services through its FFS delivery system for individuals who are not enrolled in Georgia Families. Services for individuals in the FFS delivery system are managed by the Department of Behavioral Health and Developmental Disabilities. The State as a whole has behavioral health provider access issues. Georgia is the ninth largest state but is near the bottom of all states for behavioral health provider availability.

²¹ MHPA Presentation: PsychoSocial Impact on Health: Controlling the Rising Costs of the Chronically Ill. Dr. Sam Toney, CMO, Health Integrated. November 7, 11.

²² The Kaiser Commission on Medicaid and the Uninsured. Mental Health Financing in the United States. April 2011.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Long-term Care

DCH currently provides LTC²³ services through the FFS delivery system, and serves dual eligibles as well as individuals who are enrolled in Home- and Community-based services (HCBS) waivers and the SOURCE program through this system. While DCH is the administering agency specific to Medicaid, some of these services and populations are managed by the Department of Behavioral Health and Developmental Disabilities or other offices. Georgia also has a Money Follows the Person program that began in September 2008 as a joint effort between DCH, the Department of Behavioral Health and Developmental Disabilities the Georgia Department of Human Services' Division of Aging Services (DHS/DAS) and other state and local agencies and organizations.

The rebalancing of the LTC system to rely upon HCBS services wherever possible has gained much support, as evidenced by the large number of HCBS waivers currently operated by the states and by the opportunities available to states via the Affordable Care Act. As outlined in the national debate, there are many challenges with the delivery systems typically used by Medicaid programs for long-term care. The challenges with integration of care are further aggravated for enrollees who are dually eligible for Medicare and Medicaid (i.e., dual eligibles). Similar findings and concerns have been noted by others and commonly discussed in the literature and among policy makers and program administrators. It is these concerns which led CMS to launch several recent initiatives to integrate financing and care for dual eligibles through its Medicare-Medicaid Coordination Office and Center for Medicare and Medicaid Innovation.

Last year, U.S. Health and Human Services Secretary Kathleen Sebelius encouraged the expansion of managed care to high-cost enrollees who use LTC services and supports in a [letter](#) to the nation's governors, encouraged states to expand managed care: "Just one percent of all Medicaid beneficiaries account for 25 percent of all expenditures," she wrote, noting that states don't need any special permission from Washington to cut costs by creating "initiatives that integrate acute and LTC, strengthen systems for providing LTC to people in the community, provide better primary and preventive care for children with significant health care needs..."²⁴

²³ For the purposes of this report, the term managed long-term care (LTC) is used. It is intended to be inclusive of long-term services and supports (MLTSS).

²⁴ Stateline, Crushed by Medicaid Costs, States Expand Managed Care. February 2011. Available at: <http://www.stateline.org/live/details/story?contentId=547640>.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Many others note the benefits of managing LTC supports and services. Because most LTC beneficiaries have multiple chronic medical conditions, they typically require a lot of medical services and acute care. Effective care management for people with chronic medical conditions can accomplish many tasks: preventing avoidable events; promoting early treatment to slow functional and cognitive decline; and fostering more effective disease management. To address the full complement of beneficiaries' needs, it will be important to implement strategies that more fully integrate LTC with the delivery of medical, mental health and social services.²⁵

Not surprisingly, potential challenges have been raised associated with managed LTC programs. MCOs reduce their financial risk by limiting the number of healthcare providers that members can see and by requiring these providers to accept a reduced fee for provision of care. This has created concern among Medicaid members that they will have limited ability to control their own care and decreased access to specialists.²⁶ States have struggled with establishing payment rates and pricing that will deliver shared savings to both the state and the MCO. It is also difficult to find MCOs that have LTC experience or are willing to expend the resources necessary to enter an entirely new coverage area.²⁷ Some health care providers have opposed Medicaid managed LTC out of fear that MCOs would not contract with them to provide care or would require them to accept deeply discounted fees.²⁸ There is not yet conclusive evidence that Medicaid managed LTC will reduce LTC costs over time, or increase the quality of services provided.²⁹ Moreover, some groups of enrollees, along with the providers who serve them and the advocates who represent them, have raised concerns about whether managed care delivery systems can truly meet their needs. Particularly vocal in these discussions have been people serving and representing people with developmental disabilities.

The most important take-away from the discussion about managed LTC is that covering the full scope of services for any individual offers the greatest chance for care integration and, in turn, improvements in appropriate service use and cost-effectiveness. This can be achieved via two approaches:

²⁵ United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term. April 2009.

²⁶ National Consortium for Health System Development, Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants. Available at: http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf.

²⁷ National Consortium for Health System Development, Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants. Available at: http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf.

²⁸ National Consortium for Health System Development, Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants. Available at: http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf.

²⁹ National Consortium for Health System Development, Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants. Available at: http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

- A LTC carve in to cover the full scope of acute and LTC services for all eligibility categories
- A LTC carve out to cover the full scope of acute and LTC services for specified eligibility categories

The results of the Georgia-specific scan outlined in *Chapter 4, Georgia-specific Scan* indicate that the first of these options is likely to be preferable for Georgia because, relative to the second, such a model poses a greater likelihood of enabling Georgia to achieve its goals. Carving in services poses a lesser administrative burden on providers so is more likely to be a more attractive payer for providers, and on DCH so is more likely to achieve operational feasibility from a fiscal and administrative oversight perspective.

Children in Foster Care

Children in foster care present unique challenges to Medicaid programs in delivering their health care services. Many children in foster care require care for chronic physical and behavioral health problems as well as psychosocial services; providing the necessary services and coordinating care without duplicating services and efforts is challenging. As discussed in our national scan, another challenge of managing children in foster care is their environmental instability. Care is at times disjointed and sporadic because these children are moved throughout the state and are in a variety of different custody arrangements. Shifting guardianship from birth parents, foster parents, guardians or adoptive families makes it difficult to coordinate necessary health care services, screenings and follow-ups. There is no central repository for their records. Lack of coordination between physical health and behavior health providers as well as state agencies intensifies these issues.

The Georgia Department of Human Services Division of Family and Children Services (DFCS) is responsible for assuring that children who cannot remain with their birth families be placed in safe and nurturing homes. DCH is responsible for coordinating the delivery of health care services for children in foster care. As of fiscal year (FY) 2010, 26,845 children were in foster care in Georgia.³⁰ Children in Georgia's foster care system receive health care services through Georgia's Medicaid FFS delivery system.

Children are at risk for duplication of care management and services if DFCS case workers do not have results from medical and behavioral health evaluations to meet court system due dates

³⁰ SFY 2010 Data and Thomson Reuters Commissioners Reports.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

and requirements. Due to the current eligibility guidelines, children may transition from FFS to Georgia Families and back again based on moving in and out of foster care. At times, providers are not reimbursed because case workers refer to providers who are not in a CMO's network while the child is still enrolled with a CMO. Consequently, DFCS and DJJ reimburse the provider out of a separate fund. This leads to unnecessary and duplicative payments.

Any managed care program must meet the unique needs of children in foster care. Screenings and assessments for physical, behavioral and oral health must be included in standard Medicaid managed care contracts.

Dental Services

Access to and utilization of dental care are among the most chronic challenges for Medicaid programs nationally, and children in families with low incomes have higher rates of dental caries. Nationally, children's access to dental services in Medicaid and Children's Health Insurance Programs (CHIPs) has improved since 2000. Approximately 40 percent of children received a dental service in federal fiscal year 2009 compared with 27 percent of children in 2000.³¹ The three most common reasons that dentists give for not participating in Medicaid are low reimbursement rates, administrative burden and patient behavior.³² In addition, the dental workforce has been decreasing creating even more challenges for Medicaid populations.

Dental care is the benefit most commonly carved out of Medicaid managed care contracts. Of states that have managed care programs and participated in a recent Kaiser survey, 25 reported carving out dental services and 5 of these states contract with a pre-paid health plan to administer the benefit.³³ However, some states have had successes in contracting with managed care plans or dental benefit administrators – they may have more opportunities to conduct initiatives that states would be more limited in conducting through FFS delivery systems.

DCH carved in the dental benefit for Georgia Families, and provides the benefit through the FFS delivery system for all other populations. Under Georgia Families, adult members may receive benefits in addition to those provided under the FFS delivery system, depending on the CMO in which they are enrolled.

³¹ The Department of Health and Human Services Children's Health Insurance Program Reauthorization Act, 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP. 2011.

³² Borchgrevink, A., Snyder, A., and Geshan, S. The Effects of Medicaid Reimbursement Rates on Access to Dental Care. National Academy for State Health Policy. March 2008.
http://nashp.org/sites/default/files/CHCF_dental_rates.pdf?q=Files/CHCF_dental_rates.pdf

³³ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Non-emergency Transportation Services

Historically, states have delivered non-emergency medical transportation (NET) services on a FFS basis or through a brokerage arrangement. Of 36 states that responded to a recent Kaiser Commission study, almost half the states (17) with managed care delivery systems provide non-emergency transportation outside of their MCO contracts, usually on a FFS basis or through a brokerage arrangement.³⁴

Medicaid NET services are estimated to have cost Georgia almost \$80.9 million for FY 2010.³⁵ DCH has had a regional transportation brokerage system in place since 1997 for its Medicaid population. PeachCare for Kids® members are not served through this system, and some of the Georgia Families CMOs subcontract with a broker to provide their transportation. For the brokerage system, DCH contracts with brokers for each of five regions of the State. At the time of this report, DCH held contracts with three transportation brokers. However, DCH is in process of reprocurring these contracts.

