

# **Medicaid Managed Care Stakeholders Meeting**

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Prepared by  
Carl Vinson Institute of Government  
The University of Georgia  
for the  
Department of Community Health

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## Introduction

On 24 August, 2004, Commissioner Burgess met with community health stakeholders at the Governor's Mansion for a Medicaid managed care stakeholders meeting. The Department of Community Health has proposed reforming Medicaid in order to control costs. After details of the proposal were presented to the stakeholders, they were invited to provide feedback on the proposed changes through a series of discussions facilitated by faculty from the Carl Vinson Institute of Government at the University of Georgia, assisted by staff of the Office of Planning and Budget.

This report presents a brief summary of the process and the results of the discussions. The individual responses are also included in a separate section. The presentation is available as a Microsoft PowerPoint file on the DHS web site at <http://www.communityhealth.state.ga.us/>.

## Session Summary

### Process

The session began with a presentation outlining the proposed reforms to Medicaid. The goals of the reform are:

- Improving the health care status of member population
- Establishing contractual accountability for access to and quality of healthcare
- Lowering cost through more effective utilization management
- Budget predictability and administrative simplicity

The DCH strategy is for Medicaid services to be provided by care management organizations (CMOs) in each of six regions of the state. Medicaid recipients will be required to enroll in a CMO in their region. CMO procurement will be competitive, and organizations will have to meet certain requirements to be considered. In addition, DCH has developed a list of preferred attributes for consideration, such as use of technological advances (e.g. telemedicine) and provider ownership or sponsorship of the organization. DCH contractual requirements with CMOs will ensure that all enrolled patients have access to quality medical care.

After the presentation, Dr. Steve Dempsey of the Carl Vinson Institute of Government described the process for the discussions. The stakeholders were asked six questions, four of which were discussed over the course of the meeting:

- What are the most significant issues we should be aware of in this plan to incorporate organized care practices into Georgia Medicaid?

- What requirements would you propose that the Department of Community Health include in contracts with health plans under this new model?
- What are the quality indicators that we should measure and maintain to ensure an improving health status for Medicaid members under this new model?
- Given the goals and organized care direction of this strategic plan, what suggestions for a successful implementation would you offer?

For each of the questions, the stakeholders were asked to write individual comments for the question under discussion, then they discussed their responses with the other stakeholders at their tables. Each table had a facilitator who entered responses from the discussions into networked computers. Responses were compiled anonymously and projected on a large screen for everyone to see. Dr. Dempsey then led the entire group through a review of the responses to a question. This gave the stakeholders and Commissioner Burgess the opportunity to see the results of the table discussions, ask questions about individual responses for clarification, and continue the discussion of the question with all the participants. This process was followed for each question.

Two additional questions were given to the stakeholders to be answered individually. The following questions were not discussed due to time limitations:

- What are your suggestions on how we could lessen any administrative burdens?
- What should be the requirements and responsibilities to ensure adequate member education and outreach?

Individual written comments for all six questions were collected, transcribed, and are included at the end of this report.

### **Summary of responses to the discussion questions**

#### ***What are the most significant issues we should be aware of in this plan to incorporate organized care practices into Georgia Medicaid?***

Many of the issues raised were questions about how the reforms would address problems in the current system. Where are the costs savings to the state coming from, and how are CMOs going to profit? Providers are not being reimbursed adequately now. Many are leaving the current system, so incentives are needed to increase participation. Access to care needs to be improved, especially in rural areas. More information is needed: successful models in other parts of the country, best practices, data to develop appropriate treatment guidelines, etc. Patient behavior needs to be taken into account: they need to be educated and given an incentive for not going to the ER for basic services.

#### ***What requirements would you propose that the Department of Community Health include in contracts with health plans under this new model?***

Access and choice requirements included having specialists available outside metro areas, giving people the ability to choose who they would see, transportation for patients, telephone access in emergencies and when offices are closed. Providers need prompt and accurate reimbursement. Systems and processes need to be uniform, coordinated, integrated with other agencies. CMOs need to report regularly profits, measurement data, treatment decisions, best practices, among others. Somehow encourage providers to participate.

***What are the quality indicators that we should measure and maintain to ensure an improving health status for Medicaid members under this new model?***

Some of the indicators are listed below:

- Responsiveness to problems
- Number of specialists
- Payment speed and consistency
- Denial rate
- Clinical data: blood pressure, diabetes, flu shots, asthma, congestive heart disease, etc.
- Patient utilization
- Patient compliance with disease management programs and medication
- Survival outcomes
- Hospital admissions, length of stay
- Waiting time for patients to see MDs
- Patient satisfaction
- Cost savings

Indicators should be regional, adjusted to population, and they should also correspond to indicators used nationally by organizations such as CMS and JCAHO.

***Given the goals and organized care direction of this strategic plan, what suggestions for a successful implementation would you offer?***

Get input from all stakeholders using a format like this or small focus groups. Create an advisory group of stakeholders to select the CMOs and assist in implementation. Have a representative from each specialty in the group. Do not rush: make sure all the programs are in place and run a pilot program in one of the regions to address problems that will arise before implementing this in the rest of the state. Create an oversight committee or some method to deal with any problems that might arise with the CMOs. Communicate expectations and requirements to everyone, including the Medicaid population. Simplify administration; don't increase paperwork.

## Facilitated Discussion Responses

### What are the most significant issues we should be aware of in this plan to incorporate organized care practices into Georgia Medicaid?

- Physician buy in—docs are leaving the program now.
- What are the formulas going to look like for the CMOs? Will people still have access to the current medications taken?
- Insuring access by all
- Where are the projected savings?
- A broad group of partners can impact health and behavior more than just the traditional provider can.
- Utilize "best practices": disease management, case managers to oversee compliance
- Ensure that no provider can be cut out of Medicaid through the bidding process
- Must take care that there is no "cherry picking"; have an equitable system for recruiting patients for CMOs
- When a company is at risk for managing care it generally leads to underutilization. There is a need to have user friendly access, and primary as well as specialist care.
- Capitation: provider gets paid a set amount. Prevention is the cornerstone of dentistry. This could worsen members' health and cost the state more money.
- Will the only way to save money be to provide less care?
- Quality needs to be the main goal: to ensure quality you need access and adequate reimbursement.
- Lots of docs have closed their practices to Medicaid patients and are no longer taking Medicaid patients.
- Need to have a methodology to engage physicians
- Increase physician participation in the program by initiating procedures to reverse physician flight
- Huge resistance by providers: fee for service versus the CMO model could lead to providers not participating
- Recognize that it will take 3-5 years to realize cost savings
- Educate Medicaid patients
- How can I educate patients about the new program?
- Build capacity: put resources where they're needed geographically. The rural areas are underserved.
- Integrate mental health and addictive disease services with physical health services
- All patients are not the same. Patients seek care much more sporadically.
- Population is hard to engage in treatment/care. If it feels difficult they will use the ER. Patient education with simple protocols plus follow-up.
- Kids fall in and out of eligibility. The member base will still be unstable.
- Establish credibility for the plan in broad base change; currently, the state has little credibility.

- Accountability: Medicaid patients call and they do not show up. It costs the provider since they can't book another person.
- Need to educate the Medicaid consumer
- Have considered the impact of UPL and DSH; seems to exclude the most expensive users
- Appropriate interpretation of medical evidence to develop "medically based guidelines" for appropriate treatment
- How will the current UPL system be replaced by the new system?
- Is growth in 71% or 39%?
- Did the data that was used for projections include those dual-eligibles covered by Medicare in 2006?
- Full paying people show up, sliding scale people do not show up.
- All subspecialties will need to be available, difficult to acquire and reimburse
- The CMO must include minority physicians/providers.
- There is a lot of disagreement about what are best practices. We need to have data and rationale for why this is best practice. Lessons learned from other states and organizations will help.
- Do we really have enough information to make useful comments?
- Need accountability: if patients don't show, perhaps charge them a fee.
- Provide GENUINE access to care for all beneficiaries. How do you make sure that certain areas of the State are not underserved?
- How will you marry the new program into a "broken system" (ACS)? Seems to add more confusion to a system already in trouble. Business offices are stretched, now. How will they deal with a new, additional provider claim system?
- It's always about who will get the dollars. Is it an expansion? Who is eligible?
- Concerned that providers will get less payment for more services; Medicaid recipients don't use health care system effectively.
- Mindset is for people to go to emergency room for service
- To have 2 providers, does that require a waiver?
- Work to prevent adversarial relationships between urban and rural providers
- Huge costs of trauma care. Fully understand impact on DSH, ICTF and UPL
- Older adults don't avail themselves to the services
- Emphasizing reducing costs for emergency room, but where did the data come from to support this? A lot of information we don't have.
- System should foster and incentivize care management.
- Be certain to include health status and patient condition as indicators of quality and service.
- Must make sure we have adequate provider resources and adequate access to those providers; providers must be controller of their populations
- How do we protect safety care networks from cherry-picking patients?
- Need to carve out Grady Hospital from this plan to ensure its viability. Grady provides both care and training for most state physicians. Fifty percent of physicians are trained at Grady. Don't redirect patients away from that system.

