

# Appendix L: Behavioral Health

## *Statement of the Issues*

People with a mental illness or addiction are likely to have co-occurring physical health problems, many with chronic conditions. Over half of all Medicaid members with disabilities are diagnosed with a mental illness. “For those with common chronic conditions, health care costs are as much as 75 percent higher for those with mental illness compared to those without a mental illness and the addition of a co-occurring substance use disorder results in two- to three-fold higher health care costs. Among individuals eligible for Medicare and Medicaid (also known as dual eligible individuals), 44 percent have at least one mental health diagnosis. For the 20 percent of dual eligible individuals with more than one mental health diagnosis, annual spending averages more than \$38,000—twice as high as average annual spending for the dual eligible population as a whole. The prevalence of serious mental illness is especially high among dual eligible individuals under age 65 – at least three times higher than for those age 65 and older. Meanwhile, substance use disorder, with and without co-occurring mental illness, is also more common among dual eligible individuals than among Medicare-only beneficiaries.”<sup>1</sup>

For example:

- About half of people diagnosed with schizophrenia have one or more other health conditions. These complicating factors account for 60 percent of excess mortality for that population.<sup>2</sup>
- Medicaid members with mental health conditions are 30 percent to 60 percent more likely to have hypertension, heart disease, pulmonary disorders, diabetes and dementia.<sup>3</sup>
- People with substance abuse conditions are 50 percent to 300 percent more likely to have heart disease, pulmonary disorders and HIV/AIDS.<sup>4</sup>

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<sup>1</sup> Hamblin, A. Center for Health Care Strategies and Verdier, J. and Au, M., Mathematica Policy Research. State Options for Integrating Physical and Behavioral Health Care, October 2011. Available at [http://www.chcs.org/usr\\_doc/ICRC\\_Physical\\_&\\_Behavioral\\_Health\\_Brief.pdf](http://www.chcs.org/usr_doc/ICRC_Physical_&_Behavioral_Health_Brief.pdf)

<sup>2</sup> Morbidity and Mortality in People with Serious Mental Illness. Available online: <http://theempowermentcenter.net/Articles/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf>

<sup>3</sup> United Hospital Fund. Providing Care to Medicaid Beneficiaries with Behavioral Health Challenges. February 2011.

<sup>4</sup> United Hospital Fund. Providing Care to Medicaid Beneficiaries with Behavioral Health Challenges. February 2011.

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- “Depression is associated with 67 percent increased mortality from cardiovascular disease, 50 percent increased mortality from cancer, two-fold increased mortality from respiratory disease and three-fold increased mortality from metabolic disease. Depression predicts colorectal cancer, back pain and irritable bowel syndrome later in life.”<sup>5</sup>
- People with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely because of physical health problems. Schizophrenia is associated with increased death rates from cardiovascular disease (two-fold), respiratory disease (three-fold) and infectious disease (four-fold).

As a result of co-occurring conditions, these individuals have increased spending on health care. Individuals with co-occurring mental illness and chronic conditions have more preventable hospital admissions due to non-compliance with medication and treatment plans resulting in significant costs that could be saved through better care coordination using a specialty team approach.<sup>6</sup> For example:

- The difference in spending for inpatient services for people with behavioral health conditions and those without is particularly striking. "Average annual expenditure for inpatient treatment [for people with mental illness] was \$7,017 compared to \$3,629 for others." For those with substance abuse disorders, inpatient costs averaged \$11,738 compared to \$3,301 for others. Also striking is the fact that, "the seven-day hospital readmission rate of mental health beneficiaries was 50 percent higher than non-mental health beneficiaries. Substance abuse beneficiaries' rate was 150 percent higher than [others.]"<sup>7</sup>
- For people with substance abuse conditions, average Medicaid spending was \$27,839 – only 24 percent of which was for substance abuse treatment. For those without substance abuse disorders it was \$18,051.<sup>8</sup>

Given the high rates of co-occurrence, many efforts are underway to integrate provision of physical and behavioral health services. Various methods are being implemented to achieve this integration, for example:

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<sup>5</sup> Mental Health Foundation, Physical Health and Mental Health, February 2011. Available online:

<http://www.mentalhealth.org.uk/our-work/policy/current-policy/physical-health-and-mental-health/>

<sup>6</sup>MHPA Presentation. PsychoSocial Impact on Health: Controlling the Rising Costs of the Chronically Ill. November 7, 11.

<sup>7</sup> Friedman, M. Mental Health and Medicaid Costs: Why Ignoring Mental Health Is Expensive, February 2011.

<sup>8</sup> Friedman, M, Mental Health and Medicaid Costs: Why Ignoring Mental Health Is Expensive, February 2011.

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- Co-locating physical and behavioral health services in a single clinic
- Linking clinical information systems
- Training providers in interdisciplinary practice
- Restructuring financial incentives to include risk-sharing arrangements or cross-care.<sup>9</sup>

Efforts to implement these strategies have met varying levels of success, stymied by difficulty navigating information-sharing regulations, cultural norms among providers and competing priorities.”<sup>10</sup>

Currently, behavioral health is carved in to Georgia Families, and the Georgia Department of Community Health (DCH) provides behavioral health services through its fee-for-service (FFS) delivery system for individuals who are not enrolled in Georgia Families. Services for individuals in the FFS delivery system are managed by the Department of Behavioral Health and Developmental Disabilities. The state as a whole has behavioral health provider access issues. It is the ninth largest state but is near the bottom of all states for behavioral health provider availability.