DCH staff report that fraud and abuse was a problem prior to the brokerage program, but decreased after implementation leading to significant cost savings. The brokers are better able to serve the rural areas than when the program was administered internally; however, stakeholders indicated the brokerage programs continues to lack in the following areas: a availability of transportation, particularly in the Southeast region; member choice in brokers and DCH's negotiating power given one broker is contracted per region; ability of some of the current vendors to effectively manage the program. Stakeholder recommendations included considering a system that recognizes the point is not transportation in and of itself – the point is delivering comprehensive services that also help them to access the right level of care.

Pharmacy Services

States that contract with health plans for their Medicaid programs either include prescription drug coverage in the contract or carve out coverage and administer services through the FFS delivery system. Studies have shown that managed care delivery systems are able to provide “drug coverage in a more cost-effective manner than FFS delivery systems via formulary

³⁴ Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

³⁵ A Primer on Rural and Human Services Transportation in Georgia. Prepared for the Governor's Office of Planning and Budget. Governor's Developmental Council and the Georgia Coordinating Council for Rural and Human Services Transportation. August 2011.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

management, high generic fill rates, comprehensive drug utilization, and coordination of care.”³⁶

In the past, some states chose to carve out coverage to qualify for the federal drug rebate program, for which drugs covered under MCO contracts did not qualify. Implementation of the ACA changes that program to allow states to collect federal drug rebates for prescription drugs reimbursed under capitated Medicaid managed care contracts. States that have carved out the benefit are now proposing or planning to carve pharmacy benefits into their managed care contracts given the ACA changes now allowing for collection of rebates. They report doing so “to improve coordination and integration of care”.

DCH carved in the prescription drug benefit for Georgia Families and provides the benefit through the FFS delivery system for all other populations. For the FFS delivery system, DCH has a contracted pharmacy benefit manager to help with administration of the program, including the preferred drug list. In federal fiscal year 2009, DCH spent \$270,276,141 (after rebates) for prescription drugs through the FFS delivery system.³⁷ On average, DCH's monthly payment for the first quarter of 2011 was \$41.6 million for an average of 418,957 eligibles per month.³⁸

One challenge that providers have noted is the administrative burden of having multiple formularies to manage when participating in the FFS delivery system and multiple CMOs within Georgia Families. One study finds that addressing this challenge through a carve out is the one “lone programmatic advantage of the carve out approach, but indicates it is “often over-emphasized given that physician practices must typically deal with dozens of drug coverage programs regardless as to how the Medicaid pharmacy benefit is administered.”³⁹

Potential Cost Savings by Population Associated with the Various Delivery Systems

³⁶ Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available at:

http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf

³⁷ Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available online:

http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf.

³⁸ Quarterly Utilization and Performance Review Report. SXC Health Solutions report to the Department of Community Health. May 10, 2011.

³⁹ The Lewin Group. Projected Impacts of Adopting a Pharmacy Carve In Approach Within Medicaid Capitation Programs. March 2011. Available online: http://www.mhpa.org/upload/MHPA_Paper_on_Pharmacy_Carve_In.pdf.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

One consideration when deciding which populations to carve in is the potential for achieving savings. Likewise, when selecting a delivery system, potential for savings is an important consideration. Thus, this section of Chapter 5, as well as *Appendix R*, present preliminary estimates of potential savings that could be achieved for various subgroups of Medicaid members through the implementation of the range of Medicaid delivery systems.

Because, at this time, the delivery system has not been clearly defined and due to other data limitations, Aon Hewitt Consulting (Aon Hewitt) considered for the purposes of Navigant's assessment, managed care savings estimates for state fiscal year (SFY) 2015 through SFY 2017 for members served by DCH who are not currently covered under managed care contracts. Aon Hewitt developed these projections using per member per month (PMPM) claim costs provided by DCH for several Medicaid subgroups. Detailed analyses are provided in *Appendix R*.

Aon Hewitt also notes that managed care savings for members who are using nursing home or HCBS are generally achieved by shifting the distribution of members by service setting so that more members receive services in the community and fewer receive them in the nursing home setting. Of course, this transition occurs over time, as members' nursing home admissions are delayed, so these savings will not be recognized immediately.

These savings estimates are preliminary and subject to change as the design strategy is refined and as additional data become available. They do, nonetheless, provide an indication of the general trend toward increased potential for savings as more rigorous care management is introduced. Navigant's evaluation of delivery system options in this Chapter reflect these trends in the scoring of the likelihood of each delivery system option to enable Georgia to achieve long-term sustainable savings in services, one of Georgia's goals for its design strategy. The ability of the State to recognize savings will depend upon the State's ability to successfully execute the selected delivery system; if the delivery system is not successfully executed, the savings will not accrue.

Conclusion

Based on our findings compared to the goals and strategies that DCH identified for its design strategy, Navigant recommends that DCH consider carving in to the selected delivery system all populations and services identified in this section. As DCH considers carving in each of these populations, DCH should give consideration throughout the decision-making and planning process about how the needs of these populations differ from those populations traditionally enrolled in managed delivery systems. If the selected delivery system requires use

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

of vendors, DCH should give significant consideration to how the needs of these populations differ. DCH should consider the necessary skill sets the vendor must possess to serve the population and requirements of the vendor that are specific to these populations.

Also, these discussions do not address how some special populations (e.g., Medicaid spend-down members, prisoners, emergency assistance for aliens) might or might not be included in or excluded in the delivery system. DCH should consider the options available for these individuals during the next steps and planning process.

In its planning process, DCH should employ a rational, deliberate approach to considering the timing of carving in each population and service. In our Phase III assessment, we provide approaches to phasing in each based on each delivery system option discussed. However, as DCH conducts additional planning after selecting the delivery system it will implement, more consideration should be given as to whether to use a phased approach to implementation that will work best for these populations and services. Benefits of phasing and the approach for such phasing should be considered in light of some risks. For example, using a phased approach to program implementation can create confusion for members and providers (e.g., uncertainty about the timing of members of a certain eligibility category being enrolled). Likewise, while a phased approach allows time for careful consideration of options and program design, it also allows an extended timeframe for special interest groups to lobby for changes to the design strategy. For example, providers which stand to lose revenue from a particular approach may lobby to maintain the “status quo”. Such stalling could lead to a very delayed implementation or a decision to not implement, which in turn may impact the ability to meet some identified goals. Texas’ and Hawaii’s implementations of managed long-term supports and services (MLTS) programs provide lessons about challenges of changing or adding to already implemented MLTS programs. Hawaii officials indicated “we would still be here two years later planning to include LTC benefits.” Allowing “more time during the planning stage to work with relevant stakeholders or to develop systems for implementation [may be] time well-spent that will save states resources in the long-run.”⁴⁰

Overarching themes that impact our recommendation to carve in all of the identified populations and services to the delivery system selected are as follows:

⁴⁰ Center for HealthCare Strategies, Inc. Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2010. Available online: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

- These populations for the most part do not have care management services available to them through DCH's current FFS delivery system.⁴¹ Yet, they are the populations that could benefit the most from care management.
- Serving members and providing all services through one delivery system streamlines and provides continuous coordination of care, thereby addressing potential duplication of services and contradictory care plans, and aligning incentives to effectively manage the whole person from a clinical and cost perspective.⁴²
- Clinical information is captured in one or linked information systems, which enhances opportunities for the following: accessing a more comprehensive medical history when authorizing services and for considering coordination of health care needs and disease management services; tracking member compliance and sending reminders; tracking providers' progress with meeting coordination of care requirements and sharing information; and identifying quality initiatives.
- Member confusion may be limited when all benefits are administered by one entity.
- There is opportunity to realize cost efficiencies while at the same time improve the quality of care and reduce state costs (e.g., enhanced contractor incentives to prioritize primary care and reduce emergency room visits and hospitalizations may lead to decreased costs).^{43,44}
- There is merit in considering contracting with separate vendors for some of these services, for example, implementing a separate managed LTC program or contracting with a dental benefits administrator. However, doing so would create administrative complexities for DCH and for Medicaid providers that could be avoided through implementing only one system for all populations and services.
- Providing all services to all populations under one delivery system reduces DCH administrative oversight and monitoring burden (e.g., decreases the number of

⁴¹ Some members may receive care management through HCBS waivers.

⁴² The Lewin Group. Programmatic Assessment of Carve In and Carve Out Arrangements for Medicaid Prescription Drugs. October 2007.