- Regional emergency and trauma centers don't count as CMOs, but they're necessary.
- Low-balling is a well known phenomenon: what are they doing to account for this?
- Older residents, who are most frail, are used to fee for service paying.
- ER utilization is out of control; this should be a provider problem and not a patient problem.
- CMOs should steer clear of capitation of rates for providers. That would likely drive away primary care physicians.
- Empowerment of Medicaid population. THEIR behavior patterns are driving utilization. They don't want to be empowered!
- Need to make sure that people have a way to get to the appointments—transportation
- Where are they going to find these managed care organizations—not sure they are out there now?
- This is a difficult population to care-manage, and there is a lack of resources to support them after they leave care.
- System needs to adequately pay providers and pay them in a timely manner.
- Are you going to penalize members for noncompliance? People refuse to comply. They won't go to clinics; they still use emergency rooms.
- Adequate compensation for service providers—this was a problem with the last effort
- Tremendous savings for importation of drugs from Canada
- No control in the system; consumer has right to access care anywhere
- Need to take into account the failure of previous attempts at managed care.
- Maintain quality of care.
- No incentive for Medicaid to play by the rules. Allow the providers to refuse care when patients are not covered.
- Negotiate a statewide rate for drugs
- It's mandatory; but what happens if people don't sign up? How do you enforce mandatory aspect?
- Puts a tremendous burden back onto physicians to managed care. They won't have the time to work with the patient.
- Appropriate providers have got to be in the program. If they're not there now, where are they going to come from?
- How will teaching programs be funded?
- Lack of availability of providers. Must ensure that providers do not continue to leave network.
- What will happen when you limit people's choices: access to care, patient satisfaction, provider rev., quality of care, cost?
- How will Georgia's six regions match up to other systems that divide Georgia in different ways? How will this delivery system interact with existing and overlapping delivery systems?
- Safety net hospitals are serving a disproportionate percentage of patients.
- Dentistry lacks specialists in rural areas, reimbursement not enough.
- How are consumers going to be enrolled: the state, DCH, CMO?

- How do the capitated companies reduce the amount that is being paid out: where is Georgia's margin going to come from?
- Urban vs. rural : outside of metro Atlanta it will be hard to succeed without fee-for-service for doctors and a floor for reimbursement.
- Case management can be difficult.
- Don't know if there are any successful models of care management in the country.
- Educating each individual group is going to be a major task.
- Focus on pharmacy utilization, shopping for scripts. Duplicative shopping in nursing homes.
- Will we end up with a more fragmented system?
- Problems created by ACS
- Negotiate for best prices, providers, drugs, etc., and look at it throughout the state to ensure consistency.
- Need more of a doctor-patient relationship to establish relationship
- State should consider uniform fee schedule
- Availability of reliable recent data to base assumptions on
- Provider relations are very important.
- Need to have cooperative effort, need buy in from providers and consumers
- Improved case management, coordination of care among providers
- DCH/DFACS need to coordinate.
- Why are we leaving out retirees, SHBP and regents?
- How can you measure quality factors without a large technology network? Can't sustain current care even with current imbursement.
- Prevent excess business office burdens on all providers when we introduce at least 2 new providers. ACS is a bad example.
- Medicaid patients aren't responsible
- The profit motives of private companies serving as the CMO
- The inability to direct the Medicaid population.
- Need a system where this is an alternative to the emergency room; better to see a physician who knows your history. It would prevent running tests that are not necessary.
- It would be good to have a consumer report about a CMOs performance in another state.
- Consumer due process if quality of care is not up to par
- How will Peach Care be affected? Does this fit the federal regulations?
- Adverse selection and insolvency of the plan. Who is going to pay the receivables to the hospitals and docs?
- Under this proposed model, the state and hospitals will reap rewards, not the care providers. There must be equitable alignment.
- The issue is a lot more complex than a simple correlation between utilization and rising costs.
- Can the IT system be ready to manage this system?

- Unintended consequences: the negative impact on existing federal dollars; a shrinking provider base willing to participate.
- Will this be capitation?
- Duplicate payments: the wrong checks going to people
- Timeline is going to be a challenge
- Should we be looking at Phase II first for more cost-savings?
- How will recipients get equal access to latest care methods?
- Will the growth of the system outrun the capacity of the system?
- How can we limit the administrative overhead on being reimbursed?
- Safety net issues
- They need to set guidelines so that hospitals who choose not to participate can still be paid equitably
- Concern for the difficulty in incorporating disciplined decision making
- Continuity of services throughout the region is already a problem.
- Concern for the fragility of the system.
- Look at physician decision-making best practices: focus on high cost, high frequency treatment options.
- The #1 goal of this should be to take care of providers; #2 that it is organized by MDs & nurses, not businessmen; #3, in education, there should be an alliance with organization of HMOs and Public Health.
- In rural Georgia there is no margin to absorb extra costs for this plan
- Need to ensure this (plan) does not obstruct care for women. They to have direct access to their OB/GYN.
- The psychology program is unique in that it is not solely healthcare provision. For example, a child in foster care needs mental health assessment and treatment (healthcare) , but the provider often winds up testifying as an expert in court (legal/forensic). Thus, the healthcare provider must often be competent in both domains (note: DFCS, who make the referral to the psychologist wants the psychologist to come to court and testify.)

**What requirements would you propose that the Department of Community Health include in contracts with health plans under this new model?**

- No pre-certification for ED visits: it runs afoul of EMTALA (Federal law)
- Develop required compliance rates for drug lists—will control costs
- Encourage participation of providers who previously provided Medicare services, esp. minority providers.
- Providers must be paid by the visit, because if they're paid by \$/month/enrollee, they are incentivized NOT to see patients (who end up in ED).
- Either limit profitability or require some minimum % of \$ earned by CMOs to flow to the provider.
- Financial and patient care track record is important—will they be set?
- Establish uniform contracts throughout the State.

- Billing guidelines and strict payment policies.
- Standardize template for billing
- Need systems that coordinate with one another
- Individual should be required to stay with their CMO 3-5 years but be able to move PCP
- Prompt pay requirements!!! Substantial penalties should be spelled out.
- Accept any patient who requests enrollment.
- Full and prompt appeal rights
- Establish clear preset criteria for refusal to authorize a service or pay a provider.
- What do you do in emergency to care for patients when they are out of their region?
- Case managers must be regional onsite, and know other state agencies and resources.
- Same co-pay for ED visit and provider visit; large co-pay at ED will bankrupt some facilities and hurt all.
- Cap on administrative fee charged by a CMO and full disclosure of those fees
- Continuous eligibility for children instead of having to re-up every month, together with reasonable limitation on changes in PCP
- Exclude NO rural providers.
- They need to standardize EOBs across the board.
- Include current local networks with grassroots relationships that focus on access and health status (such as community health centers).
- Provider payments can't be below provider costs.
- Timely denial management program.
- Culturally appropriate services, i.e. linguistics.
- They need to have community provider reps full time to educate enrollees.
- Keep primary case management fee or some other incentive for primary care
- Require that all providers participate in a uniform data system.
- It is better sometimes for the consumer to go directly to the provider for the service instead of through a gatekeeper.
- Need to have a service-level agreement on system speed of response, and an access plan that considers transportation and geographic locations
- Mandatory lock-in period is good; but need to address eligibility issues
- Full range of necessary providers and adequate numbers for access
- Guidelines for participation so it balances out patients over the available providers
- Requirement to develop region pilot success and failure stories so that information will be shared. Best practices are sometimes considered proprietary, but they need to be shared.
- Responsibility for transportation for patients
- Have CMOs fund 24-hour nurse line
- Ensure inclusion of small or solo practices. They can't survive with reimbursements that are lower than the cost of providing the care. Large practices can absorb low reimbursements.
- Evaluate incentives for patients to participate.
- Full disclosure of their books
- Outreach to members and providers—need to educate and communicate to all

- Accountability for CMO: payments must be timely and accurate. Regular, accurate reports must be provided to providers regarding claim status.
- Need a way to transfer patients from one region to another, and ensure that patients are only in the system once. Need a standard database, maybe a standard ID card.
- Disclosure of clinical, financial assumptions
- Disease management programs for the top 6: asthma, hypertension, heart disease, congestive heart failure, stroke, women's health
- Limits on administrative costs for CMOs
- Must follow payment and CPT guidelines from Dept. of Insurance which HMOs currently must follow
- Will provider networks survive after the failure of this project?
- Traditional high volume Medicaid providers need a cushion of protection, e.g. carve out Grady and Savannah.
- Referrals by other providers must integrate with other social service agencies and community services.
- Any willing provider for guaranteed access
- Timely measurement data should be shared with the docs on a quarterly basis so there's time for them to adjust.
- Be specific about expectations of CMOs so they can explicitly address how they will meet the criteria.
- Disclosure of decision criteria for treatment decisions and clinical pathways
- Uniform claims process, uniform reporting requirements (quality measurements)
- Database should be able to easily track quality of care for patient.
- Follow interqual requirement vs. Milliman & Roberts (utilization guidelines—should claim be paid?)
- Set of guidelines for provider participation governing how providers enroll and how members will be recruited.
- Requirement that the health plan itself be at-risk for unapproved service, not the providers
- Timely reimbursement or penalty should apply
- Licensure by the State Insurance Dept. is needed
- Require multi-year contracts for CMOs to prevent them "bailing" after the first year.
- CMOs need to provide financial assistance to encourage doctors to adopt EMR/EHR systems.
- Choice of Doctor is important: different family members may not like the same Doctor.
- Implement performance guarantees in 4 areas: COST SAVINGS, QUALITY OUTCOMES, PROVIDER SATISFACTION, PATIENT SATISFACTION
- Ensure adequate statewide reporting.
- Build in performance requirements with financial hold-backs
- Need to produce evidence they can handle volume and truly manage care
- Must measure the outcome of care, impact on health status, performance reports
- Access to a specialist: most of the providers are in urban areas. People everywhere want to go to the best providers.