In many state Medicaid programs, physical health and behavioral health services are administered through separate delivery systems, which have been found to present significant challenges in coordination of care and care management. There are many benefits to be considered in serving members through one delivery system so as to enhance care management opportunities for the “whole person.” Industry guidance confirms that behavioral health issues impact physical health outcomes and significantly increase cost of physical health care, especially for chronic diseases such as heart disease and diabetes.

## *Redesign Options and Recommendations for Behavioral Health Populations and Services*

A variety of approaches should be considered for behavioral health populations and services. These approaches are described in the following narrative, and the advantages and disadvantages of each are outlined in Figure 1 at the end of this Appendix:

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<sup>9</sup> The Kaiser Commission on Medicaid and the Uninsured, Mental Health Financing in the United States. April 2011.

<sup>10</sup> The Kaiser Commission on Medicaid and the Uninsured, Mental Health Financing in the United States. April 2011.

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- **Carve in behavioral health services.** In this risk-based managed care delivery system, behavioral health services would be included in the benefit package, along with physical health services, and the cost of the benefit would be included in the capitation rate, similar to the current model for Georgia Families. The health plan would be responsible for managing the behavioral health benefit for its enrolled population, either through a subcapitated arrangement or by developing its own behavioral health provider network, payment rates and policies governing the behavioral health benefit.
- **Carve out services to be managed by a different vendor or community vendors.** In this risk-based managed care delivery system, behavioral health services would be carved out to a different vendor specifically focused on managing behavioral health services. The vendor would be responsible for managing the behavioral health benefit for the same population managed through the physical health plan and developing its own behavioral health provider network, payment rates and policies governing the behavioral health benefit.
- **Carve out population with physical health to also be managed by behavioral health providers.** In this model, individuals with specific behavioral health diagnoses would be carved out of the physical health delivery system. Their full needs, both physical health and behavioral health, would be managed and coordinated by behavioral health care providers.

Having one entity to manage a member's full needs presents the opportunity to:

- Streamline disease and care management services, thereby omitting potential duplication of services as well as contradictory care plans
- More easily enforce coordination of care requirements because providers are contracted with the same vendor
- Have both physical health and specialty behavioral health providers in network, thereby increasing opportunity to have care managed for the whole person within one network
- Increase access to clinical information – since the vendor's information system will capture all member physical health and behavioral health clinical information. The vendor's information system can more easily send reminders and follow up if

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providers are not meeting coordination of care requirements and sharing information

- Consider a member’s clinical history and special disease management and coordination of care needs when authorizing behavioral health services
- Have one blended capitated rate for all physical health and behavioral services, thereby reducing incentives for “dumping” and the associated negative cost and quality of care impacts
- Reduce administrative oversight and monitoring burden by contracting with one vendor for both physical health and behavioral health management

Providing physical health and behavioral health services through the same delivery system has the potential to improve hospital discharge planning, reduce high readmission rates and more completely address the health needs for members with chronic conditions and co-occurring behavioral health diagnoses. The federal government has recognized this need for coordination, and is taking steps to improve coordination for dually eligible individuals: “Even though Medicare generally provides acute care and Medicaid primarily non-acute services for dual eligibles with mental illness, utilization of services within the programs is linked, as management of mental illness impacts physical health and vice versa.

Coordination across programs is hampered by use of separate administrative and data systems for the two programs. The 2010 health reform law includes a demonstration program to improve care coordination for dual eligibles, which could improve the interaction between these two funding sources.”<sup>11</sup> Treating members with co-occurring health conditions is critical to realizing cost-efficiencies while at the same time improving the quality of member care and reducing state costs.

In light of the considerations discussed above and outlined below, we include in our assessment of options a carve in to cover behavioral health populations and services through the managed care delivery system.<sup>12</sup> Keeping these design issues in mind, Figure L.1 below provides advantages and disadvantages of carving in management of behavioral health care populations and services.

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<sup>11</sup> The Kaiser Commission on Medicaid and the Uninsured, *Mental Health Financing in the United States*. April 2011.

<sup>12</sup> Should the State of Georgia decide to move forward with a behavioral health carve out, then the scores in the evaluation of options in Chapter 5 must be updated, and the results of the evaluation may change.

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**Table 1: Advantages and Disadvantages for Carving In or Carving Out Behavioral Health**

	Carve In	Carve Out Services (To be managed by a different vendor or community vendors)	Carve Out Population (With physical health to also be managed by behavioral health providers)
<b>Advantages</b>	<ul style="list-style-type: none"> <li>• Care for whole person managed by one health entity</li> <li>• Having both provider types in one network provides opportunity to manage care for the whole person</li> <li>• Streamlined disease and care management</li> <li>• Creates opportunity to decrease duplication of services and contradictory care plans</li> <li>• Improves availability of clinical information due to one or linked information systems when authorizing behavioral services and for considering disease management and coordination of care needs</li> <li>• Allows leverage with providers to enforce coordination of care requirements and to hold them accountable for outcomes using pay-for-performance and value-based purchasing strategies</li> <li>• One blended capitated rate creates efficiencies</li> <li>• Places burden of making sure members receive required services on health plans and creates avenue to hold them accountable.</li> <li>• Limits DCH administrative oversight and monitoring burden by contracting with one set of vendors</li> </ul>	<ul style="list-style-type: none"> <li>• Some stakeholders prefer behavioral health services be managed separately from physical health services</li> </ul>	<ul style="list-style-type: none"> <li>• Care for whole person managed by one entity</li> <li>• Having both provider types in one network provides opportunity to manage care for the whole person</li> <li>• Creates opportunity to decrease duplication of services and contradictory care plans</li> <li>• One blended capitated rate creates efficiencies</li> <li>• Meets the needs of some stakeholders who advocate for members with serious mental illnesses, special health needs and chronic conditions by having all physical health and behavioral health care needs coordinated by behavioral health providers</li> <li>• May encourage some members to be more compliant with treatment plans, e.g., medication compliance, when coordinated by their behavioral health providers</li> </ul>