⁴³ Stephen Zuckerman et al., *Has Medicaid Managed Care Affected Beneficiary Access and Use?*, 39 INQUIRY 221, 224, 234 (2002).

⁴⁴ Stephen Zuckerman et al., *Has Medicaid Managed Care Affected Beneficiary Access and Use?*, 39 INQUIRY 224 (2002).

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

contracts DCH must manage, vendor responsible for monitoring of its subcontractors for these services if DCH allows subcontracting, etc.)

- Vendors have leverage with providers to enforce coordination of care requirements and to hold them accountable for outcomes using pay-for-performance and value-based purchasing.
- One blended capitated rate for all services under one contract addresses vendor incentives for “dumping” and the associated negative cost and quality of care impacts.

Additionally, Figure 5.8 presents opportunities specific to each population and service when carving into one delivery system.

While risk-based managed care with all services and populations offers potential for Georgia to achieve its Medicaid redesign goals, achieving these goals by implementing a comprehensive managed care model is not a given. Such comprehensive Medicaid managed care programs must be designed and implemented using a deliberate and rational approach. The decision to implement such a comprehensive program should not be taken lightly: designing and implementation of such a program is not as straightforward as designing and implementing a traditional Medicaid managed care program. The intricate decisions made during the program design and planning process will influence the degree to which the program is able to achieve its potential. Thus, Georgia should consider the issues set forth throughout this chapter and in the appendices to this chapter in designing and implementing its comprehensive Medicaid managed care program.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.8. Opportunities by Population and Service when Carving In to One Delivery System

Populations and Services	Having one entity to manage a member’s full needs presents the opportunity to:
Behavioral Health	<ul style="list-style-type: none"> • Manage care for the whole person when both physical health and specialty behavioral health providers are in one network • Improve hospital discharge planning, reduce high readmission rates and more completely address the health needs for members with chronic conditions and co-occurring behavioral health diagnoses
LTC, HCBS and Dual Eligibles	<ul style="list-style-type: none"> • Manage care for the whole person when both acute and long term care services are rendered through a single network. • Institute a truly independent and standardized assessment process • Potential to align payment with quality and performance goals
Children in Foster Care	<ul style="list-style-type: none"> • Maintain continuity of clinical care management regardless of child’s custody arrangement • Limit DCH’s duplication of efforts when children transition in and out of foster care • Eliminate need for transition to a different delivery system when transitioning out of foster care
Dental Services	<ul style="list-style-type: none"> • Allow for coordination of care for EPSDT services by having health and dental services provided through one entity • Provide options to negotiate payments for specialty dental services⁴⁵ • Provide options to pay for services (such as oral health supplies) that may not be reimbursed through Medicaid

⁴⁵ Snyder,A. Increasing Access to Dental Care In Medicaid: Targeted Programs for Four Populations. National Academy for State Health Policy. March 2009. http://www.vfc-oh.org/cms/resource_library/files/02e970cafdbec983/increasing_access_to_dental_care.pdf

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Populations and Services	Having one entity to manage a member’s full needs presents the opportunity to:
Non-emergency Transportation Services	<ul style="list-style-type: none"> • Place responsibility on health plans for assuring members receive appropriate NET services • Increase access to transportation services, as health plans would have a vested interest due to the impact lack of transportation has on missed appointments, appropriate utilization and continuity of care • Improve care coordination when health plans contracting directly with the transportation brokers, as health plans would have more control over transportation vendors and making sure that they are working together to meet the needs of the whole person • Serve Medicaid and PeachCare for Kids® populations through one system may address confusion when members “churn” among programs • Provide negotiating leverage with transportation brokers given the increased number of covered lives, as the health plans would be contracting for both the Medicaid and PeachCare for Kids® populations • Allow more flexibility in the choice of transportation brokers given health plans would not be subject to state procurement requirements
Pharmacy Services	<ul style="list-style-type: none"> • Allows for monitoring of drug utilization to identify and outreach to members who have high or inappropriate utilization patterns and to identify those needing care management • Allow access to real-time pharmacy and medical claims data for care coordination purposes and for identifying quality initiatives from a member health outcomes perspective and physician prescribing pattern perspective⁴⁶ • Allow DCH to receive rebates that may more than offset increases in capitation rates to account for higher prescription drug costs for MCOs with implementation of the ACA⁴⁷

⁴⁶ The Lewin Group. Programmatic Assessment of Carve In and Carve Out Arrangements for Medicaid Prescription Drugs. October 2007.

⁴⁷ Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available at: http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Phase III. Identification and Evaluation of Georgia-Specific Delivery Systems

The purpose of this section of the report is to present Phase III of Navigant's evaluation of the redesign options. Using the results of Phase I, we identify delivery system options best suited to Georgia. Then, we develop permutations of those delivery system options tailored to Georgia, i.e., Georgia-specific delivery system options.

The generic delivery system options evaluated in Phase I were single strategies; however, states around the nation often apply a combination of strategies to best address the needs of particular populations or to otherwise address their unique needs. When these combinations of models operate simultaneously, they are often referred to as hybrid or side-by-side models.

Sometimes states implement two models consecutively, to achieve a phased approach to implementation. For example, states can phase their implementation of new delivery systems to enroll more traditionally managed populations, like low-income needy mothers and children, first, followed by members who are aged, blind and disabled but not using LTC services, and so on.

Below are the combined, or hybrid, strategies that we have identified as having the greatest potential of enabling Georgia to meet its redesign goals and strategic requirements. These Georgia-specific options present a variety of combinations of the generic delivery systems determined in Phase I as having the greatest likelihood of enabling DCH to meet its goals and strategic requirements. They reflect not only our consideration of combinations specific to meeting needs of particular populations, but also our consideration of the need for a model that can be implemented statewide, provides solutions for all populations and is administratively simple for DCH to administer and for providers to participate.

- Option 1: Georgia Families Plus
- Option 2: Georgia Families Plus Transitioning to "Commercial Style" Managed Care Program
- Option 3: Georgia Families Plus Transitioning to "Commercial Style" Managed Care Program that Requires Use of ACOs and PCMHs
- Option 4: Georgia Families Plus and Free Market Health Insurance Purchasing

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Below we present each of the Georgia-specific delivery system options that we recommend DCH consider for the future design strategy.⁴⁸ These options assume that:

- The delivery system can be implemented statewide
- The delivery system can apply to all populations
- DCH can use a phased approach to including some populations, likely with the more traditionally managed populations being included first and those with more complex or special needs being enrolled later

In Phase III, we once again evaluate the options using a modified version of the Kepner-Tregoe decision-making method, as we did in Phase I. As in Phase I, the scoring of each option is based upon the relative likelihood that the option will enable Georgia to achieve its goals.

In our discussion below of each option, we first describe the rationale for the delivery system in terms of opportunities and risks followed by a presentation of tables that provide a high-level overview of various design features for each of the options. Please note that this listing of risks and opportunities and design features is not exhaustive, since the delivery systems we are evaluating are defined at a high-level. Also, these discussions do not address how some special populations (e.g., Medicaid spend-down members, prisoners, people receiving emergency assistance for aliens) might or might not be included in or excluded in the delivery system.

The process of designing any new program requires more extensive planning and consideration after initial selection of the delivery system. Once DCH selects a delivery system for implementation, DCH will next begin a planning process to define the more intricate aspects of the design strategy. For example, if DCH includes additional populations such as children in foster care; people who are aged, blind and disabled; and people who are using LTC services in the selected delivery system, DCH should give significant consideration to the unique needs of each of these subpopulations. DCH must recognize what different skill sets vendors must have and what requirements to include in contracts specific to these populations.

We present later in this Chapter examples of key design features DCH should consider during its planning process. Additionally, general descriptions, as well as advantages and

⁴⁸ Please note that across options that include the same models, we repeat language for that model as applicable. For example, Georgia Families Plus is included in each of the five options and we have provided duplicative information to describe the model within each option description. The purpose of this duplication is to facilitate review of each option separately.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

disadvantages, of each generic delivery system option can be found in *Chapter 3: National Environmental Scan* and Figure 5.9. As noted above, with any of the options, DCH would make some internal operational changes to address programmatic concerns identified by stakeholders and improve administrative efficiencies and contractor oversight.

Option 1 – Georgia Families Plus

With this option, DCH would enroll all populations, including children in foster care, dual eligibles and individuals who are aged, blind and disabled, in Georgia Families Plus. Additionally, all services would be carved in, including behavioral health, transportation, dental, LTC and HCBS waiver services. Georgia Families Plus further expands upon the current Georgia Families program by incorporating value-based purchasing⁴⁹, further encouraging implementation of medical homes, reducing administrative complexities and burdens for providers and members, increasing patient compliance through incentives and disincentives, increasing focus on health and wellness programs and preventive medicine and continuing to build upon current efforts to focus on quality. DCH would begin the program by enrolling current Georgia Families enrollees and use a phased approach to implementing additional populations and services.