- Compliance with Georgia prompt payment law
- Need a method to ensure that the number of quality providers is adequate. How do you keep the cost adequate enough for quality providers to participate? There needs to be a balance of cost and access.
- Require the MCO to provide the interface with ACS to incorporate all Medicaid Accounts Receivables.
- Where does the Indigent Care Trust Fund fit into this project?
- Require CMOs to provide behavioral educational materials on obesity, smoking, safety, etc.
- Must pay state rate
- Disease management: support should be provided to rural areas for implementation.
- Denial of claims by payer is a huge concern. Emergency rooms have to pay for patients who come to the ER when their claims are denied. Denial of claims is one way insurance companies make money.
- Needs to be timely reimbursement and less complicated system for getting paid
- Must report profits made from this program
- Time phased procedures—don't need a quota type of system
- Must have real people on the ground—local provider reps
- Need to ensure long-term savings as well as short-term savings
- There should be incentives for truly organized care management. Innovation, health maintenance activities should be rewarded.
- Hot line, such as an emergency line, to talk to the Doctor or Nurse to get advice immediately for burns, flu, etc.
- Other states should have experience with managed care. Show us how their programs work.
- Provide adequate data to manage their patients
- If you go out of plan, it is important that the gatekeepers process is not cumbersome for people to go out of network, i.e. referrals made up properly
- Agree that they (CMOs) waive their ERISA exemptions and abide by GA law.
- QUESTION: ARE WE TALKING ABOUT A FULLY CAPITATED SYSTEM, or are we talking about something between fee for service and capitation? Capitation, through care management, may result in providers not providing care. The over-utilization problem is partly due to malpractice suits. If providers don't do everything they can for a patient, resulting in over-utilization, they leave themselves open for lawsuits. Managed care organizations aren't liable for malpractice suits. Capitation, through PCP, will cause providers to drop out due to rising costs and falling reimbursements. Look at the costs of treating minor problems, like colds. There could be cost savings in treatment of those.
- Bookkeeping must be quick and easy to fix.
- Treatment should be physician driven, not CMO driven
- Requirements for data collection for providers and patients
- Transportation issues are critical.

- Plans are not permitted to make medical necessity decisions. It would be helpful if State could impact that.
- What resources will CMOs bring to underserved areas to build capacity?
- Doctor's should be located within a ten mile radius of patients.
- Consumer satisfaction levels through surveys?
- Physicians or providers should be paid at a cost plus percentage, or capitated rates must be actuarially sound.
- Simplify enrollment process for providers by standardizing credentialing process.
- Ensure that money is not taken away from patient services.
- Follow CPT rules for payment of physicians.
- Have the state pay physicians' liability premiums. That would attract more physicians.

**What are the quality indicators that we should measure and maintain to ensure an improving health status for Medicaid members under this new model?**

- Need to assure indicators are still valid
- Collect blood pressure data on patients.
- Collect information on average HBA1C.
- Diabetes data
- Get away from C/S rates as a quality indicator; there are better indicators to use.
- Flu shots data
- Self-management goals by patients
- Appropriate screening for patients as per physician guidelines
- Must be clinically sound (providers) ; must be operationally sound (CMOs); and must improve outcomes (patients).
- CMO performance
- Same as nationally examined indicators to minimize duplicated effort
- Patient satisfaction
- Keep it basic
- Change of clinical indicators, mortality rates
- Collect data on asthma, congestive heart disease, diabetes, flu shots, on patients.
- Focus on clinical measures, not just processes.
- Define desired outcomes for disease management categories and measure percent achieved.
- Prevention care provided; immunizations, for example
- Patient cost per positive outcome as defined above
- Responsiveness to provider-based problems
- Fewer ER visits
- Measure the extent to which children who are screened and need something actually get it.
- Make sure quality indicators are risk-adjusted to population differences and geography.
- Compliance within disease management programs

- Provider: use of non formulated drugs, frequency of ER utilizations, up-to-date immunizations, speed of first available appointment
- Quality indicators will vary around the state, because they are established by different groups; patients vary around the state.
- Health status in the information age is the responsibility of the individual. I can think of no measure that the provider can be responsible for.
- Patients needing services don't always follow up and get the services.
- Patient utilization
- Could the patient access care, and were there enough specialists.
- Quality outcomes, measure screening, well-care utilization by members
- Quality indicators need to be regional and be determined by the medical specialty organizations they represent.
- Measures of access to care, appropriate level of care
- Patients: DNKA rate, ability to locate patient, communications with patient, frequency of ER utilizations, re-admission rate, Ambulatory Care Sensitive Conditions
- ID and require all Medicaid patients to provide quality indicator data. Establish 4-5 indicators in the database.
- National organization: CMS, JCAHO; avoid duplication
- Compliance versus recidivism
- Compliance rates with the preferred drug rates
- Waiting time to see an MD or to have a procedure
- CMO: speed of payment, denial rate, reason for the denial, administrative fee as percentage of total patient care payment
- Provide incentives to providers who measure clinical outcomes.
- Member satisfaction with CMO functions (e.g. accessibility, were they treated with dignity and respect, was treatment relevant to health need)
- Older adult wellness indicators that reflect immunizations and life style choices (exercise, correct use of medications, obesity, need to actively participate in their program).
- Clinical indicators for high risk and chronic conditions (e.g. blood sugar level)
- Medication compliance through medication therapy management
- This is about the budget. The state should consider systemic indicators initially, before specific medical indicators.
- Consistency of provider reimbursements
- Increased independence and greater degree of recovery for members with mental health issues
- Outcomes-based measurements
- Survival outcomes, hospital admissions, length of hospital stay, monitor drugs utilized
- Members with mental health and AD issues understanding more about their physical health conditions
- Need more community based care, health care in the least restrictive setting; it's cost effective. Don't emphasize institutional care.

- CMOs should be funded specifically to try innovative approaches which apply regionally.
- Medication compliance
- More appropriate drug may not be in current formulary but might save \$ in the outcome
- Flu vaccines for under age 2 and over age 65 (would be nice if flu vaccines were paid at cost)
- Shift the responsibility for improving health status from the provider to the member.
- Measure drug compliance
- Are disease management protocols followed?
- Measure against Medicaid populations nationwide, not a commercial population
- Quality indicator for CMOs: patient education ... patient education ... patient education !!!
- Outcome measurement
- Need standardized quality indicator methodology across CMOs
- Provider satisfaction surveys
- Increase of the use of other services, because they are not in compliance ( DFCS, jail— send people to the ERs)
- Provide financial incentives for the patient for wellness (immunizations).
- New patient access (what % are seen in first 90 days of enrollment).
- EDUCATION
- Patient satisfaction, do they have access to specialists? etc.
- Patient education = PAYDIRT
- Cost savings, quality outcomes, provider satisfaction, patient satisfaction
- What is our rate of wellness compared to our cost to achieve that wellness?
- Decreased pharmacy costs
- Pay patients to achieve clinical goals.

**Given the goals and organized care direction of this strategic plan, what suggestions for a successful implementation would you offer?**

- Wait until after the election.
- Has to be well-planned and should not be prematurely implemented (i.e., ACS)
- Monitor bad debt and charity write-offs of providers in the first two years.
- Obtain buy-in from all stakeholders.
- Patient has to feel the care is good and the provider HAS to get paid in a timely fashion.
- Pilot project for 6 months to a year
- Using this format, have small focus groups discuss all of the issues determined today.
- Don't implement it until ABSOLUTELY ready to do so.
- Assure providers will not be left on the short end of the stick.
- Implement no action without a proven pilot data site.
- Educate the Medicaid population.
- Do the opposite of ACS.

- Extensive education of public and providers, involving enrollees and providers as educators to others.
- GO SLOWLY AND DO NOT RUSH. MAKE SURE EVERYTHING IS READY. BE SURE TO INCLUDE PROVIDERS IN DETAILS.
- Educate physicians and patients about what is coming using newsletters, newspaper articles, etc.
- Make patients accountable and responsible for their own care.
- Get a handle on the current Medicaid reimbursement issues before implementing this plan.
- Billing and payment issues need to be ironed out prior to implementation.
- Let people comment after the RFP has been written.
- Do not implement the plan until all programs are in place.
- Counter any potential negative press by engaging consumer and advocate groups for buy-in and support.
- Open dialogue with the stakeholders
- No complicated administrative procedures; easy rules to follow
- Input from providers
- Create method for DCH to intervene if problems arise with CMOs (e.g. unexpected w/ACS). Don't lock providers into a bad situation.
- Need to set a staged implementation approach, and set success criteria to move forward in implementation.
- Recognize what is driving the health care system so that you can set correct margins for management. The drivers are: fear of malpractice suits, money, bad lifestyle choices of the patients, ridiculous overall finance system.
- Give incentives to providers to go into rural areas
- Pilot the system in one region first long enough to work the kinks out.
- Mandatory enrollment classes for all Medicaid patients so that the rules can be explained before they get their card.
- Have a representative from each specialty assigned to the task force developing the plan to make sure their special needs are considered.
- See what the pitfalls are and make corrections.
- DM programs should be consistent across programs. Docs should not have to manage multiple DM programs for the same disease.
- Simplify administration for providers (standard EOB, standard "clean claim," 1 location to check eligibility, 1 location to check claims status)
- Do not increase paperwork.
- Choose one region for a pilot program, and only implement the plan in the other 5 regions once the issues have successfully been addressed in the pilot region.
- Anticipate startup wrinkles in the initial phase: need to have extra resources available, and individuals that are devoted full time to implementing this process.
- Put penalties in contract with CMOs.
- Education of providers and patients
- Educate ... educate ... educate

- Do not let a clerk on a phone dictate/overrule a physician's judgment.
- Develop an advisory board of provider groups to select the CMOs.
- Have an advisory group of representatives of stakeholder groups to advise implementation, which also creates buy-in from the different groups.
- Keep everyone informed through a bi-directional flow
- Demand communication on bundling issues, admin. guidelines, payment expectations
- Financial incentives to patients to improve their health status
- Develop mechanism to reward providers if successful
- Smaller focus groups w/specific provider groups to get buy-in from leadership and address key issues
- Get patient input.
- Make sure that there is not a lot of duplication of administrative procedures; using 6 different systems may create this. It may be beneficial to keep one ACS type system.
- The CMOs incentive is to maximize profit.
- CMO Oversight Committee
- Establish a strong communications plan between the State, CMOs, and providers
- Providers must continue to be engaged to make this work. Simply turning this over to the CMOs would be disastrous.
- Detail expectations and requirements up front in RFP.
- Full rollout not in all regions at once

## Individual Written Responses

### What are the most significant issues we should be aware of in this plan to incorporate organized practices into Georgia Medicaid?