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	Carve In	Carve Out Services (To be managed by a different vendor or community vendors)	Carve Out Population (With physical health to also be managed by behavioral health providers)
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>• May be challenging for health plans to build networks due to overall shortage of behavioral health providers in Georgia</li> <li>• Some stakeholders object to physical health plans managing behavioral health benefits</li> </ul>	<ul style="list-style-type: none"> <li>• Creates challenges in accessing member clinical information, as it is housed in two different vendor systems</li> <li>• May present challenges in behavioral health services authorization without current clinical history and special disease management and coordination of care needs</li> <li>• Requires DCH to perform, administrative oversight and monitoring activities for multiple plans</li> <li>• Creates challenges in determining responsible entity for payment of some services or medications</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health vendors/providers may not have expertise to manage high-risk medical conditions</li> <li>• Most behavioral health vendors/ providers may not have infrastructure to integrate, manage cases and coordinate service delivery, i.e., must establish contracts and relationships with physical health providers, negotiate hospital contracts</li> <li>• Behavioral health vendors/providers may have difficulty developing a cohesive treatment team of physical and behavioral health providers</li> <li>• May negatively impact physical health outcomes and cost, especially for chronic diseases</li> <li>• May present challenges in behavioral health service authorization without current clinical history and special disease management and coordination of care needs</li> <li>• May present challenges and disrupt continuity of care for individuals who are forced to transition from one set of health plans (i.e., those for enrollees without behavioral health needs) to another set (i.e., one of the plans that serves people with behavioral health needs)</li> <li>• Requires development and enforcement of clear set of criteria to determine which enrollees should be enrolled into each set of health plans</li> <li>• Creates challenges in determining responsible entity for payment of some services or medications</li> <li>• Requires DCH to perform administrative oversight and monitoring activities for two sets of plans</li> </ul>

# Appendix M: Long-term Care Services

## *Statement of the Issues*

As noted in *Chapter 3: National Environmental Scan*, states are increasingly moving toward operating Medicaid managed long-term care (LTC) programs<sup>1</sup> rather than paying for long-term care services on a fee-for-service (FFS) basis. This appendix discusses some of the key options and considerations in selecting an approach to providing LTC services. This discussion of the approach to long-term care services is somewhat more extensive than the discussion of other potential carve outs (which are addressed in other appendices), because the delivery system options are complex and numerous. Furthermore, Medicaid managed LTC is an area currently receiving much focus nationally and which, in light of the complex and diverse needs of the enrollees receiving LTC services, requires particularly careful consideration.

As described in Chapter 4, the Georgia Department of Community Health (DCH) currently provides LTC services through the FFS delivery system, and serves dual eligibles as well as individuals enrolled in Home- and Community-based Services (HCBS) waivers and the SOURCE program through this system. While DCH is the administering agency specific to Medicaid, some of these services and populations are managed by the Department of Behavioral Health and Developmental Disabilities or other offices. Georgia also has a Money Follows the Person program that began in September 2008 as a joint effort between DCH, the Department of Behavioral Health and Developmental Disabilities the Georgia Department of Human Services' Division of Aging Services (DHS/DAS) and other state and local agencies and organizations. Through December 2010, Georgia experienced a two percent increase in annual spending on HCBS. As of June 30, 2011, 651 individuals have been transitioned back to the community and another 212 individuals were in the process of transitioning. The State had estimated transitioning over 1,300 individuals by 2011, but cited a variety of reasons for not being able to do so. For example, although the State has met project benchmarks set by CMS the State had challenges in the following areas:<sup>2</sup>

- Working across agencies and across disabilities
- Performance contracting, limiting ability to control implementation
- Hiring competent transition coordinators

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<sup>1</sup> For the purposes of this report, the term managed long-term care (LTC) is used. It is intended to be inclusive of long term services and supports (MLTSS).

<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured. Case Study: Georgia's Money Follows the Person Demonstration. December 2011. Available at: <http://www.kff.org/medicaid/8262.cfm>

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Some features of Georgia's HCBS programs are unique and use designs that could enable Georgia to overcome some of the challenges of traditional fee-for-service long-term care delivery systems. For example, the SOURCE program is designed to function as a medical home of sorts and to coordinate a broader scope of services than a traditional HCBS care management function. When a person enrolls in SOURCE Care Management, the SOURCE site becomes the member's primary care provider of record, and each member chooses a physician, nurse practitioner, or physician assistant on the SOURCE panel. Members receive:

- A primary care plan to monitor and treat ongoing, chronic conditions (patients with a new physician also receive an initial physical exam)
- Treatment of illnesses and injuries by preferred primary care physician, nurse practitioner, or physician assistant
- Access to a 24-hour phone line for medical advice or triage
- Coordination of other medical services, including specialists and hospital care

On the other hand, nursing home admissions are subject to limited checks and balances, and, as a result, examination of the nursing home admissions in Georgia might reveal opportunities to further enhance reliance on HCBS. Likewise, nursing home reimbursement policies warrant careful examination to consider incentives they might or might not introduce for encouraging use of HCBS. Overall, for both its HCBS and nursing home settings, Georgia would benefit from the collection, analysis and use of independently generated outcomes and performance data. Doing so will better enable DCH to understand where opportunities lie to improve quality and cost-effectiveness and, eventually, to link performance to payment and to inform future program design changes and interventions.