While some challenges have been identified, overall Georgia Families is working for a large number of members. Creating Georgia Families Plus would expand DCH's ability to develop a more quality-based program focused on improved outcomes through value-based purchasing, as described in *Chapter 4, Georgia-specific Environmental Scan*. It would also be designed to improve administrative efficiencies for providers.

This option enables DCH to continue to evolve its risk-based managed care program. As with most newly implemented delivery systems and as discussed in *Chapter 4, Georgia-specific Environmental Scan*, Georgia Families has been focused on development of infrastructure and operations. DCH has over the past couple of years begun to move to a program that is based on quality and outcomes. Georgia Families Plus would enhance DCH's ability to do so through value-based purchasing, which bases payment on quality and not volume. DCH has already built an infrastructure for operating a risk-based managed care program. By making some significant changes to the current program to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to improve care for members currently served through Georgia Families as well as individuals currently in the FFS delivery system who do not have access to care management

⁴⁹ See *Chapter 4: Georgia-Specific Scan* for a discussion about value-based purchasing.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

services or other benefits of managed care. There is increased opportunity to care for the “whole person” by implementing one well managed delivery system. This option will also allow for DCH to maximize budget predictability.

To this point, caring for the “whole” dually eligible Medicare-Medicaid member would be an important component of this delivery system. DCH could pursue financing options for duals via the demonstration offerings currently available through the Center for Medicare and Medicaid Innovation (CMMI), or DCH could pursue streamlined financing by requiring all participating health plans to be Medicare Advantage Special Needs Plans.⁵⁰

Risks are associated with this model that must be considered. Our Georgia scan found significant discontent among some providers with Georgia Families. DCH will also need to be diligent in educating stakeholders about the significant differences between Georgia Families Plus and Georgia Families. Stakeholders voiced concern that DCH will only “tweak” Georgia Families, which they believe does not go far enough in creating an effective delivery system. Georgia Families Plus is much more – moving to a value-based purchasing system focused on quality and outcomes. Also, enrollment of the additional populations would require submission of a waiver application to CMS for approval, which could delay timelines. CMS, however, has recently approved waivers for California and Texas to expand their managed care programs to new populations. Texas’ “approval is the latest signal the administration will give broad leeway to states to expand managed care in Medicaid if they meet performance measures showing they are improving care.”⁵¹ A value-based purchasing model would include such performance measures.

Figure 5.9 below presents a high-level overview of design features we would recommend for Option 1.

⁵⁰ A more extensive discussion of these options is provided in discussion of Phase II within this Chapter, under Long-Term Care, HCBS and Dual Eligibles.

⁵¹ Galewitz, P. Kaiser Health News. Administration Ties Medicaid Managed Care Expansion to Performance. December 13, 2011.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.9: Design Features for Option 1 – Georgia Families Plus

Feature	Description
DCH Roles	<ul style="list-style-type: none"> • Conduct required procurements • Develop quality measures • Set rates and pay health plans • Provide oversight and monitoring of contractors
Covered Populations	<ul style="list-style-type: none"> • PeachCare for Kids®: Georgia Families Plus • LIM: Georgia Families Plus • Children in Foster Care: Georgia Families Plus • ABD (not receiving LTC): Georgia Families Plus • ABD (HCBS): Georgia Families Plus • ABD (Institutions): Georgia Families Plus • Dual Eligibles: Georgia Families Plus • Potential Expansion Population: Georgia Families Plus
Covered Services	<ul style="list-style-type: none"> • All State Plan services, including behavioral health, dental, NET and pharmacy services • LTC services, including administration of HCBS waiver services • Care management services
Contracting Needs	<ul style="list-style-type: none"> • Contracts with health plans • Enrollment broker • Actuarial services • Provider credentialing vendor • External Quality Review Organization
Payment Structures	<ul style="list-style-type: none"> • Full risk-based managed care program using risk adjustment • Value-based purchasing
Federal Authorities	<ul style="list-style-type: none"> • 1915(b) waiver or 1115 waiver
Other	<p>Encourage health plans to:</p> <ul style="list-style-type: none"> • Contract with ACOs and PCMHs • Assist providers with forming PCMHs

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Option 2 – Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program

The ultimate aim under this option is to enroll many of Georgia Medicaid members in “commercial style” managed care. *Chapter 3: National Scan* outlines some of the innovative approaches being employed by commercial insurers to encourage healthy behaviors by their members. Among the tools used by commercial managed care plans are copayments, deductibles, HRAs, incentive payments and prizes and a myriad of other creative strategies. While some of these can be used in a limited fashion in traditional Medicaid managed care programs, the vast majority of these tools – most notably copayments and deductibles – are not permitted in Medicaid for certain populations and services without seeking federal waiver authority.^{52,53}

As is widely recognized, having health insurance makes the insured less sensitive to changes in price or overall costs of care. Thus, insurers are not always inclined to make health behavior decisions that result in the most efficient and economic use of services, or that result in the best outcomes. To address this challenge, commercial health plans have designed and refined these strategies so that their members stand to gain or lose from their health behavior decisions – so that the members “have some skin in the game” and are incented to make good decisions about their health and health care. Using “commercial style” managed care in Georgia Medicaid would aim to do the same for selected groups of Georgia Medicaid members. This option is essentially Option 1 with “Commercial style” managed care levers applied to some populations.

“Commercial style” managed care is not well suited to all Medicaid populations, so the following populations would not be targeted for enrollment in the commercial model initially: children in foster care; individuals who are aged, blind and disabled; and dually eligible individuals. There would be an annual enrollment period each calendar year, and enrollees would be locked in to their selected plan for the entire calendar year. Members who have breaks in Medicaid eligibility would be re-enrolled in the same plan if their eligibility is effective again in the same calendar year.

⁵² The Deficit Reduction Act of 2005 allows states to implement cost-sharing requirements for Medicaid members without waiver approval, but exempts some populations. States may impose cost-sharing requirements on members who are above 100 percent federal poverty level (FPL), but the requirement may not exceed five percent of their income.

⁵³ U.S. Department of Health and Human Services. Medicaid Cost-Savings Opportunities. February 3, 2011. Available online: <http://www.hhs.gov/news/press/2011pres/02/20110203tech.html>

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Once the State gains experience operating the “commercial style” managed care program for the other populations, it could consider expanding the program to include some of the populations below. Including these populations will require significant thought and creative design to address their unique needs.

While the long-term goal is to implement “commercial style” managed care for some populations, the reality is that obtaining federal approval will take time, and expansion and enhancement of Georgia Families will require substantial effort. To avoid potential challenges with implementing two new programs at one time, Georgia Families Plus would be implemented first given some infrastructure already exists for operating it. Additionally, we anticipate federal approval of the “commercial style” managed care program would require a longer timeframe. DCH would use a phased approach to eventually roll Georgia Families Plus enrollees into the “commercial style” managed care program after receiving federal approval to enroll these populations and when the program has evolved to a state that it would be manageable for Georgia Families Plus enrollees.

With this option, DCH would implement Georgia Families Plus for children, including children in foster care, for dual eligibles and for individuals who are aged, blind and disabled. Additionally, all services would be carved in to Georgia Families Plus, including behavioral health, transportation, dental, LTC and HCBS waiver services. The “commercial style” would include behavioral health, transportation and dental services.

Georgia Families Plus expands upon the current Georgia Families program by incorporating value-based purchasing,⁵⁴ further encouraging implementation of medical homes, reducing administrative complexities and burdens for providers and members, increasing patient compliance through incentives and disincentives, increasing focus on health and wellness programs and preventive medicine and continuing to build upon current efforts to focus on quality. The “commercial style” managed care program is also a full risk-based managed care program with value-based purchasing.⁵⁵ However, it includes all levers used by commercial health plans to encourage patient compliance and participation in their health care and to encourage providers to participate in initiatives to promote quality and improved health outcomes. For example, it would include incentives, such as HRAs and penalties, such as cost-sharing, to encourage appropriate member behavior and participation in their health care. Members would receive HRAs for use in purchasing certain health care related services or items not covered by Medicaid or for copayments.

⁵⁴ See *Chapter 4: Georgia-Specific Scan* for a discussion about valued-based purchasing.

⁵⁵ See *Chapter 4: Georgia-Specific Scan* for a discussion about valued-based purchasing.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

While some challenges have been identified, overall Georgia Families is working for a large number of members. Creating Georgia Families Plus would expand DCH’s ability to develop a more quality-based program focused on improved outcomes through value-based purchasing. It would also be designed to improve administrative efficiencies for providers.

This option enables DCH to continue to evolve its risk-based managed care program, first through Georgia Families Plus and even further through the “commercial style” model. As with most newly implemented delivery systems, Georgia Families has been focused on development of infrastructure and operations. DCH has, over the past couple of years, begun to move to a program that is based on quality and outcomes. Georgia Families Plus would enhance DCH’s ability to do so through value-based purchasing, which bases payment on quality and not volume. The “commercial style” model would even further enhance DCH’s ability to use a variety of “levers” to encourage appropriate member behavior and provider participation in quality and care management efforts. DCH has already built an infrastructure for operating a risk-based managed care program. By making some significant changes to the current program to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to improve care for members currently served through Georgia Families as well as individuals in the FFS delivery system who do not have access to care management services. There is increased opportunity to care for the “whole person” by implementing one well-managed delivery system. This option will also allow for DCH to maximize budget predictability.