- Appropriate providers/access
- Risk not just on providers
- Appropriate funding to match desired outcomes
- The devil is in the details/don't handle like ADS – Consider test region
- Make sure administrative system works
- Not denial management
- Member responsibility
- Federal regulations/UPL
- (Were projections adjusted for removing Medicaid/Care dual eligibles? – Ex. Dual eligibles – Pharmaceutical in '06)
- Inability to consistently direct the Medicaid population
- What happens when Emergency Room remains the first choice?
- Providers selection
- Availability of reliable recent data to base assumptions (ACS)
- Administrative and cost burden on providers
- Member and provider education
- Access to care for member
- Concern for unintended consequences i.e., negative impact on existing federal dollars flowing, potential for shrinking physician based (willingness to “play”)
- Concern of fragility of system, and inability of most hospitals to “absorb” a hit like ASC impact during an extended \_\_\_\_ - up.
- Concern for difficulty in incorporating the discipline of decision-making in this population
- Previous failure of managed care with this population
- Flawed Data – Medicaid clause out
- Loss of Provider Networks, especially in rural areas
- Decreased quality of care
- For Users – How does Georgia plan to initially educate Medicaid users of the new approach? What efforts will be made to use education to develop more/improved use of preventive medicine rather than visits to the Emergency Room?
- For MCOs – What requirements will be incorporated into the Georgia approach so that MCOs will work with users in looking for “ways to say yes” rather than deny care.
- Provider Buy-In (Access issues especially in rural areas where there is a lack of providers per population)
- Many providers have chosen not to enroll additional Medicaid patients into their practice
- Education of Medicaid patients to the new system

- Available of care
- Cost (impact on current budget – impact should cuts occur)
- Growth with client base
- Need to educate the population we are dealing with
- Need for adequate access to care
- Availability of adequate care providers
- Available of adequate resources
- UPL/DSH issues
- Excludes one of the most expensive groups
- Does this require waivers
- That it is organized by M.D.s and nurses – **Not Business Types**
- Take care of **Providers!**
- Education of members – Hospital and providers cannot bear the burden of member education
- HMO education of physicians in rural areas where no HMO's currently exists
- Denial Management Guidelines – Need to influence CMO to use interqual. criteria rather than Milliman and Roberts
- Rate determinations – What happens to providers that choose not to participate?
- Assurance of good Provider (Primary Care) Network
- What re actual cost saving projections and where is it expected from?
- What assurances or penalties will be imposed to ensure appropriate outcomes?
- If Healthcare Providers are losing money on population what reason should they continue to see them?
- Why introduce another (HMO/CMO) entity which will require some form of profit
- If there is cost savings will provider really deny benefit
- UPL – How will it impact it?
- No denial management
- “Organized Care” is itself a “glittering fuzz ball” Medicaid recipients historically do not access the healthcare system efficiently. Providers should not be at-risk.
- UPL is a major concern
- I am concerned we will give less payment for the same services/demand and no new models emerge or are incentives
- Difficulties in “manage” this – Compliance with medical requirements, mobility/episodic utilization, lack of resources to support care, education and literacy
- Availability of providers – Doctors willing to participate, hospitals willing to participate, network supplies
- Arrangements with safety net providers – UPL, ICTF, AME/IME
- Inexperience of CMOs to lead
- Increase physician participation in the program (currently physicians leaving the systems in significant numbers)
- Eligibility determination must be strengthened to access only eligibility participants
- Low credibility of DCH's ability to implement comprehensive change – ACS debacle

- You must take care there is no cherry picking this could undermine the success of one CMO over the another and could result in patient's being left without coverage
- Rural Georgia has a high Medicaid population and makes it more difficulty for survival of practitioners where there are "bumps in the road" they have no way to absorb these transitions costs
- When setting up these requirements, practitioners will have more administrative burden "have to hire more staff" if they are required to get pre-approved or permission for certain services. This comes at a time many rural practices are cutting staff to survive.
- Need to assure this does not obstruct care for women to have direct access to their OB/GYN
- Access to care by all eligibles in all sectors/regions
- Adequate compensation to providers of services
- Willingness to support MCOs by allowing restrictive levels of service
- Depoliticize the procurement process by having a very transparent process that ensures selections are the best possible
- Integration of Mental Health, Addiction Disease needs/services with physical health
- Safety net issues – Prevent members from falling through the cracks
- Case Management/Care Management for people with MH/AD needs will have to include a lot of orientation and education for members of their families – follow-ups by providers/CMO will be critical.
- Assure access
- Utilize Best Practices
- Reduce motivation by providers to "Game the System" and measure outcomes
- Health Status Improvement can be attributed to HC System – 10%, Env – 20%, Behavior – 50%, Biology – 20%
- Any solution should have significant involvement of partners who can impact the environment and behaviors in addition to traditional providers
- Access/utilization control
- Fees
- Quality of Care (Maintained)
- Educational level of members/DFACS
- Provider enrollment
- Need for more specialist in rural areas
- Engaging the patient into service
- Follow-ups on patients
- At-risk typically leads to under utilization. This needs to be balanced with measure on access and early intervention.
- Informing individuals of benefits available and coordination
- Coordination of all medical care
- Access to physicians by members without cumbersome referral processes
- Ensure the inclusion of Minority Physicians who currently have provided a large part of care given to this particular patient population
- Carve out to ensure the ongoing viability of Grady

- The efficiency to retain and manage the population/information throughout the Medicaid Programs (Training)
- Make the system easier for the providers and facility
- Single database from DFACS/DCH
- Current imbalance of Medicaid dollars going to institutional/segregated "Care"
- Children in institutions
- Lack of options for supporting families to keep children/family members at home
- Provider rates in community services are disposable
- We're pretty close to **last** in the nation in supporting individuals with disabilities to live at home/in the community
- Not everyone being sent to nursing homes need nursing home care
- If there isn't enough to go around, stop funding expensive services that don't work
- Must maintain a broad network of providers to ensure access to services
- Must be careful that the saving achieved by case management are not greater than the administrative cuts
- Must ensure the Medicaid population is education about the process
- Covering actual costs of provider services
- Fast of payment for services
- Close management of eligibility of each provider and member
- **True** cost savings
- Complete understanding of services not just cost incentives
- Every person has a set of different needs, therefore, individualized planning that includes and is driven by the individual "Buy-In"
- Education and incentives to change from current system – Continue reinforcement and education
- Direct linkage to a case manager that is familiar with individual and services offered in region.
- Provider reimbursement rates comparable to private insurances – Equitable reimbursement
- Frustration with current commercial insurance providers regarding obtaining services – This could be remedied by individual case managers
- Need to/difficulty to involve physicians, engage physicians
- Available but credibility problems of "Best Practices" data – Diverse opinions
- Physician involvement/oversight of care practices
- Care criteria approved by healthcare providers
- Patient/member incentives to follow care guidelines
- Primary care system/caregivers must be closely aligned with plan to provide preventive care
- Disincentives to patient/members to use Hospital ER services for non-urgent care
- Utilize **existing referral patterns in local communities** between primary caregivers, specialists, etc.
- Role of Public Health entities
- Role of CSBS (mental Health and SA)

- Access to providers
- Regions
- Must identify practices that are open to Medicaid – Currently many Georgia providers are listed; however, a substantial number of practices do not accept Medicaid patients unless through the ER
- What happens when you limit people’s choices?
- How will **effective** patient education be accomplished?
- How will plan effectiveness be evaluated and assessed?
- Computer systems to track Rx use – Are they adequate to measure utilization?
- Current ACS situation.
- Trying to “manage” an unmanageable population – Not a “predictable” population using a “predictable” approach
- Physician buy-in – As physicians are already leaving Medicaid
- Maintaining access by all to Medicaid
- Preventing exclusion – Especially Rural Providers
- We **must** spend a great deal of time understanding **HOW** these MCOs are going to achieve cost savings?
- When setting up provider networks, we should be careful to ensure that small hospitals are not cut out of the business. WHY? Referral centers don’t have enough room to accommodate all Medicaid patients, transportation is a huge issue for this population – they are going to end up in the ER anyway – locally
- The empowerment of this population depends upon them. (Noncompliance and behavior) from the members is a **HUGE** utilization driver – not necessarily the provider’s choices – so are you going to penalize them (the members for non-compliance?)
- How are we going to be sure we get primary and specialty care providers – as I understand more and more are dropping out of Medicare?
- Providers have 17-month debacle of ACS and eroded the goodwill it cause
- Parallel to commercial plan population not always reasonable standard
- Don’t think doctors will tolerate capitated plans – Should be fee for services with a floor to reimbursement
- If reimbursement does not meet cost of doctors seeing patients they will not keep seeing Medicaid patient and access will not be adequate
- Quality has to be main goal but for quality care you have to have access and for adequate access you have to have adequate reimbursement
- No decrease in eligibility
- Access to care for **ALL** low income children
- Quality of Care
- Cost-Effective Care – Look for opportunities to improve cost effectiveness
- Reimbursement for providers
- The deciding physician population able/willing to take care of the Medicaid patients
- Physician payment for Medicaid is currently below the cost of the care of the patient – How will this change?