The rebalancing of the long-term care system to rely upon HCBS services wherever possible has gained much support, as evidenced by the large number of HCBS waivers currently operated by the states and by the opportunities available to states via the Affordable Care Act. As outlined in the national debate, there are many challenges with the delivery systems typically used by Medicaid programs for long-term care, and many of these exist in some or all of Georgia's (as well as other states') HCBS waiver programs:

- Medicaid is provider-driven with much of the decision-making in the hands of others, who through "case management" determine what services are available, the amount of services to be provided, and from whom the individual will receive those

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- services.<sup>3</sup> Such an approach poses questions about program integrity and the appropriateness of services being provided. It also raises questions about whether funds are being spent efficiently and whether services are authorized based on need or want.
- “Section 1915(c) waivers require states to demonstrate cost-effectiveness when compared to a specific institutional level of care, including nursing facilities, intermediate care facilities for the mentally retarded (ICF-MRs), acute-care hospitals, and residential treatment facilities serving children and adolescents under age 21. Hence, states are required to create separate programs for each target population (e.g., elderly and physically disabled, developmentally disabled, etc.). Despite similarities in waiver management requirements, service definitions, and overlapping provider networks, in most cases states administer each waiver program separately, losing not only opportunities for management efficiencies, but also creating competition between waivers for the same workforce. Combining and consolidating HCBS programs for all target groups and eligibility categories would resolve most of these issues.”<sup>4</sup>
  - States typically have multiple HCBS waivers each serving different populations. However, some individuals could qualify for multiple waiver programs and they often provide similar sets of services. States have been challenged with using consistent service definitions across waiver programs, and may pay providers different rates for the same service depending on the waiver under which treatment is being provided. Also, assessments are often provided by different agencies using or applying guidelines differently.<sup>5</sup>
  - Early studies on the cost-effectiveness of HCBS reflect greater utilization of acute care services among this population than among residents of nursing facilities.<sup>6</sup>
  - The following factors might explain this pattern: acute/medical needs are being met by nursing facilities; residents of nursing facilities are being underserved and acute

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<sup>3</sup> CMS, New Options to Support Individuals With Disabilities and Long-Term Care Needs. Available at: <https://www.cms.gov/smdl/downloads/Rvltcneeds.pdf>

<sup>4</sup> Center for Healthcare Strategies, Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options. May 2010. Available at: [http://www.chcs.org/usr\\_doc/LTSS\\_Policy\\_Brief\\_.pdf](http://www.chcs.org/usr_doc/LTSS_Policy_Brief_.pdf)

<sup>5</sup> United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term. April 2009

<sup>6</sup> Richard W. Ronder, Theodore Kastner, Steven J. Parker, Kevin Walsh. Serving People with Developmental Disabilities in Medicaid Managed Care, *Managed Care Quarterly* 1999; 7(2): 23–30. Available at: <http://www.aspenpublishers.com/books/kongstvedt/Readings/Chapter%2031/MCO%207-2.p23-30.pdf>

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care needs are not being met; or acute care and long-term care are not well coordinated in either setting. Regardless of the reason, it is clear that many states do not integrate acute care with LTC services, often resulting in fragmentation, opportunities for cost-shifting, and/or other negative, unintended consequences. For example, nursing facilities routinely call 911 in circumstances where another, less-expensive approach may be more appropriate.<sup>7</sup>

The challenges with integration of care are further aggravated for enrollees who are dually eligible for Medicare and Medicaid (i.e., dual eligibles) and leaves states with little incentive to manage acute care utilization for the population of beneficiaries that is dually eligible for both programs.<sup>8</sup> As noted by Mathematica Policy Research:

“Care is highly fragmented and poorly coordinated. Medicare pays for short-term post-hospital [skilled nursing facility] stays, [prescription] drugs, and physician services. Medicaid pays for long-term NF care and alternative home-and community-based services (HCBS). Medicaid has little or no information on Medicare-provided services. Incentives and resources for coordinated and cost-effective LTC for duals are not well aligned. Costs of avoidable hospitalizations for dual eligibles fall on Medicare, so Medicaid has few incentives to invest in programs to reduce hospitalizations. Nursing facilities benefit financially if dual eligible Medicaid residents are hospitalized and return after three days at higher Medicare [skilled nursing facility] rate. Medicaid has lost access to Rx drug information needed to manage and coordinate care, and is generally not informed about hospitalizations”.<sup>9</sup>

Similar findings and concerns have been noted by others and commonly discussed in the literature and among policy makers and program administrators. It is these concerns which led CMS to launch several recent initiatives to integrate financing and care for dual eligibles through its Medicare-Medicaid Coordination Office and Center for Medicare and Medicaid Innovation.