To this point, caring for the “whole” dually eligible Medicare-Medicaid member would be an important component of this delivery system. DCH could pursue financing options for duals via the demonstration offerings currently available through CMMI, or DCH could pursue streamlined financing by requiring all participating health plans to be Medicare Advantage Special Needs Plans⁵⁶

Risks are associated with this model that must be considered. Our Georgia scan found significant discontent among some providers with Georgia Families. DCH will also need to be diligent in educating stakeholders about the significant differences between Georgia Families Plus and Georgia Families. Stakeholders voiced concern that DCH will only “tweak” Georgia Families, which they believe does not go far enough in creating an effective delivery system. Georgia Families Plus is much more – moving to a value-based purchasing system focused on

⁵⁶ A more extensive discussion of these options is provided in discussion of Phase II within this Chapter, under Long-Term Care, HCBS and Dual Eligibles.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

quality and outcomes. Also, enrollment of the additional populations in both models would require submission of a waiver application to CMS for approval, which could delay timelines. The “commercial style” model will face additional hurdles in gaining CMS approval, depending on the types of levers DCH decides to include. For example, CMS may not approve cost-sharing requirements for certain populations. CMS, however, has recently approved waivers for California and Texas to expand their managed care programs to new populations. Texas’ “approval is the latest signal the administration will give broad leeway to states to expand managed care in Medicaid if they meet performance measures showing they are improving care.”⁵⁷ These value-based purchasing models would include such performance measures.

Figure 5.10 below presents a high-level overview of design features we would recommend for Option 2.

⁵⁷ Galewitz, P. Kaiser Health News. Administration Ties Medicaid Managed Care Expansion to Performance. December 13, 2011.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.10: Design Features for Option 2 – Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program

Feature	Description
DCH Roles	<ul style="list-style-type: none"> • Conduct required procurements • Set rates and pay health plans • Provide oversight and monitoring of contractors
Covered Populations	<ul style="list-style-type: none"> • PeachCare for Kids®: Georgia Families Plus • LIM: Georgia Families Plus (children); “Commercial Style” (adults) • Children in Foster Care: Georgia Families Plus • ABD (not receiving LTC): Georgia Families Plus • ABD (HCBS): Georgia Families Plus • ABD (Institutions): Georgia Families Plus • Dual Eligibles: Georgia Families Plus • Potential Expansion Population: “Commercial Style” • Note: DCH could consider phasing other populations into “commercial style” managed care at a later date, if desired.
Covered Services	<ul style="list-style-type: none"> • For both programs: All State Plan services, including behavioral health, dental and non-emergency medical transportation, care management services • Georgia Families Plus: LTC, including administration of HCBS waiver services
Contracting Needs	<ul style="list-style-type: none"> • Contracts with health plans • Enrollment broker • Actuarial services • Provider credentialing vendor • External Quality Review Organization
Payment Structures	<ul style="list-style-type: none"> • Full risk-based managed care program using risk adjustment and value-based purchasing • Commercial style plan members would have HRAs for use in purchasing certain health care related services or items
Federal Authorities	<ul style="list-style-type: none"> • 1115 waiver
Other	<p>Encourage health plans to:</p> <ul style="list-style-type: none"> • Contract with ACOs and PCMHs • Assist providers with forming PCMHs

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Option 3 – Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program that Requires Use of ACOs and PCMHs

The ultimate aim under this option is to enroll many of Georgia Medicaid members in “commercial style” managed care. *Chapter 3: National Scan* outlines some of the innovative approaches being employed by commercial insurers to encourage healthy behaviors by their members. Among the tools used by commercial managed care plans are copayments, deductibles, HRAs, incentive payments and prizes and a myriad of other creative strategies. While some of these can be used in a limited fashion in traditional Medicaid managed care programs, the vast majority of these tools – most notably copayments and deductibles – are not permitted in Medicaid for certain populations and services without seeking federal waiver authority.^{58,59}

As is widely recognized, having health insurance makes the insured less sensitive to changes in price or overall costs of care. Thus, insurers are not always inclined to make health behavior decisions that result in the most efficient and economic use of services, or that result in the best outcomes. To address this challenge, commercial health plans have designed and refined these strategies so that their members stand to gain or lose from their health behavior decisions – so that the members “have some skin in the game” and are incented to make good decisions about their health and health care. Using “commercial style” managed care in Georgia Medicaid would aim to do the same for selected groups of Georgia Medicaid members.

“Commercial style” managed care is not well suited to all Medicaid populations, so the following populations would not be targeted for enrollment in the commercial model initially: children in foster care; individuals who are aged, blind and disabled; and dually eligible individuals. There would be an annual enrollment period each calendar year, and enrollees would be locked in to their selected plan for the entire calendar year. Members who have breaks in Medicaid eligibility would be re-enrolled in the same plan if their eligibility is effective again in the same calendar year.

Once the State gains experience operating the “commercial style” managed care program for the other populations, it could consider expanding the program to include some of the populations

⁵⁸ The Deficit Reduction Act of 2005 allows states to implement cost-sharing requirements for Medicaid members without waiver approval, but exempts some populations. States may impose cost-sharing requirements on members who are above 100 percent FPL, but the requirement may not exceed five percent of their income.

⁵⁹ U.S. Department of Health and Human Services. Medicaid Cost-Savings Opportunities. February 3, 2011. Available online: <http://www.hhs.gov/news/press/2011pres/02/20110203tech.html>

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

below. Including these populations will require significant thought and creative design to address their unique needs.

While the long-term goal is to implement “commercial style” managed care for some populations, the reality is that obtaining federal approval will take time, and expansion and enhancement of Georgia Families will require substantial effort. To avoid potential challenges with implementing two new programs at one time, Georgia Families Plus would be implemented first given some infrastructure already exists for operating it. Additionally, we anticipate federal approval of the “commercial style” managed care program would require a longer timeframe. DCH would use a phased approach to eventually roll Georgia Families Plus enrollees into the “commercial style” managed care program after receiving federal approval to enroll these populations and when the program has evolved to a state that it would be manageable for Georgia Families Plus enrollees.

With this option, DCH would implement Georgia Families Plus for children, including children in foster care, for dual eligibles and for individuals who are aged, blind and disabled. Additionally, all services would be carved in to Georgia Families Plus, including behavioral health, transportation, dental, LTC and HCBS waiver services. The “commercial style” would include behavioral health, transportation and dental services. The only difference between Option 2 and Option 3 is that participating CMOs would be contractually required to include ACOs and PCMHs in their provider networks. Requiring inclusion of ACOs and PCMHs in provider networks may help to move the Medicaid program to a more patient-centered program that involves teams of providers sharing responsibility for care of the whole person. Other states have been incorporating PCMHs into their programs and working successfully with MCOs to do so. Pennsylvania, for example, worked with a CHIP health plan to develop a program to better coordinate care with PCPs through mechanisms such as “communication among multiple practitioners and facilities, and providing family-centered education to the family to support adherence to the physician medical care plan.” The Commonwealth planned to consider including requirements in its MCO procurement to encourage coordination, “especially with regard to chronic needs, and to assist practices to become medical homes.”⁶⁰

Georgia Families Plus expands upon the current Georgia Families program by incorporating value-based purchasing,⁶¹ further encouraging implementation of medical homes, reducing administrative complexities and burdens for providers and members, increasing patient

⁶⁰ Beesla, R., Kaye, N., Takachand, M. Strategies States Can Use to Support the Infrastructure of a Medical Home. May 2008. Available online:

http://nashp.org/sites/default/files/shpbriefing_pcmhsupport.pdf?q=Files/shpbriefing_pcmhsupport.pdf.

⁶¹ See *Chapter 4: Georgia-Specific Scan* for a discussion about value-based purchasing.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

compliance through incentives and disincentives, increasing focus on health and wellness programs and preventive medicine and continuing to build upon current efforts to focus on quality. The “commercial style” managed care program is also a full risk-based managed care program with value-based purchasing.⁶² However, it includes all levers used by commercial health plans to encourage patient compliance and participation in their health care and to encourage providers to participate in initiatives to promote quality and improved health outcomes. For example, it would include incentives, such as HRAs and penalties, such as cost-sharing, to encourage appropriate member behavior and participation in their health care. Members would receive HRAs for use in purchasing certain health care-related services or items not covered by Medicaid or for copayments.

While some challenges have been identified, overall Georgia Families is working for a large number of members. Creating Georgia Families Plus would expand DCH’s ability to develop a more quality-based program focused on improved outcomes through value-based purchasing. It would also be designed to improve administrative efficiencies for providers.