- How will the Medicaid population be informed of new plan – the burden will fall on physician/physician’s office?
- How to collect data if CMOs are doing payments?
- Rural vs. Urban
- Broad vs. Focused
- DM – Priority
- Reimbursement rates no less than now
- Incorporate existing community-based networks
- Technology – Electronic health records/ID cards
- Patients approach to world more chaotic – Episodic in care seekers
- Patients difficult to reach/teach
- Patient/Providers don’t see need for change
- No reinforcement for small providers to participate
- Funding for trauma care – How at regional level and trauma centers be reimbursed for trauma care?
- UPL Payments – How will the current UPL payments be incorporated in MCO Plan?
- Understanding projected cost savings and in what areas?
- Impact for ICTF, DSH and UPL payments on high volume Medicaid providers?
- Financial objective and financial outcomes must be clear to public
- If the plan does not fundamentally change health care to allow providers to refuse care when not covered, there will be no savings to the overall system, just shifts.
- Education level of participants
- “One time savings” of managed care
- Costs will continue to rise – perhaps as much as they currently do.
- Phase I does not address the most costly populations. Are there projections of savings?
- Is this a proven method of Medicaid cost savings?
- The Psychology Program is unique in what it is not solely a healthcare provision. For example, a child in foster care needs mental health assessment and treatment (healthcare), but the provider often winds up testifying as an expert in court (legal/forensic). The healthcare provider must often be competent in **both** domains. (Note: DFACS, who makes the referral to the psychologist, **wants** the psychologist to come to court and testify!!)
- Community makeup – Access to providers, variety of providers
- Accountability of patient – Awareness of importance of keeping appointments
- Capitation is not the proper method of dentistry. Prevention is the cornerstone of dentistry. Without prevention, dental disease only worsens, possibly leading to more debilitating disease and cost more to the state. Capitation encourages under-utilization; therefore, it is not appropriate for dentistry.
- Resistance by provider to going from fee for service to managed care plan, especially with dentistry.
- Capitated plans in dentistry does not work. Objection is under-utilization and in dentistry you must utilize the services to have good oral health. Prevention is essential in oral health and access to dental services is critical. Currently there are few providers

especially dentist and this change could cause more dentists to drop out and create an access problem.

- CMOs – Will they be restrictive or open?
- Member buy-in – Effective strategies to educate communities and providers
- Regional reorganization?
- Technical systems of accountability and tracking
- Continuity of regional services
- Older adults prefer choice of providers
- Older adults experience problems relative to transportation to doctors, pharmacy and other related providers
- Older adults have not experienced health care systems other than fee for service HMO's median have decreased for older consumer
- Are you considering costs savings through Rx importations and collective bargaining for lowest drug costs fro all state sponsored health plans?

**What requirements would you propose that the Department of Community Health include in contracts with health plans under this new model?**

- Region multi-year contracts so CMOs don't bail after the first year
- Provider payments must not be below provider's responsible cost
- Traditional high volume Medicaid provider must be protected...establish patterns with noncompliance
- Standardize billing into needed template for billing
- Incentives for provider, patient, pharmacy and payee
- Data Collection/Public
- Lock-in period
- We realize this move towards managed is fait accompli, but participation in this process is not an endorsement.
- Demonstrable track record – Customer feedback from other states where they have opened.
- Capacity to develop, not just "acquire"
- Safeguards so that people don't lose services in the transition to this model. Safeguard against total objectification of people
- Willingness to work in urban and rural settings; plan for access
- Did death rates go up or down in the states where you were the MCO?
- Performance responses
- Rate increase justifications
- Clear profile of eligibility
- Disclosure of practices
- Access plans – Transportation – Geographic minimum distances, etc., timelessness plans
- Measure outcome or impact of care – Not just "count" incidents of care and report
- Definitive plan for "non-compliant" member – Alternative providers or alternative reimbursement systems

- Rapid member appeal processes/treatment occurs during appeal
- Rapid providers appeal processes
- Multi-year financial planning – Savings are multi-year for good decisions made in one year
- Recognized on-site case managers who know or get to know the person that works closely with DFACS case manager
- Consumer satisfaction survey's/consumer input in building
- Large provider networks and resource building to enhance quality and quantity of providers
- Timeliness of response
- Access plan – Addresses transportation
- No pre-certification for ED visit
- Pre-certification for runs afoul of **federal law**
- Providers must be paid by the visit and not paid/month/enrolled; money/month/enrollee incentives for provider **NOT** to see patients who then end up in ED
- Same co-pay for ED visit and provider visit large co-pay at ED will bankrupt some facilities and hurt all
- PSE to oversee with Insurance Commissioner and Public Health
- Provisions for minimum beneficiary coverage for – Emergency, inpatient, outpatient, other services
- Realistic performance standards for CMOs
- Guidelines needed in administrative burden placed on providers
- Guaranteed response times to prior authorization requests
- Guidelines needed on acceptable adjusted quality measures
- Disclose profit margin and actuarial analysis
- Need to disclose actuarial analysis
- How will CMOs increase resources in rural areas
- Multi-year contract for the CMO (two years)
- Establish performance criteria (quality and cost) for CMO > “Criteria must be transparent to providers/public)
- CMO must be “at risk”, no just providers
- Well documented guidelines on denials – Don’t make providers “chase” their payments
- CMO must disclose up-front the revenue codes or tests **not** covered in plan
- Require CMO to educate members on plan
- Require CMO to reduce E.R. utilization and increase primary care utilization
- No contractual ties by CMOs to other managed care plans that providers may be required to participate in
- CMO must be required to publish (to providers) prior to implementation any plan changes or payment changes
- “Outliers’ must be addressed (high cost disease categories/cases)
- High cost technologies (implants, etc) and drugs must be addressed to adequately pay their “pass through” cost to providers
- Exclude to Rural Provider (Any willing Rural Provider)

- Prompt Payment of Claims
- Protect payments at cost based for critical access hospital
- Mandate migrant inclusion
- ER reporting of critical trends
- Performance guarantees (Cost, quality outcomes, providers, patients)
- All payment implications must meet cost report inclusion and compliance
- No exclusion of providers
- Interface with ASC to help incorporate and manage all current Medicaid A/R
- Timely Denial Management Program
- Experience elsewhere
- Financial/patient care tract record
- Disease Management programs **in place**
- Development of regional pilot success stories (novel cost saving strategies) to share with other regions
- Compliance rates with Preferred Drug List should be at x rate (90%, 95%, 100%?)
- Any outlier claims must have an appeal process...We must ensure that CMOs do not control costs – By: Denying payment to providers; But: Setting up guidelines that say **AHEAD** of time...*You* will only get this...instead putting the provider in the position to be the patient's financial counselor
- All CMOs must give equal access to all providers
- Penalties to non-compliance with payment guidelines
- A **cap** on the MCOs administrative fee
- A safety provision in case of plain solvency. In multi-state corporations if Georgia operations go bankrupt, then we can collect from other operations.
- Place guidelines on how providers enroll **and** how plans enroll numbers
- Prompt pay with appropriate penalties
- Minimum quarterly updates to providers to discuss his/her practice compared to both regional and state peers to fix before
- Specific penalties for non-compliant patients i.e. loss of benefits
- Minimum number
- Exclude no rural providers
- Disease management that practices \_\_\_\_\_ > urban assets rural
- Satisfaction survey
- No reject/eject requirement for health plan and providers
- Provider Pool Development – Minority provider, specialty provider
- Care management for high users and users of expensive services
- Coordinate patient benefits
- Responsive and timely payment system
- Patient Education
- Insure minority participation and specialist pool
- Create guideline for provider enrollment to limit movement in and out based on fees
- Encourage participation of providers who previously participated in Medicaid