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<sup>7</sup> Center for Healthcare Strategies, Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options. May 2010. Available at: [http://www.chcs.org/usr\\_doc/LTSS\\_Policy\\_Brief\\_.pdf](http://www.chcs.org/usr_doc/LTSS_Policy_Brief_.pdf)

<sup>8</sup> Center for Healthcare Strategies, Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options. May 2010. Available at: [http://www.chcs.org/usr\\_doc/LTSS\\_Policy\\_Brief\\_.pdf](http://www.chcs.org/usr_doc/LTSS_Policy_Brief_.pdf)

<sup>9</sup> Mathematica Policy Research, Inc. Managed Long Term Care: Options for New York and Examples From Other States. July 8, 2011

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Last year, U.S. Health and Human Services Secretary Kathleen Sebelius encouraged the expansion of managed care to high-cost enrollees who use long-term services and supports. In a [letter](#) to the nation's governors, Secretary Sebelius encouraged states to expand managed care: "Just one percent of all Medicaid beneficiaries account for 25 percent of all expenditures," she wrote, noting that states don't need any special permission from Washington to cut costs by creating "initiatives that integrate acute and long-term care, strengthen systems for providing long-term care to people in the community, provide better primary and preventive care for children with significant health care needs..."<sup>10</sup>

Perhaps the current state of affairs – and the opportunities for the future – are best summed up by Melanie Bella, who is now Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services (CMS) while she was Senior Vice President at the Center for Health Care Strategies in her testimony before the Senate Committee on Aging.

"For many in the field of publicly financed care, myself included, integrated care for the dual eligibles represents the single most important opportunity for reforming the current U.S. health care system. It is tantamount to a Holy Grail that has been pursued literally for decades. The first efforts to integrate care for dual eligibles began in the early 1980s with efforts like the On Lok/Program of All Inclusive Care for the Elderly (PACE) program and social health maintenance organizations (HMOs), and eventually the state-based Medicare-Medicaid integration waivers in Massachusetts, Minnesota, and Wisconsin.

While there are gems among all of these programs, after 30 years most remain relatively small in scale. More than 95 percent of the dual eligibles who could benefit from fully integrated approaches are still in various forms of *un-integrated* and *un-managed* care. Even among those who could benefit the most, the highest risk duals with multiple acute and long-term care needs, the percentages in integrated care are truly discouraging. This is the case, although most experts you could bring here to testify would assert that truly integrated care could significantly improve the lives of beneficiaries and reduce the growth in Medicare and Medicaid costs for taxpayers....

What do I mean by truly integrated care? In its purest form, it is where one entity is programmatically and financially responsible for providing all Medicare and Medicaid reimbursable services. That means both acute care and long-term supports and services as is the case with PACE, Wisconsin's Partnership Program, New Mexico's Coordination

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<sup>10</sup> Stateline, Crushed by Medicaid Costs, States Expand Managed Care. February 2011. Available at: <http://www.stateline.org/live/details/story?contentId=547640>

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of Long-Term Services, Minnesota's Senior Health Options, and a limited number of other model programs. "<sup>11</sup>

Many others note the benefits of managing long-term care supports and services. Because most long-term care beneficiaries have multiple chronic medical conditions, they typically require a lot of medical services and acute care. Effective care management for people with chronic medical conditions can accomplish many tasks: preventing avoidable slow functional and cognitive decline; and fostering more effective disease management, such as better glucose monitoring for diabetics. In order to address the full complement of beneficiaries' needs, it will be important to implement strategies that more fully integrate long-term care with the delivery of medical, mental health, and social services.<sup>12</sup>

Because the vast majority of our nation's Medicaid long-term care recipients continue to be served in a fee-for-service environment, experience with and evidence about the impact of Medicaid managed long-term care is somewhat limited. <sup>13</sup> Findings related to access to care and quality of care are more conclusive than those related to the impact of Medicaid managed long-term care on costs, as outlined in the following excerpts from the literature.

- A growing body of evidence from similar programs in other states and countries suggests that programs similar to MMLTC are effective in delaying nursing home placements and reducing the number of unnecessary hospitalizations.<sup>14</sup>
- As noted by CMS, in Minnesota, Medicare and Medicaid payments are combined at the health plan level. The combining of payments and benefits under one health plan gives care coordinators and care providers maximum flexibility to design treatment plans that may keep beneficiaries more independent, provide alternatives to higher cost services, and prevent, defer, or reduce lengths of stay in both acute and long-term care settings.<sup>15</sup> Experiences in Minnesota and with PACE have demonstrated

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<sup>11</sup>CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>12</sup> United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term. April 2009

<sup>13</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>14</sup> United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term April 2009

<sup>15</sup> CMS, Long-Term Care Capitation Models: A Description of Available Program Authorities and Several Program Examples. August 2007 Available at: [https://www.cms.gov/IntegratedCareInt/Downloads/LTC\\_Capitation.pdf](https://www.cms.gov/IntegratedCareInt/Downloads/LTC_Capitation.pdf)

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- that managed long-term care, like managed acute care, reduces the use of high cost services, including emergency rooms, hospitals and nursing homes.<sup>16</sup>
- Managed long-term care increases access to HCBS waiver and other community services People enrolled in managed LTC programs are generally not subject to caps on the number of "slots" available for HCBS waiver services. Plans have the flexibility to provide LTC services to members who need them when they need them, and have incentives to do so when community services can prevent or reduce institutional use.<sup>17</sup>
  - Managed long-term care generally includes a care coordination mechanism to assist consumers and families with the system. While this is generally also true in fee-for-service HCBS programs, HCBS programs typically are not responsible for consumers when an acute episode results in hospitalization, often the time when coordination is most important. Managed LTC contractors, on the other hand, usually have financial incentives to manage transition periods because of their ongoing risk. (The incentive is greatest in programs with the most comprehensive quality performance and risk designs.)<sup>18</sup>
  - Managed care models allow states to share the risk of budgetary cost increases with its managed care contractors. As the number of people in the long-term care FFS system increases over time, a state's aggregate risk increases. However, payment systems still require refinement to assure that capitation rates are aligned with program goals.<sup>19,20</sup>
  - State Medicaid officials value being able to hold plans accountable, and being able to work with plans in a systematic way on quality goals, something that is not possible in fee-for-service, where multiple providers are providing care, but none are responsible for overall quality outcomes. In managed long-term care, a negative