This option enables DCH to continue to evolve its risk-based managed care program, first through Georgia Families Plus and even further through the “commercial style” model. As with most newly implemented delivery systems, Georgia Families has been focused on development of infrastructure and operations. DCH has over the past couple of years begun to move to a program that is based on quality and outcomes. Georgia Families Plus would enhance DCH’s ability to do so through value-based purchasing, which bases payment on quality and not volume. The “commercial style” model would even further enhance DCH’s ability to use a variety of “levers” to encourage appropriate member behavior and provider participation in quality and care management efforts. DCH has already built an infrastructure for operating a risk-based managed care program. By making some significant changes to the current program to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to improve care for members currently served through Georgia Families as well as individuals in the FFS delivery system who do not have access to care management services. There is increased opportunity to care for the “whole person” by implementing one well managed delivery system. This option will also allow for DCH to maximize budget predictability.

To this point, caring for the “whole” dually eligible Medicare-Medicaid member would be an important component of this delivery system. DCH could pursue financing options for duals via the demonstration offerings currently available through CMMI, or DCH could pursue

⁶² See *Chapter 4: Georgia-Specific Scan* for a discussion about value-based purchasing.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

streamlined financing by requiring all participating health plans to be Medicare Advantage Special Needs Plans⁶³

Risks are associated with this model that must be considered. Our Georgia scan found significant discontent among some providers with Georgia Families. DCH will also need to be diligent in educating stakeholders about the significant differences between Georgia Families Plus and Georgia Families. Stakeholders voiced concern that DCH will only “tweak” Georgia Families, which they believe does not go far enough in creating an effective delivery system. Georgia Families Plus is much more – moving to a value-based purchasing system focused on quality and outcomes. Also, DCH can include requirements for use of ACOs and PCMHs in CMO contracts; however, contract requirement will not assure that CMOs will be successful in enrolling them. Enrollment of the additional populations in both models would require submission of a waiver application to CMS for approval, which could delay timelines. The “commercial style” model will face additional hurdles in gaining CMS approval, depending on the types of levers DCH decides to include. For example, CMS may not approve cost-sharing requirements for certain populations, including most children and pregnant women. CMS, however, has recently approved waivers for California and Texas to expand their managed care programs to new populations. Texas’ “approval is the latest signal the administration will give broad leeway to states to expand managed care in Medicaid if they meet performance measures showing they are improving care.”⁶⁴ These value-based purchasing models would include such performance measures.

Figure 5.11 below presents a high-level overview of design features we would recommend for Option 3.

⁶³ A more extensive discussion of these options is provided in discussion of Phase II within this Chapter, under Long-Term Care, HCBS and Dual Eligibles.

⁶⁴ Galewitz, P. Kaiser Health News. Administration Ties Medicaid Managed Care Expansion to Performance. December 13, 2011.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.11: Design Features for Option 3 – Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program that Requires Use of ACOs and PCMHs (i.e., Option 2 plus required use of ACOs and PCMHs)

Feature	Description
DCH Roles	<ul style="list-style-type: none"> • Conduct required procurements • Set rates and pay health plans • Provide oversight and monitoring of contractors
Covered Populations	<ul style="list-style-type: none"> • PeachCare for Kids®: Georgia Families Plus • LIM: Georgia Families Plus (children); “Commercial Style” (adults) • Children in Foster Care: Georgia Families Plus • ABD (not receiving LTC): Georgia Families Plus • ABD (HCBS): Georgia Families Plus • ABD (Institutions): Georgia Families Plus • Dual Eligibles: Georgia Families Plus • Potential Expansion Population: “Commercial Style”
Covered Services	<ul style="list-style-type: none"> • For both programs: All State Plan services, including behavioral health, dental and non-emergency medical transportation, care management services • Georgia Families Plus: LTC, including administration of HCBS waiver services
Contracting Needs	<ul style="list-style-type: none"> • Contracts with health plans • Enrollment broker • Actuarial services • Provider credentialing vendor • External Quality Review Organization
Payment Structures	<ul style="list-style-type: none"> • Full risk-based managed care program using risk adjustment and value-based purchasing • Commercial style plan members would have HRAs for use in purchasing certain health care related services or items
Federal Authorities	<ul style="list-style-type: none"> • 1115 waiver
Other	<p>Require health plans to:</p> <ul style="list-style-type: none"> • Contract with ACOs and PCMHs • Assist providers with forming PCMHs

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Option 4 – Georgia Families Plus and Free Market Health Insurance Purchasing

With this option, DCH would implement Georgia Families Plus for children, including children in foster care, and for individuals who are aged, blind and disabled and a free market health insurance purchasing program for low-income needy adult populations and potential expansion populations.

The free market model would give DCH the opportunity to implement an entirely new concept for Medicaid programs. It would give members increased choice of health plans which may increase their access to providers and would give members the responsibility for managing their own care. This option will also allow for DCH to maximize budget predictability. Under the free market model:

- DCH would define standard benefit packages, which would include all Medicaid covered services or be benchmark benefit packages as allowed through the Deficit Reduction Act (DRA). Like Medicaid, standard benefit packages would have limits on copayments and would not have deductibles. DCH might also establish other rules governing the delivery of care to Medicaid members. Most members would be required to make copayments. (For example, foster children would be excluded from this copayment requirement.)
- Insurers would offer the standard Medicaid benefit package as one of their products. Insurers would also be required to offer a health rewards account to every member, and funds from that account would not transfer if the member changed plans.
- Interested insurers would seek certification from the State authorizing them to offer the Medicaid standard benefit package. (Either the Department of Insurance or DCH could certify plans.)
- DCH would limit participation to less than six insurers. DCH could also elect to be open to any willing qualified insurer.
- DCH would not contract directly with health plans and would not process claims.
- Medicaid members would be given a credit with which to purchase a standard Medicaid benefit insurance product from a certified insurer.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

- Under the free market model, members would be able to purchase their insurance through the free market.
- DCH would provide choice counselors to aid members in selecting a health insurer.
- There would be an annual enrollment period each calendar year, and enrollees would be locked in to their selected health plan for the entire calendar year. Members who have breaks in Medicaid eligibility would be re-enrolled in the same plan if their eligibility is effective again in the same calendar year.
- An open enrollment period would be held at the end of each year, when members would have the option to select a different health insurer.
- Members who join Medicaid during the calendar year would be permitted to select an insurer mid-year. Enrollment with that insurer would begin in the month following enrollment.
- Medicaid would no longer pay claims or operate a FFS program or other infrastructure for members who participate in this free market program.

Georgia Families Plus expands upon the current Georgia Families program by incorporating value-based purchasing,⁶⁵ further encouraging implementation of medical homes, reducing administrative complexities and burdens for providers and members, increasing patient compliance through incentives and disincentives, increasing focus on health and wellness programs and preventive medicine and continuing to build upon current efforts to focus on quality. Additionally, all services would be carved in to Georgia Families Plus, including behavioral health, transportation, dental, LTC and HCBS waiver services.

To avoid potential challenges with implementing two new programs at one time, Georgia Families Plus would be implemented first given existing infrastructure for operating it. Additionally, we anticipate federal approval of the free market health insurance purchasing program would require a longer timeframe, and the Supreme Court's ruling on the constitutionality of the ACA and any decisions required on Georgia's part based on that ruling may also impact timelines .

While some challenges have been identified, overall Georgia Families is working for a large number of members. Creating Georgia Families Plus would expand DCH's ability to develop a

⁶⁵ See *Chapter 4: Georgia-Specific Scan* for a discussion about valued-based purchasing.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

more quality-based program focused on improved outcomes through value-based purchasing. It would also be designed to improve administrative efficiencies for providers.

This option enables DCH to continue to evolve its risk-based managed care program. As with most newly implemented delivery systems, Georgia Families has been focused on development of infrastructure and operations. DCH has over the past couple of years begun to move to a program that is based on quality and outcomes. Georgia Families Plus would enhance DCH's ability to do so through value-based purchasing, which bases payment on quality and not volume. DCH has already built an infrastructure for operating a risk-based managed care program. By making some significant changes to the current program to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to improve care for members currently served through Georgia Families as well as individuals in the FFS delivery system who do not have access to care management services.

Risks are associated with this model that must be considered. Our Georgia scan found significant discontent among some providers with Georgia Families. DCH will also need to be diligent in educating stakeholders about the significant differences between Georgia Families Plus and Georgia Families. Stakeholders voiced concern that DCH will only "tweak" Georgia Families, which they believe does not go far enough in creating an effective delivery system. Georgia Families Plus is much more – moving to a value-based purchasing system focused on quality and outcomes. Also, enrollment of the additional populations would require submission of a waiver application to CMS for approval, which could delay timelines. CMS, however, has recently approved waivers for California and Texas to expand their managed care programs to new populations. Texas' "approval is the latest signal the administration will give broad leeway to states to expand managed care in Medicaid if they meet performance measures showing they are improving care."⁶⁶ A value-based purchasing model would include such performance measures.