- The database system would be easy to incorporate into the populations and DCH.  
DATA
- Easy access to providers and facilities
- Ability to adjudicate claims in an appropriate and efficient manner
- What is your track record for efficiently adjudicated claims
- Carve out to include Minority Physicians
- Ensure participation and inclusion of small or solo practices
- Timely reimbursement or penalties should apply
- That there be uniformity through the CMOs
- Realistic performance standards
- Is this a fully capitated system?
- Include current local networks with grassroots relationships
- Money needs to stay in Georgia – Consider economic development issues
- Specific about cost savings expectations – Where are they to come from?
- Limit profit percentage of CMOs
- Provider payments to be timely, accurate; regular \_\_\_\_\_ to providers if claims submitted, etc., sufficient and immediate penalties for performance
- “Refusal to cover/pay for services” clearly based on present criteria
- Limit on administrative costs/profits built in
- Quality assurance measures
- Accountability measures
- Patient satisfaction measures
- Reports on quality and outcome measures must be available ASAP for providers
- How will patients be enrolled?
- Will DCH require compatible systems for health plans?
- Provisions to **stop** MCOs **from** limiting care
- What type of payment system for MCOs?
- The providers be paid at cost plus percentage; also in accordance with Georgia law; also capitated rates to providers have to be on an actuarially sound basis
- The plans don’t make medical necessity decisions (such decisions regulated by Medical Board California – litigation?)
- That patients are entitled to all protections of Georgia patient Protection Act
- That plans are not considered ERHA i.e. are subject to Georgia Insurance Laws (including prompt pay)
- CPT guarantees control
- Denial claims is a **huge** concern. Need rational systems so providers aren’t left holding the bag. Fear less or no payment for more services.
- Payments/incentives for truly organizing care – e.g. for CHS, asthma and other chronic conditions plus health maintenance and prevention activities
- Licensure by state insurance
- Compliance with Georgia Prompt Payment laws
- Performance requests with financial holdback – Quality payments, financial, prompt payments

- Bundling guidelines
- Standardized EOPs; clean claims
- Follow payment guidelines DOI for HMOs
- Published Denial Guideline
- Lessen Administrative Burden; No Retrospective Denials
- Require all plans to have small administrators
- One location for checking eligibility and claims status
- Prompt pay
- Make sure they don't take money away from patient services
- Mental Health and Pregnancy related services, Immunization for children
- Simplify enrollment process for providers – Standardized credentials
- Payment guidelines and follow CPT rules for payment of physicians
- Standardized EOP – Help make additional CMO added to ACS easier
- Local “Patient Reps” for education of enrollees
- Grievance Procedures for Denial Managements
- Mandatory Lock-In Good, however, need to address members who lose and gain eligibility on a monthly basis. Lock-in eligibility also.
- Open access to medications – especially psychiatric medications since brain disorders (mental illness) affect individuals different. What works for patient A may not work for patient B.
- Contract with Emergency Crisis Service Providers to provide intake/triage/care assessment
- Provide patient education and incentives. Education should include community resources, support, and advocacy. Family education
- Must include doctors within 10 mile radius of patient
- Care is physician driven
- Specific providers
- Sufficient notice or penalty for withdrawing /canceling service
- Outreach to providers and members – This is very important!
- With current system, there is confusion among members and providers. Communication is key, often, providers just call our association if they need to know about changes or if they just need help with problems (i.e., enrollment, claims issues, etc)
- Members are confused as well. They don't understand covered services, providers, etc.
- The parameters should be clear about what is expected of the provider
- Choice of doctor
- Ability for patients to have access to second opinion and specialists that have a track record of providing high quality of care
- Provider required to spend time with patient; not push quota per hour etc.
- Patients can call and get advice on whether doctor visit is needed or appropriate
- Process simple for consumer to navigate gate keeper; referrals to specialist for sixth time frame to allow specialists treatment
- Doctor driven care not administrator
- Access to good location of care providers in plan

- “Gatekeeper” not be mandated for eligibility to a provider when health condition is evident – patient self-referral allowed – eyes, dental, existing state laws OB, ultrasound
- Be made without additional hoops for compliance imposed on provider
- Includes psychology services
- For Part I have a co-pay
- A way to ensure that contractual arrangements don’t interfere with doctor’s decision on appropriate care
- Mandatory education/outreach programs (examples of models that have worked in other states)
- Clear, concise UM plans. Can’t change manuals as they go
- CMO can’t control costs by focusing on denial mgt. instead of UM
- Health plans must share risks
- Providers must accept Medicaid to be in other state plans. Must avoid “cherry” picking
- Timely and adequate payments
- Organization should have Medicaid managed care experience
- Adequate and timely data management and reporting
- Billing guidelines and strict payment policies
- States Rates?
- AWP for guaranteed access (Any willing provider)
- Will provider networks survive after the failure of this project
- True contracting with providers not coerced pricing for services
- They must pay state rates/they must work with provider groups to bring adequate money to the Medicaid Program
- All plans must use uniform systems
- Must be penalized if don’t meet state standards
- Must have “real people” working in the areas to actually meet and help population – Not telephones!
- Profits from this program and CMOs must be reported
- That is the health plan at risk and not just “disallow” cost of uncovered service (which puts cost, and risk) on provider
- Evidence of ability to handle volume
- Evidence of truly managing care, not just disallowing payment
- Promptness in payment, response to calls
- Consider requirement FFS (no capitation) with **floor**
- Uniform schedules and reporting requirements
- Provide 24-hours nurse call systems
- Not capitation for providers
- Adequate re-imbursment for physicals
- Paying for out of region care (if patient has an emergency)
- Prevention care
- Contracts should be longer than one years – 3 – 5 years
- Prompt payment
- Reimburse physicians fee for service with floor to reimbursement

- Have CMOs fund advice line for referral to ER/after hours care
- Uniform reimbursement rates
- Uniform credentialing
- Uniform claims process
- Uniform quality measure process/reporting requirements
- Continues eligibility for children
- Keep the Primary Care Case Management Plan (which pays Primary Care Physicians as pmp fee) to manage Medicaid patients
- Uniform payment to providers through each region/CMO
- CMOs assistance to encourage physicians to incorporate EMR/EHR Systems in practices
- Uniform pharmacy benefits for all CMOs
- Clause for state to monitor fiscal stability of plans frequency (two of top three HMO's in Tennessee Care went bankrupt)
- Prompt payment
- Uniform Claims Submission Process
- Provider Support Services must be staffed well and have rapid response
- Programs should pay for 24 hours night time Pediatric Triage Telephone Service (Protocol Balance)
- A floor for reimbursement (statewide) should be set up that is fair and sufficient to affect rising overhead of providers
- Plans should pay PCCM that cares overhead that is not otherwise reimbursed (Telephone advice, filling out forms for BCW, Head Start, etc.)
- Require strong programs by CMOs in all regions
- Eliminate cigarette smokers – Stop Smoking Programs for **Parents** of cared for children (**With Incentives**) – **This Will Reduce Health Care Costs!**
- Weight Control – Exercise Education and Programs for Elevated BMI (overweight) with **Incentives** – **This Will Reduce Health Care Costs!**

**What are the quality indicators that we should measure and maintain to ensure an improving health status for Medicaid members under this new model?**

- For older adults, wellness indicators that reflect appropriate utilization of immunization and lifestyle choices (exercise program use of medication, weight control (obesity), healthy heart, diabetes and cancer risk factors).
- Education on how to be an active participant in health care plan.
- Health care provided in least restrictive setting – 20,000 older adults are on waiting lists for community based care. Community-based care is rationed out where as institution care is guaranteed.
- Family “ER” visits
- Patient compliance to pharmaceutical necessity
- Patient responsibility – Patient could face penalty if they do not follow through – Set limits
- Need to make sure we don't have another ACS – Frustrates all participants

- Could the patient access care?
- Adequate numbers of providers – Generalists and Specialists.
- Education component for physical health and dental health
- Methods to provide patient input
- Physician input – Number of physicians/providers enrolled per region
- Increases in client participation and other regional services/systems, i.e., DFACS, Jails
- Increase in ER utilization (a decrease)
- Levels of consistency/or inconsistency of provider reimbursements
- Low birth weight babies (%)
- Immunization rates
- Readmission rates for ACSCs.
- Pneumonia vaccine rates for older adults
- Flu vaccine rates for vulnerable populations
- Provider – Cap not necessary to provider. Standard, hospital, immunization
- Patient – DNKA, ability to locate, frequency of ER use
- CMO – CAP and risk, speed of payment, denial rate – spell out reason, Administrative fee% of payment.
- Performance criteria – Improved health
- “Risk adjusted” based on the population
- Consumer satisfaction – Provider/Member
- Cost/Benefit – Describe \_\_\_\_\_ in RFP
- Most integrated setting (\_\_\_\_\_ services)
- Base **payment** on **outcomes**
- Citizen monitoring of outcomes/practices
- Need to make sure the quality indicators are risk adjusted to reflect the actual level of the population
- Need to focus on Outcome Measurement
- Payment should be based on the indicators and the outcomes obtained
- Actual changes in disease and presenting problems that are a result of no treatment: High blood pressure, asthma incidents, diabetes, mental health incidents, etc.
- Monthly rates
- Institution by 1,000 members – LOA, ER, Long-term care, Pharmacy
- Not claims based
- Performance standards on key clinical measurement
- Provider satisfaction responses
- Preventive care indicators (immunizations, annual physicals, well baby checks, pap smears, diabetes checks done, reduction of frequency of ER visits, etc.) must be tracked by CMO and goals for improving use of preventive care must be in place.
- Quality measure must be determined using acuity, population demographics, as well as other (community) locally accepted parameters
- Focus on outcomes and measures
- Quality should include performance of the **CMO** as well as performance of providers
- Mortality and morbidity rates