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<sup>16</sup> US Dept. of Health and Human Services, *The Past, Present and Future of Managed Long-Term Care*. April 2005. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

<sup>17</sup> US Dept. of Health and Human Services, *The Past, Present and Future of Managed Long-Term Care*. April 2005. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm> <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

<sup>18</sup> US Dept. of Health and Human Services, *The Past, Present and Future of Managed Long-Term Care*. April 2005. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm> <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

<sup>19</sup> US Dept. of Health and Human Services, *The Past, Present and Future of Managed Long-Term Care*. April 2005. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm> <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

<sup>20</sup> Kaiser Commission on Medicaid and the Uninsured, *Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider*. October 2011. Available at: <http://www.kff.org/medicaid/upload/8243.pdf>

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quality indicator in one year can be turned into a focused quality improvement effort in the next.<sup>21</sup>

Not surprisingly, there are also some potential challenges associated with managed long-term care programs. Some of the key challenges are highlighted below.

- MCOs reduce their financial risk by limiting the number of healthcare providers that recipients can see and by requiring these providers to accept a reduced fee for provision of care. This has created concern among Medicaid beneficiaries that they will have limited ability to control their own care and decreased access to specialists. In addition, many fear that the reduced fees paid by the MMLTC organization may decrease the quality of medical providers enrollees can access, and result in an insufficient number of plans and/or providers available to meet their needs.<sup>22</sup>
- States have struggled with establishing payment rates and pricing that will deliver shared savings to both the state and the MCO. It is at times difficult to find MCOs that have long-term care experience or are willing to expend the resources necessary to enter an entirely new coverage area.<sup>23</sup>
- Quality measures are not well developed for long-term care services. Thus, measuring the impact of Medicaid managed LTC programs can prove challenging, and, using quality performance as the basis for financial incentives can prove still more challenging. Having reliable quality measures will be critical to enabling states to build appropriate incentives into their contracts and to assure access to and quality of care are maintained in the new delivery system.
- Some healthcare providers have opposed MMLTC out of fear that MCOs would not contract with them to provide care or would require them to accept deeply discounted fees.<sup>24</sup>

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<sup>21</sup> US Dept. of Health and Human Services, *The Past, Present and Future of Managed Long-Term Care*. April 2005. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm> <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

<sup>22</sup> National Consortium for Health System Development, *Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants*. Available at: [http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC\\_Brief.pdf](http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf)

<sup>23</sup> National Consortium for Health System Development, *Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants*. Available at: [http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC\\_Brief.pdf](http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf)

<sup>24</sup> National Consortium for Health System Development, *Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants*. Available at: [http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC\\_Brief.pdf](http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf)

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- There is not yet enough experience and data and thus conclusive evidence that MMLTC will reduce long-term care costs over time, or increase the quality of services provided.<sup>25</sup> Furthermore, capitation rate setting is particularly challenging.
- Whether in a fee-for-service or managed care model, rebalancing to focus on community-based care requires a sufficient supply of providers to deliver the full spectrum of long-term care services, as well as a supply of acute care and other (e.g., behavioral health) providers sufficient to meet the needs of those enrollees living in the community. A shortage of such providers – statewide or in selected geographic regions – could stall progress toward rebalancing which, in the Medicaid managed LTC environment, could pose particular challenges related to health plan capitation rates that are built upon underlying assumptions about the consumer needs that can be met in the community.
- Regardless of the managed long-term care delivery system (i.e., carved in or carved out), rigorous state oversight of the contracted health plans is critical. Identifying the necessary state resources to conduct such oversight can be particularly challenging amidst state budget shortfalls.
- Because, as a nation, our experience designing, operating and evaluating the impacts of Medicaid managed LTC is limited, so, too, is the experience of health plans in administering such programs. Furthermore, organizations that have experience coordinating long-term care and are familiar with the community and its providers typically do not have the financial resources to bear the financial risk associated with Medicaid managed LTC.<sup>26</sup> Conversely, the national health plans that do have financial resources and experience operating Medicaid managed LTC programs are less likely to be familiar with each Georgia community’s network of long-term care providers.

Because the Medicaid managed LTC landscape is changing rapidly, some of these challenges might be lessened in the months and years to come as other states move forward with their Medicaid managed LTC initiatives.

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<sup>25</sup> National Consortium for Health System Development, Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants. Available at:

[http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC\\_Brief.pdf](http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf)

<sup>26</sup> The National Consortium of Health System Development, Medicaid Managed Long-Term Care: Background for Medicaid Infrastructure Grants. Available at:

[http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC\\_Brief.pdf](http://www.nchsd.org/libraryfiles/MedicaidGeneral/MMLTC_Brief.pdf)

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Moreover, some groups of enrollees, along with the providers who serve them and the advocates who represent them, have raised concerns about whether managed care delivery systems can truly meet their needs. Particularly vocal in these discussions have been people serving and representing people with developmental disabilities. The Kansas excerpt below is representative of the discussions taking place in many states and on a national level, and similar discussions may take place in Georgia as it closes long-term institutions for and considers managed LTC for people with psychiatric conditions and developmental disabilities. Representatives of many other subgroups have raised and will raise unique considerations regarding the coverage of those subgroups.