The free market model will face additional hurdles in gaining CMS approval, as it is a model that does not exist and places significant responsibility with the member which may not be appropriate for all Medicaid members. Additionally, DCH would have little to no oversight of the health plans in which members would have the opportunity to enroll, which may create concerns with whether members have access to care and care management, whether members use services appropriately and are encouraged to do so, and whether health plans' provider

⁶⁶ Galewitz, P. Kaiser Health News. Administration Ties Medicaid Managed Care Expansion to Performance. December 13, 2011.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

network composition is sufficient to meet Medicaid members’ needs. The federal government, however, is looking for creative solutions to problems in the Medicaid program.

Figure 5.12 below presents a high-level overview of design features we would recommend for Option 4.

Figure 5.12: Design Features for Option 4 – Georgia Families Plus and Free Market Health Insurance Purchasing

Feature	Description
DCH Roles	<ul style="list-style-type: none"> • Conduct required procurements • Set rates and pay health plans • Define benefit packages • Provide oversight and monitoring of contractors
Covered Populations	<ul style="list-style-type: none"> • PeachCare for Kids®: Georgia Families Plus • LIN: Georgia Families Plus (children); Free Market (adults) • Children in Foster Care: Georgia Families Plus • ABD (not receiving LTC): Georgia Families Plus • ABD (HCBS): Georgia Families Plus • ABD (Institutions): Georgia Families Plus • Dual Eligibles: Georgia Families Plus • Potential Expansion Population: Free Market
Covered Services	<ul style="list-style-type: none"> • Georgia Families Plus: All State Plan services, including behavioral health, dental and non-emergency medical transportation, LTC services, including administration of HCBS waiver services, care management services • Free market health insurance purchasing: Benchmark benefit packages that include all the full scope of Medicaid services, including EPSDT services
Contracting Needs	<p>For Georgia Families Plus:</p> <ul style="list-style-type: none"> • Contracts with health plans • Enrollment broker • Actuarial services • Provider credentialing vendor • External Quality Review Organization

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Feature	Description
Payment Structures	<ul style="list-style-type: none"> • Georgia Families Plus: Full risk-based managed care program using risk adjustment and value-based purchasing • Free market health insurance purchasing: Members provided a credit for purchase of insurance through the free market
Federal Authorities	<ul style="list-style-type: none"> • 1115 global waiver
Other	For the free market model: <ul style="list-style-type: none"> • Possible role for Department of Insurance in establishing regulations, certifying health plans and conducting health plan oversight • May need to establish a customer service function to assist individuals in selecting a plan

As with our assessment of generic delivery system options, Figure 5.13 presents an assessment of the above-described delivery system permutations using a modified Kepner-Tregoe decision-making method. Scoring is based on our perspective and understanding of each option and how it will apply to Georgia. Those options with the highest total scores have the greatest likelihood of enabling DCH to achieve its goals for the Medicaid and PeachCare for Kids® programs. However, as DCH refines the design strategy through ongoing planning, it may wish to revisit the individual scores. This initial scoring of options is a tool to help inform DCH’s decision-making and provides a framework for conducting a rational decision-making process.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.13: Assessment of Delivery System Permutations for the Medicaid and PeachCare for Kids® Design Strategy⁶⁷

Likelihood that the Option will...	Wt.	Option 1: Georgia Families Plus	Option 2: Georgia Families Plus Transitioning to "Commercial Style" Managed Care	Option 3: Georgia Families Plus Transitioning to "Commercial Style" Managed Care Req. PCMH and ACO	Option 4: Georgia Families Plus and Free Market Purchasing
Goals:					
Enhance appropriate use of services by members	33%	●	●	●	●
Achieve long-term sustainable savings in services for members	33%	●	●	●	●
Improve health care outcomes for members	34%	●	●	●	●
Strategies for Medicaid and PeachCare for Kids® Redesign					
Gain administrative efficiencies to become a more attractive payer for providers	20%	●	●	●	●
Ensure timely and appropriate access to care for members within a reasonable geographic areas	20%	●	●	●	●
Ensure operational feasibility from a fiscal oversight and administrative perspective	20%	●	●	●	●
Align reimbursement with patient outcomes and quality versus volume of services delivered	18%	●	●	●	●
Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%	●	●	●	●
Develop a scalable solution to accommodate potential changes in member populations as well as potential changes in legislative and regulatory policies	4%	●	●	●	●
Weighted Average Score		7.1	7.6	8.0	6.5

⁶⁷ As DCH refines the design strategy through ongoing planning, it may wish to revisit the individual scores. This initial scoring of options is a tool to help inform DCH's decision-making and provides a framework for conducting a rational decision-making process.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

Phase IV: Recommendations and Next Steps for Program Design

Phase IV presents our recommendations for the delivery system for the future design strategy of the Medicaid and PeachCare for Kids® programs, as well as recommended next steps in the planning process for the overall program redesign.

A. Future Design Strategy Recommendations

Based on our assessment, we recommend DCH consider implementation of one of the following three delivery systems:

- Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program that Requires Use of ACOs and PCMHs
- Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program
- Georgia Families Plus

Each of these delivery systems incorporates a managed care model. Through implementation and operation of Georgia Families over the past six years, DCH has built an infrastructure for operation of a managed care model. Additionally, Georgia Families has realized successes and improvements in health outcomes. However, care is currently managed for the majority of Medicaid members but not those members who have the highest risks and use the costliest care. It is time for the program to evolve to one that purchases for improved outcomes and value and not for structure or process. The best opportunity for improving quality of care for members is by caring for the whole person

Also, Navigant recommends that DCH consider carving in to the selected delivery system all populations and services identified in Phase II of our assessment. As DCH considers carving in each of these populations, DCH should give consideration throughout the decision-making and planning process about:⁶⁸

- How the needs of these populations differ from those populations traditionally enrolled in managed delivery systems

⁶⁸ See the Conclusions subsection and *Appendices L through Q* for more information about recommendations for carving in populations and services.

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

- How the needs of these populations differ in consideration of contract requirements and skill sets for potential vendors
- Whether to use a phased approach to including these populations and services in the selected delivery system

We recognize that some stakeholders voiced concerns with Georgia Families, and some have advocated for particular population or service carve outs (e.g., behavioral health, dental, etc.) or have recommended moving away from a managed care model. Often, Medicaid agencies evolve in their role as purchasers. In the early evolutionary phases, they are often more focused on developing infrastructure, designing and implementing new delivery systems and refining program design to move towards increasingly higher quality targets. DCH and the CMOs have refined the initial infrastructure and are working on the next generation of quality initiatives, improvements and innovations. DCH staff managing these initial managed care contracts had a learning curve. Staff turnover did not support seamless monitoring and movement to operating in a managed care environment. DCH now has a history operating in a managed care environment and staff now have the background and experience to seamlessly manage and monitor a managed care program and take it to the next level of value-based purchasing. DCH has identified areas for improvement with Georgia Families and is implementing contract changes and monitoring and performance improvement initiatives to address these areas.

Additionally, as previously discussed in this report, our assessment found that some of the concerns and frustrations voiced by stakeholders are not due to the Georgia Families program design, but result from operational issues within the Medicaid program. Some are due to misunderstandings of current program operations or historical challenges that may no longer exist, which DCH could work to remedy through improved communications. DCH's current leadership is working to communicate to stakeholders about the following efforts that are currently underway:

- Improve the provider credentialing process through collaboration with CMOs to establish a shared credentialing function. This will significantly reduce provider burden, reduce CMO administration costs and streamline DCH oversight.
- Improve eligibility processes: DCH will be implementing a new eligibility system in January 2014.
- Improve CMO contract monitoring. DCH is currently reviewing contract language and reporting requirements and revising those to focus on issues of most

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

importance. DCH should continue to work to improve internal operations, including development of more extensive and thorough contractor management and oversight processes.

DCH should also address other concerns and challenges raised by stakeholders, such as provider access, administrative complexity and member communications.

The recommended delivery systems identified through our assessment can help DCH to further evolve its managed care delivery system. Through the recommended delivery systems, there is opportunity to improve quality of care for members and provide for increased budget predictability if effectively implemented and operated. In order to realize these opportunities, DCH must allow for significant thought and time for planning the program design and approach to implementation. DCH will also need to make sure adequate networks exist and that the design strategy includes appropriate incentives for members, health plans and providers.

B. Next Steps for Program Design

Now DCH must consider its redesign options and select a delivery system to implement and populations and services to carve in. Regardless of the delivery system selected, DCH will undergo a major program planning effort. In addition to the delivery system options, populations and services analyzed in this report, there are many program design features that DCH should consider in its program planning process. We outline in Figure 5.14 examples of features that we believe to be key in planning and that could be considered as part of any of the delivery system options recommended. The exact questions will depend upon the delivery system DCH selects, but this is a sampling of some of the most important questions DCH is likely to face.

We also recommend that throughout the planning process, DCH review research and literature to drive lessons learned. As equally important is to stay abreast of how others states are proceeding with their planned reforms. States have an opportunity to learn from each other in this time of reform. We recommend beginning discussions with CMS very early in the planning process to keep them apprised of potential approaches that DCH is considering and to gain feedback about those approaches. Since the beginning of this redesign effort, DCH has been committed to gaining stakeholder input, and we would encourage DCH to continue involving the community throughout the planning process.