- Clinical Pathways – Outcome methodology
- Actual change in clinical indicators status: i.e., diabetes within certain parameters, BP within certain parameters – Quality outcomes
- Consumer Satisfaction
- More Preventive Care
- Quality Indicators – For plans? for providers?
- Standards should be other Medicaid populations
- Decreased hospitalizations
- Decreased ER use
- Decreased pharmacy costs
- Increased immunization rates
- Increased health supervisor visits
- Rates should be judged on same Medicaid managed care population from other states not commercial payment
- Number of ER visits
- Number of patient well visits/sick visits
- Responsiveness to prouder problems
- Wait time to see MD/Get a procedure
- Compliance with prescribing medications from Preferred Drug List
- Vaccination rates
- Have defined desired outcomes for disease management categories and measure % achieved
- Patient cost/positive outcome as defined
- Define obesity benchmarks to gauge all patients
- Define acceptable weight variations for congestive health failure
- Identify required Medicaid patient quality and indicate stats required for individual management tools and benchmarks.
- This is a great idea but you CANNOT hold the provider (or the plan) responsible for an individual's health choices. Any and all quality indicators measuring the success of the provider's (or plans) performance must be technical based (e.g. nosocomial infections, med errors, cost per case.
- Improving Health Status? What elements affecting health status are under the control of the plan or provider? USE THOSE!!
- PIE IN THE SKY – Health status in the information age is the responsibility of the individual
- Immunization rates
- E.D. utilization
- Outcomes – number down per day stay
- Compliance on programs – Diabetes for blood sugars
- Patient provider satisfaction/UMO
- Management of the patient's care – Not the money
- Access to appropriate level of care – Utilization of management
- Follow-up on missed appointments for ongoing care

- Care management
- Education and Outreach
- Reduction in crisis/ER visits
- Management of Provider Pool – Access to specialty care, consumer choice, no rejections
- Administration – Timely payment, timely authorization, ease of processes for UM
- Statewide – Uniformity in access to care, Statewide of service availability
- Create a system that allows communication between primary care physicians and other specialists
- Methods to measure compliance to eliminate retreatment
- Survival outcomes, hospital admissions, length of stay
- Mechanism to review formology for more appropriate use of newer drugs
- Drop in ER utilization
- Maintain detailed records of physicians (provider) complaints regarding use or management of system
- Maintain detailed records of patient complaints with regard to use or management of CMO systems
- Data to be able to track Medicaid members complaints concerning a provider and facility
- Utilization by providers and facilities
- Database access for providers in order to review patient history and utilizations
- Infant Mortality
- ER Visits
- Hypertension
- Diabetes
- Induction Rate
- Get these from each medical specialty
- Average HbA1C
- Blood Pressures (130/80)
- Flu Shots
- Self-Management goals by patients
- Appropriate screening for patients as per physician guidelines
- Use of service!
- Cost of care
- Outcome/quality of care
- Medication Compliance through Medication Therapy Management
- National Organizations – CMS, JCAHO – Avoid duplication (Clinical)
- GHA PHA – which mission
- Quality outcomes
- Measure screening, wellcare utilization by members
- HEIDUS measure are inadequate – Need to expand required measures – Need attention by DCH leadership with collaboration of physician and providers
- Provider satisfaction measures
- Well child visits

- Prenatal care
- Appropriate use of E.D.
- Member satisfaction with DMO functions – Case of access, treated with dignity and respect, got the help needed
- Medication compliance
- Members with MH and AD issues increase their independence and achieve a greater degree of recovery
- Members with MH and AD issues understand more about their physical health conditions
- Are disease management protocols followed
- Outcomes measured
- Patient satisfaction
- Risk adjusted mortality
- Infant mortality cut by birth weight
- Immunization rates
- Return to ER within 72 hours
- Risk adjusted complications rate
- Cancer serenity rates – breast, cervical, prostate
- Stroke outcomes
- Visits per enrollee/primary care provider
- Patient satisfaction
- Provider (physician and hospital) satisfaction
- I am skeptical that this can be achieved. It is more about budget. If the state does not adequately reimburse providers, quality will go down. There is a real risk the system will fail.
- Monitor the number of physicians participating in Medicaid and geographic coverage.
- Monitor the number of hospitals participating in Medicaid and geographic coverage
- Number of dollars spent for top conditions. Measure if improvement in clinical conditions occurs.
- Establish quality indicators for top chronic and acute conditions and measure trends
- Need to assure indicators are still valid
- Get away from C/S rates as a quality indicator with a change in practice guidelines since 1998. Low C/S rate is no longer an indicator of quality care (VBAC and C/S on demand)
- Please talk to us at the Georgia OB/GYN Society
- Rhogam management would be better
- Induction rates
- Pap smear in OB visit
- Group B Strep test and treatment in labor
- Diabetic management in pregnancy – Protocol
- Mammogram and Pap smear
- Must be clinically sound – Provider
- Must be operationally sound – CMO
- Must improve outcomes – Patients

- ER visits
- Low birth weight
- Infant mortality
- Obesity
- Diabetes
- Have CMOs **fund** specific quality resources (health clinics) by region!
- Same as **NATIONALLY** examined indicators, to minimize duplicated effort
- Keep basic

**Given the goals and organized care direction of this strategic plan, what suggestions for a successful implementation would you offer?**

- Clear and concise contracts, guidelines for service
- I'm sorry we didn't get to Phase Z. I'm very worried about managed care for services and supplies for individuals with disabilities.
- The CMOs are incentivized to maximize profit. The state is trying to limit budget expenses. Patients will demand services. Providers are where all forces come to bear. Providers must be treated fairly and have incentives that reward performance. Sadly, to date, experience with HMO and other payers has been cutting payment with demands ever increasing.
- Need protection from arbitrary behaviors by CMOs – standards of performance, period of payment
- Need rewards and incentives for creative approaches
- Providers must continue to be engaged to make this work. Simply turning this over to CMOs will be disastrous. I applaud today's effort. Continue to include us!
- Detail expectations and requirements up front in RFP. Selection based on compliance with requirements
- Financial holdbacks against CMO until compliance with quality, utilization, financial parameters have been met
- Full rollout at all regions at once (otherwise you will see movements between regions and adverse selection)
- Smaller focus groups with specific provider groups to get buy in from leadership and address key issues. Less broad-based input and more solid, focused discussion.
- Recognize that lower cost through more effective utilization will cost more. Better outcomes cost more
- Simplify administration for providers: a. standard EOB b. standard "clean claim" c. 1 location to check eligibility d. 1 location to check claims status
- Put penalties in contract w/CMOs
- Educate, educate, educate
- Demand communication on bundling issues, admin guidelines, payment expectations
- Develop mechanism to reward providers if successful

- Make patient accountable and responsible for their own care
- Do not implement plan until all programs are in place
- Create method for DCH to intervene if problems arise w/CMO (ex. Unexpected problems w/ACS) Don't lock providers into bad situation
- Incentive providers into rural areas
- Wait till after the election
- Pre-educate Medicaid formulation
- Has to be well planned and should not be permanently implemented (i.e. ACS)
- Buy-in from ALL stakeholders
- Assure providers, will not be left on the short end of the stick
- Know and understand your data prior to implementation
- Enlist provider input (understand how the current managed care organizations work)
- No capitation to groups of doctors (providers)
- Requirement to partner with minority groups and/or organizations
- Review system and penalties to CMO for inappropriate denial of or administration of care
- Be sure plan is such that you have enough primary care and multiple specialists
- Must recognize the impact that patient has vs. provider (i.e. if patient continues to use ER and ambulance for transportation – vs. ongoing patient care by provider)
- Do not implement
- Someone at DCH with superior knowledge in state and fed regulation related to healthcare needs to take charge and lead. Need greater healthcare expertise.
- Test, test, test! Try a model in one region before rolling out statewide
- Get current, accurate baseline data
- Have a good understanding of cost (either savings or increased costs) in achieving desired outcomes
- Tell organization (MCOs) what state expects/demand.
- Need statewide system
- Do hand on friendly care management for patients with chronic disease instead
- Flexibility
- Buy-in by ALL stakeholders (providers, governor, gen. assembly) and all agree to work to make sure there is adequate funding
- "Do No Harm" to existing provider groups – many are providing tremendous care to the community served but are struggling to remain open. If this new (reform) places additional burdens or in fact damages these fragile systems, whole communities will be damaged and no care available
- Remember CMOs do not deliver care
- Adequate database that is reliable and believable
- Who is the client in Manager Care Programs?
- Pilot 2 areas for 6 months prior to the rest
- Extensive education, especially regarding physician providers, and even more so the recipients
- Meet with the numerous stakeholder groups to get input

- Don't implement until CMOs are ready and providers are informed, trained and ready – pilot well and first
- Identify a person or department in DCH who will be responsible for the implementation – and for fixing the problems
- Assess impact of program on providers in Atlanta, other urban, rural north, rural south (particularly rural providers). The safety net may need some protection
- Case management/disease management should use local providers. If local infrastructure does not exist, CMO should use expertise to grow local Georgia infrastructure
- Choose one region, only after successfully resolving 'all' issues – proceed to others
- Goal to provide most effective, comprehensive care with least amount of administrative cost
- The model must be created such that all component (patient, physician, DFACS) are consistent with guidelines for care
- Must have intense dialogue between all healthcare providers, pharmacist, etc.
- Need to study pilot program for 6 months to 1 year
- Have to prepare on intensive program to educate providers and patient population about program i.e. newsletters to physicians, materials to be dispersed in offices of providers, some newspaper activity
- A well coordinated, easily understandable member education plan
- A way to involve the provider community in ongoing dialogue with DCH and HMOs. This may include policy development or quality improvement
- Provide to the provider information on an ongoing basis that can improve their ability to bill effectively – reduce administration and provide more time for patient care/interaction
- Review all aspects of the initial startup. Include representative or team from the provider for each specialty and facilities in order to address the needs for appropriate protocols (i.e. – claims submissions, billing policies, reimbursement, etc.) will reduce administrative burden for the future
- Get it right the first time, that's the main thing...Billy Joel
- Good/broad patient education, provider education of the changes
- Easy rules to follow. No complicated administration even though we are talking about state government
- Run sophisticated financial models forecasting the impact of each MCOs proposal on the providers – tell the providers what their analysis shows
- Form an advisory board of providers reps that will help choose CMOs that are awarded contracts (this will increase buy-in)
- Town hall meetings
- Mandatory enrollment classes for all Medicaid patients before giving them their card
- Implement NO action without a proven pilot beta site
- Thorough discussion with all players
- Do not force feed program
- Get a handle on current Medicaid reimbursement issues before implementing plan