“Services for persons with developmental disabilities are most generally needed on a life-long basis with the desired outcome of improving or maintaining optimal functioning in daily activities of life. We do not fit into a medical service model which are episodic in nature with the intended result of resolving the medical problem or illness. There is little evidence to prove that application of managed care model to long-term care services for persons with developmental disabilities results in a quality system of supports that enables such persons to live independently, inclusive and productive lives in the community of their choice. Only four states in the union have even attempted applying managed care to developmental disabilities long-term care services. None of the developmental disabilities systems in those states are comparable to the robust supports we have here in Kansas. Further, each of those states proceeded cautiously, taking years to incorporate developmental disabilities long-term care into their managed care plans.”<sup>27</sup>

As evidenced by the discussion above, the people using LTC services have diverse and complex needs, and the delivery system that serves them must be robust and flexible to meet those needs, with sufficient direction and oversight to assure that the health plan is tailoring its service to meet the unique needs of the people it is serving and complying with the states requirements governing the delivery of care to those people

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<sup>27</sup>Letter from Gerald Michaud, President, Developmental Services f Northwest Kansas, Inc December, 2011.

Available at:

<http://www.dsnwk.org/BBoard.nsf/topicThread.xsp?documentId=7D607ADB75FAF1418625796E0058A91B&action=openDocument>

# Appendix M: Long-term Care Services

## *Redesign Options and Recommendations for Long-term Care Services*

Many approaches should be considered for long-term care redesign. These approaches are illustrated in Figure M.1 below, then described in more detail in the following narrative.

As illustrated in Figure M.1 and described by Robert Kane and colleagues in *Managed Long-term Care and the Rebalancing of State Long Term Support Systems: Topics in Rebalancing State Long-Term Care Systems*,<sup>28</sup> LTC consumers may be in:

- A Medicaid FFS arrangement (including traditional HCBS waiver services) for the full scope of services
- A Medicaid managed care plan for their acute care only
- Managed care for their LTC only
- Managed care covering all Medicaid services (i.e., acute and LTC services)

Dually eligible consumers may be in managed care for either Medicare or Medicaid or for both.

Figure M.2 at the end of this appendix outlines the advantages and disadvantages of the various approaches to carving out LTC services and populations. As discussed above and in Figure M.1, retaining the status quo FFS arrangement for LTC services poses some challenges and, as a result, is not likely to enable Georgia to achieve its goals for Medicaid redesign. For example:

- As people who use LTC services are enrolled in a new delivery system, their long-term care services will remain the responsibility of the State. Such an arrangement poses incentive and opportunity for “dumping” high cost enrollees from the acute care system to the LTC system – which, in turn, negatively affects costs and quality.

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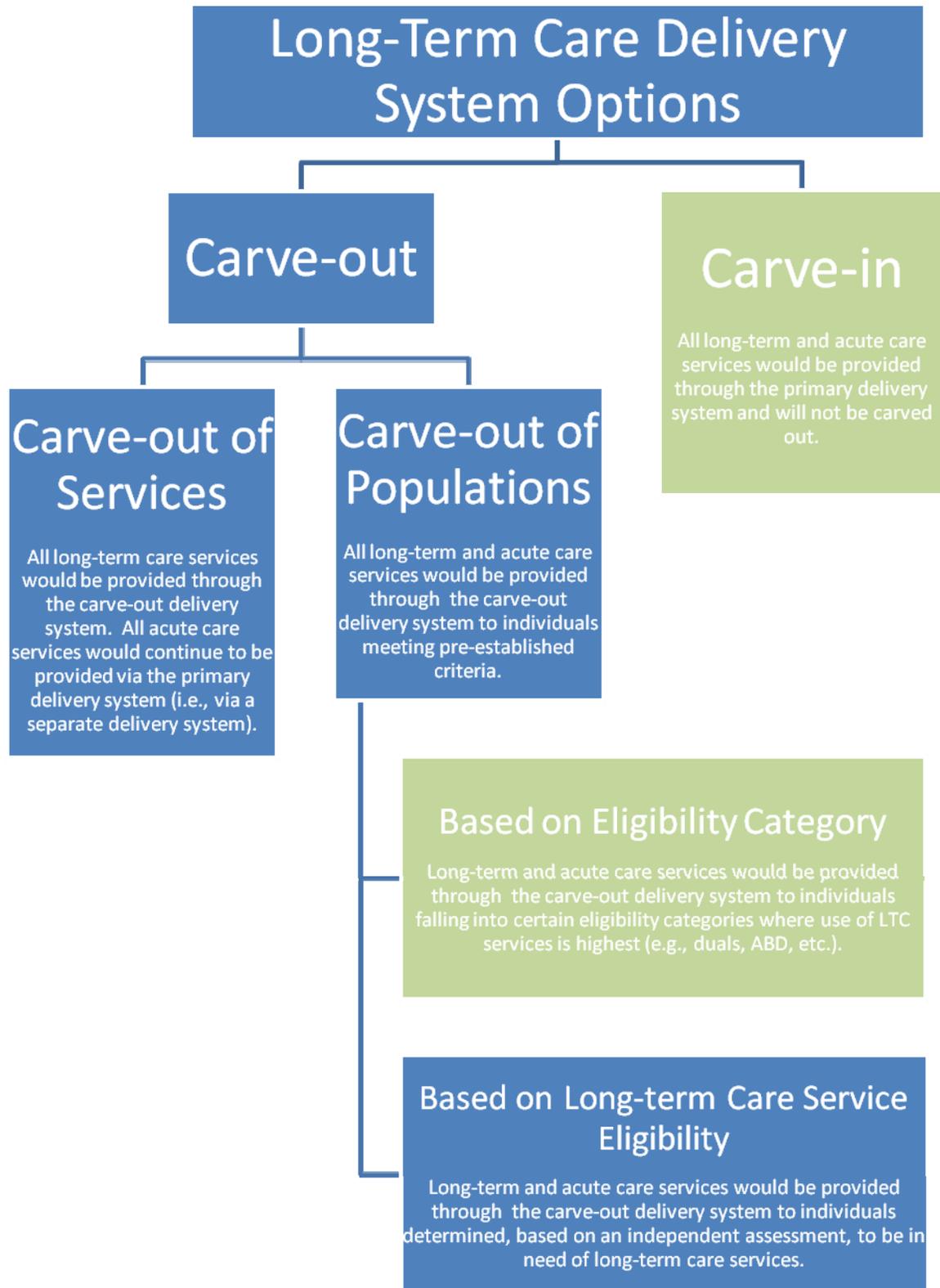
<sup>28</sup> CMS, *Managed Long-term Care and the Rebalancing of State Long Term Support System*. December 2007.