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Figure 5.14: Examples of Key Design Features to Consider After DCH Selects Design Strategy

Program Features	Overview	Examples of Key Decisions (Applicable Key Decisions Will Depend Upon Design Strategy Selected)
Delivery System “Levers”	Some delivery system options are not viable administratively or operationally as stand-alone options, but could be incorporated into other models. For example, DCH could explore options to require or encourage health plans to implement HRAs, HSAs, etc. The more “levers” that are achievable and implemented, the higher the likelihood of meeting goals.	<ul style="list-style-type: none"> • What “levers” could the delivery system include? • Which levers are most likely to be effective and improve outcomes? • Will the State implement “levers”, such as HRAs, to encourage member responsibility? If so, to what populations will they apply? • To what populations would the levers apply? • What approvals are required to include these levers?
Care Management and Disease Management	DCH should decide how prescriptive to be with regard to care management and disease management programs, and consider options for streamlining care management across programs.	<ul style="list-style-type: none"> • Will DCH specify conditions that must be managed? • Will DCH specify minimum qualifications for case managers? • Who will perform risk assessments for each population? • Will vendors be at risk for their programs?
Medication Therapy Management	DCH could implement a medication therapy management program. Two options may be: <ul style="list-style-type: none"> • Provide a case management fee to pharmacists • Require vendors to implement as part of care management programs 	<ul style="list-style-type: none"> • Will Medication Therapy Management benefit members, and if so, what type of program would provide the most benefit? • To what populations would the program apply? • What services would be offered? • How would the program coordinate with other care management activities?
Contracted	DCH must determine the types of vendors, if any, with	<ul style="list-style-type: none"> • What types of vendors will be allowed to bid to

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Program Features	Overview	Examples of Key Decisions (Applicable Key Decisions Will Depend Upon Design Strategy Selected)
Vendors	which it will contract to help administer the delivery system.	<p>administer the program (e.g., local and national health plans, ACOs, Special Needs Plans, etc.)?</p> <ul style="list-style-type: none"> • How many vendors will DCH procure for each service area? Will the six service areas be maintained, changed or consolidated? (CMS will likely require a choice of at least two vendors per service area if the program is mandatory.) • If DCH elects to carve in behavioral health services, will the health plans be required to administer in-house? Or, will they have the flexibility to subcontract the behavioral health services? • If DCH elects to carve in HCBS, will DCH contract with an independent entity to develop individualized budgets or to conduct needs assessments? • Will other DCH contracts need amending, or will additional procurements be needed? • Can enrollment broker services for Medicaid and PeachCare for Kids® be consolidated into a single contract? And should any other services or contractor functions be incorporated into that contract?
Special Populations	DCH should give special consideration throughout the planning process to special populations. When carving in each special population, DCH should give consideration throughout the decision-making and planning process about how the needs of these populations differ from those populations traditionally covered under Medicaid managed	<ul style="list-style-type: none"> • How do the needs of these populations differ from those populations traditionally enrolled in managed delivery systems? • What are the necessary skill sets vendors must possess to serve these populations?

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

Program Features	Overview	Examples of Key Decisions (Applicable Key Decisions Will Depend Upon Design Strategy Selected)
	<p>care programs.</p>	<ul style="list-style-type: none"> • What should we require of vendors specific to these populations? • If DCH elects to carve in populations and services such as LTC and behavioral health, will DCH procure separate vendors to provide these services? • How will DCH serve special populations such as Medicaid spend-down members, prisoners, emergency assistance for aliens?
<p>Payment Strategies</p>	<p>DCH may employ various payment strategies to assure that providers are fairly reimbursed and that vendors’ and providers’ incentives are aligned with those of DCH. Examples of payment strategies include</p> <ul style="list-style-type: none"> • Risk Adjustment: Adjust payment rates for certain populations • Pay-for-Performance: Provide incentive payments to vendors and providers for meeting predetermined quality indicators. • Bundled Rates: Provide payments for all services rendered during one episode of care under one rate. • Value-based Purchasing: Develop a payment strategy that considers quality performance and cost when contracting with health plans or providers and is not based solely on volume 	<ul style="list-style-type: none"> • What payment strategies will DCH implement for vendors? • How can DCH use value-based purchasing to evolve the current system to one that focuses more on quality and outcomes? • What payment strategies will DCH implement for providers? Will DCH allow vendors to propose payment strategies for providers? • Will DCH require physician incentive arrangements? • How will payment rates be determined (e.g., will DCH adjust rates by age and eligibility category, based on the results of the LTC assessment, etc.)?

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

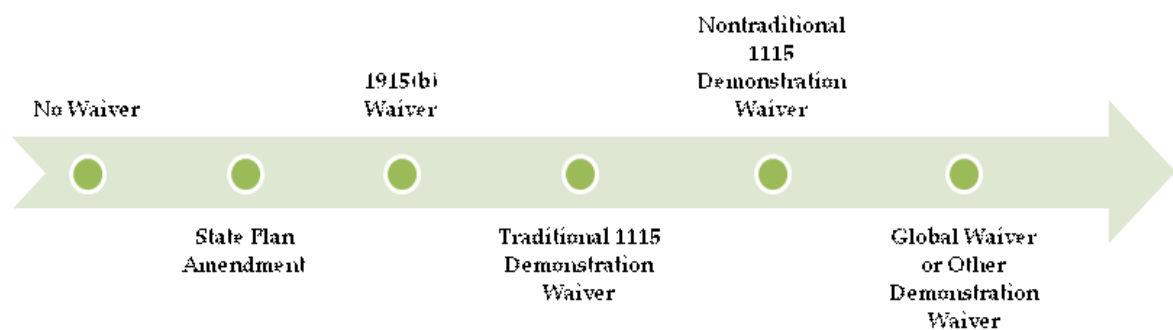
Program Features	Overview	Examples of Key Decisions (Applicable Key Decisions Will Depend Upon Design Strategy Selected)
Penalties and Rewards	DCH could offer rewards for engaging in healthy lifestyle activities (smoking cessation, weight loss programs) and penalties for unhealthy behavior. For example, DCH could consider requiring implementation of rewards accounts or limiting coverage for inappropriate use of services (e.g., limits to the number of hospital days covered per year, coverage limits for inappropriate ER use)	<ul style="list-style-type: none"> • What penalties and rewards could DCH include in the delivery system? • To what populations would they apply? • What approvals are required to include the penalties and rewards? • How will the rewards and benefits be determined?

Chapter 5: Options for Georgia’s Future Design Strategy for Medicaid and PeachCare for Kids®

In addition to identifying program design features, DCH should spend significant time considering implementation needs and operational issues. For example:

- What federal approvals are required for the program, and how do the required approvals impact the implementation timeline? Required federal approvals will depend on the delivery system implemented, populations included and the program design features selected by DCH. Figure 5.15 provides an overview of the types of federal approvals that could be required, ranging in order from least to most complex.

Figure 5.15: Spectrum of Federal Approvals – Least to Most Complex



- Will DCH use a phased approach to implementation of the new delivery system? If so, on what basis will it phase in – by population, by geographic location, by program requirement (e.g., impose a requirement that any willing provider be permitted to join MCO networks for the first year of operation), other?
- What changes, if any, are needed to DCH’s organizational structure to allow for operations that will result in a successful program? For example, where will certain functions be housed? What will the contract monitoring structure be? What staff trainings and supports are required to allow for a smooth transition and ongoing operations?
- What information systems and other operational changes are necessary? Identifying information systems and operational changes as early in the process as possible is necessary. As a representative from another state’s Medicaid agency indicated, “shelving” certain items to complete after implementation due to insufficient implementation timeframes results in problems down the road.

These are just a few of the program design features and next steps that DCH should consider. As noted in *Chapter 1: Overview of Program Goals*, this report is the first in a series of steps DCH

Chapter 5: Options for Georgia's Future Design Strategy for Medicaid and PeachCare for Kids®

is taking to fully develop a new design strategy. Based on the delivery system DCH ultimately implements, DCH will then need to conduct a planning process to further determine all key design and programmatic features. For this planning process, DCH should:

- Develop a high-level implementation timeframe
- Convene a team of people to develop recommendations for detailed program design features
- Convene advisory groups and/or task forces, as needed
- Vet the preliminary recommended detailed program design features with stakeholders
- Modify the recommended program design features to reflect stakeholder feedback
- Identify and develop strategies to mitigate risks
- Develop a detailed implementation plan and timeline, including waiver submission and phased approaches, as necessitated by the detailed design strategy

The above steps are likely to be iterative, and the processes for internal DCH approvals and for stakeholder input will require further development. Continued use of a deliberate decision-making strategy, coupled with advance planning and a strong communication strategy, will help DCH to achieve its goals and strategic requirements for the future Medicaid and PeachCare for Kids® design strategy.