- Massive education plan for ALL describing what is happening. Too much confusion with providers and patients
- Counter any potential negative press. Engage consumer groups (patient advocacy groups) for buy-in and support. They can help with education.
- Prompt pay to providers/physicians
- Financial incentive to Medicaid population (Green Stamp Plan)
- Payment at Medicare rates
- Educate patients about signing up for plans
- Have people to “walk” patients through process
- Decrease unnecessary utilization but this has to be patient driven regarding unnecessary doctor’s visits and ER/urgent care visits
- Possible waiver for ER co-pay/office visit co-pay for unnecessary utilization (how to determine this would be a big issue)
- Focus on disease management first.
- Place a floor on reimbursement rates
- Lower cost through more cost-effective utilization while maintaining high-quality action
- Educate physicians
- Could be mandatory for Medicaid participants but not be onerous Example: quarterly cost-effectiveness CME representation by CMO newsletter or cassette or CD or email including a quiz at the end
- Be careful not to increase patient co-pays , etc. to a population that has limited ability to pay
- Revenue growth should not be the only yardstick to measure outcomes. Given the rising demographics of the aging population, the need will increase as well as the costs
- Global tactics such as drug population and negotiating drug costs for all state programs would allow expanded revenues for direct reasons
- Having a system of administrators, timely payments to recipients and vendors while ensuring no duplicity payments or fraudulent claims. GBI has been successful catching crooks that drive up the total program costs
- Keep the open dialogue w/stakeholders – every category of service has different perspectives – put their suggestions into play
- Go slow – don’t move forward with implementation until the plan/program is ready
- Be sure to include the providers in developing the plan with specific details of the plan
- Give details of the RFP in time for public comment and provide for adequate implementation time
- Multiple regional education forums to ensure every eligible resident understands, or at the very least, has access to information about the plan
- Phase-in each part of the plan
- Make corrections along the way in areas where need arises
- Do not increase paperwork!!
- Do not let a clerk on a phone dictate/overrule a physician’s judgment
- Keep everyone informed
- Don’t implement until ready to do so – ACS example

- Monitor bad debt and charity write-offs of providers in first two years
- Should have a phased in approach by region
- Second, phase in the program by service line
- Frequent monitoring of reporting requirements during early stages
- Address issues quickly and effectively (means have man power to follow up in initial phase)
- Have progressive phases
- Extensive public provider member education/explanation
- “Pause” points in enrollment and rollout for “lessons learned” assessment
- Public report card quarterly – enrollment, savings, lessons learned
- Use a provider based “team” (hospitals, doctors, non-acute providers) as advisors in the implementation process. Truly empower them to help develop best implementation plan. You will get better “buy-in” if you do this!
- Use other state’s experiences (successes and failures) to our advantage in Georgia
- Consider rolling out new program on a “pilot” basis in one or two geographic regions before going to all six
- Have specific “go or no-go” criteria for each stage of implementation. Do not go forward until the majority of criteria are met in stage 1, 2, 3 etc...
- Enrollee and provider education – local forums
- Involve enrollees and providers as educators/mentors to others
- Billing issues/payment issues “ironed out” prior to implementing
- Incentives for improving health C clinical pathways
- Multi disciplined team
- Do not start prematurely – have all ducks in a row

### **What are your suggestions on how we could lessen any administrative burdens?**

- Be mindful of requirements for provider paperwork
- Have a provider-friendly claims and enrollment system
- DCH to talk with division of MHDDAD during this process to include them as a partner (I am not from the division!)
- Pay providers for some of their administrative tasks. Providers do a lot of case management with members to get them to services they need
- Require adoption of electronic health records and electronic administrative and business office systems
- Managed care always increased paperwork, which is time consuming, and takes time away from patients. Don’t do paperwork for the sake of paperwork.
- Stay in contact with providers (i.e. managed care directors in hospitals) – they know the administrative pitfalls. Continue to involve providers as key advisor through the planning/implementation process – don’t just do what the CMO wants to do...
- Pay providers for care provided – don’t make providers ‘chase’ their payments because of denied claims and administrative paperwork of “gotchas”.

- Make sure this is a care management system NOT a denial management system of care.
- Uniform policies and procedures for every CMO
- Prompt payment requirements
- Keep providers and stakeholders involved with feedback
- Verify CMO administrative capacity before selection – ACS?
- Identify DHR and DCH administrative costs that will be reduced/eliminated and track success on that.
- Do not offload to contractors and avoid 20% administrative layer that takes money away from health services
- Require ALL MCOs to comply with single payment model
- The north district is oddly shaped. Perhaps you should divide it east and west.
- Dispute resolutions process between CMO and providers that is truly independent
- Prompt payment, sensible claims and denials, management and resolution
- Standardization for CMOs – EOB, claims process, performance parameters
- Require departmental insurance license
- Compliance with Prompt Payment Laws
- Standardize EOB
- Provider education
- Local provider reps for enrollees so providers do not have to spend their time educating enrollee
- Smart Card
- Eliminate unnecessary utilization review guidelines
- Eliminate administrative denials
- Electronic payment and claims submissions
- Standardize EOB, claims, etc.
- Smart Card with health record embedded and credit to provider upon service
- Simplify credibility
- Make pre-certification easy – do not require for routine services
- Reduce/eliminate redundant paperwork
- Do as much electronically as possible and have the system coordinated in a manor to reduce dual entry. (i.e. prior auth enters data into billing system. Eligibility feeds through authorization, etc.)
- Common data requirement of providers, make the MCOs adjust their systems
- Minimize any or frequent changes; restrict flexibility
- Hard Medicaid recipients pick up their monthly check from their primary care provider – drive compliance
- Eligibility and claims system that is statewide, accurate and timely. Don't allow MCOs to shift burdens to providers. Have MCO surveys/quality card from providers/patients and consider in contract
- Flexibility
- Limit pre-authorization and referral requirements
- Provider education workshops
- Set local coverage decisions

- Reality need to be time limited. Mechanism for early dispute resolution must be in place. Entire group perspectives should not be personalized by with holders payment when only one provider is in audit
- Formulate detailed/comprehensive guideline and ensure all parties are educated
- Access to central data system. Prepare for initial startup in a timely and effective manor
- Make access and use of system simple for patient and providers
- Technology
- Standardization
- Dump ACS
- Uniform payment
- Make credibility, promote reporting, EOB, etc. All uniform throughout CMOs Make it user friendly

**What should be the requirements and responsibilities to ensure adequate member education and outreach?**

- Implement incentives to member to follow care guidelines
- Require CMOs to meet performance criteria on “member education contact hours”, providing written material to members, plan documents
- Media education and local presentations
- Association presentations
- Through departments in state
- Local enrollee’s and providers as trainees/mentor’s
- More closely with DFCS/Public Health and other state agendas to coordinate
- Each member must complete workshop
- Provide providers with plan info and give that at the time of service
- Each MCO should provide programs to search each mentor during a contract cycle
- Enrollment training program – best time to capture their attention
- It must be local
- It must be at level (educational) member can understand
- For people with MH or AD, a lot of physical health education is needed – but, if providers are to do it, it must be paid for
- Facilitators and provider relations in each county
- Require advocate in each ER for 1<sup>st</sup> year
- Require working w/local entities if educational facilities exist
- Maybe “mandatory educational requiring” for enrollees: healthy lifestyle/choices, value at immunity, prenatal care, strike education, heart care, cancer
- Education s the key to utilization (along with disease management or health promotional and screen activities
- CMOs should foster and develop this. Increased providers should be able to creatively approach this with funding opportunities from CMOs and the state.
- Local provider reps – full-time in a central location in each county

- Give providers a place to send the patient w/questions
- Place enrollee advocate in ER's for 1<sup>st</sup> year to help offer alternatives to ER visit
- Discharges from program for non-compliance
- Require education by public health dept
- Case management should include education to the patient about their disease
- Start teaching children in school the correct chain of events – when to go to MD office vs. ER
- A behavior by educating early when to utilize services
- Medicaid is NOT a gift – it should be utilized wisely or it will go away
- Involve the patients in designing the outreach and education plan. Do not use typical methods of distribution, pamphlets in MDs Office, DFCS office, etc.
- Get information to where the individuals live – public housing, churches, neighborhood organizations, cultural groups
- Use of case management services and regional medical directors for case review and/or disputes based on objective medical care practices
- Required training for Medicaid eligibility by enrolled members. Be participatory
- Mailings
- Required ongoing training to continue participation. (yearly?)
- Require number of provider and member workshops per year
- Require local representatives in each city
- Work with state societies and specialists
- There is no way this can be overstated! NO understanding = NO success = Great Provider Damage/Failure
- This must be a requirement of managed care organizations and NOT providers
- Serious penalties for CMOs for failure to educate
- Again “real people” on the ground in the different areas
- Rewards for appropriate outreach and guidance to member.
- State payment to providers for education outside of the payment for care
- Use existing providers
- Should be CMO responsibility