Available at:

[http://www.sph.umn.edu/hpm/ltrcresourcecenter/research/rebalancing/attachments/topicpapers/Topic\\_3\\_Implications\\_of\\_Managed\\_Long\\_Term\\_Care\\_for\\_Rebalancing.pdf](http://www.sph.umn.edu/hpm/ltrcresourcecenter/research/rebalancing/attachments/topicpapers/Topic_3_Implications_of_Managed_Long_Term_Care_for_Rebalancing.pdf)

# Appendix M: Long-term Care Services

Figure M.1. Long-term Care Delivery System Options



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- Retaining a separate FFS delivery system would introduce some administrative burdens for some providers (particularly those, like physicians and hospitals, who deliver services to Medicaid enrollees who use LTC services and others who do not or who deliver services for multiple waivers) and might, in turn, reduce availability of providers.
- Retaining a separate FFS delivery system would also introduce administrative inefficiencies for DCH, since it would need to retain two separate delivery systems.
- Likewise, reimbursing LTC services on a FFS basis does not align reimbursement with patient outcomes and quality versus volume of services delivered – one of DCH’s redesign goals. Such a model then, in turn, would not promote improved health care outcomes to the same degree as a risk-based managed care model.

Managed care, and more specifically risk-based managed care, poses opportunities for payers to overcome many of the challenges with the current delivery system. Similar to the FFS carve out arrangement described above, a risk-based delivery system covering just long-term care services and no acute care services presents risk of “dumping”, akin to what now exists between Medicare (which covers acute care services) and Medicaid (which covers long-term care services and other wrap-around services) for dual eligibles. On the other hand, a risk-based delivery system covering the full continuum of services for each eligible individual offers many opportunities for improvements in quality, access and costs.

The most important take-away from the discussion above is that covering the full scope of services for any individual offers the greatest chance for care integration and, in turn, improvements in appropriate service use and cost-effectiveness. This can be achieved via two approaches which are listed below and highlighted in Figure M.2:

- A long-term care carve in to cover the full scope of acute and long-term care services for all eligibility categories
- A long-term care carve out to cover the full scope of acute and long-term care services for specified eligibility categories

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The results of the Georgia-specific scan outlined in Chapter 4 indicate that the first of these options is likely to be preferable for Georgia because, relative to the second, such a model poses a greater likelihood of enabling Georgia to achieve its goals:

- **A carve in model poses a lesser administrative burden on providers so is more likely to be a more attractive payer for providers.** The carve out model would require DCH to contract with two sets of health plans: one set to serve the more traditional Georgia Families populations and another to serve the MMLTC population. While it is possible there could be some overlap in health plans serving both Georgia Families and MMLTC, it is likely that there will be different plans contracted to serve both. Many of these providers (and particularly physicians and hospitals) would, under the second option, likely find themselves approached by and contracting with some or all of both sets of health plans.
- **A carve in model poses a lesser administrative burden on DCH so is more likely to achieve operational feasibility from a fiscal and administrative oversight perspective.** Since the carve out model would require DCH to contract with two sets of health plans, DCH would need to procure, negotiate contracts with, and monitor the activities of two sets of plans.

In light of these considerations, we include in our assessment of options a long-term care carve in to cover the full scope of acute and long-term care services for all eligibility categories.<sup>29</sup> The success of this approach is dependent upon the ability of the State to contract with vendors who are qualified to provide the full scope of services to all populations, including the many smaller groups of people – each with unique needs and provider communities – now served via Georgia’s HCBS waiver programs.

Thus, one key question for Georgia relates to the capacity of health plans to accept risk for and appropriately manage the full scope of acute and long-term care services. A handful of national companies and some regional companies have or are gaining extensive experience with managed LTC— and they and others may gain more experience as other states, like Kansas, move forward with their Medicaid reforms. States will need to work closely with their selected plans to develop and implement successful programs. Even for national plans that have experience with MLTS, states have found that ongoing collaboration between the state and managed care contractors is critical for ensuring that the state’s program goals and financial

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<sup>29</sup> Should the State of Georgia decide to move forward with long-term care carve out to cover the full scope of acute and long-term care services for specified eligibility categories, then the scores in the evaluation of options in Chapter 5 must be updated, and the results of the evaluation may change.

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incentives are aligned in the rate-setting process, and for assuring that the contractors are providing the services requested by the state.<sup>30</sup> States with managed LTC experience have also stressed that states must be sure that MCOs accustomed to coordinating medical services have an appreciation of the full range of services and supports, particularly non-medical supports, when long-term services and supports are included in managed care programs.<sup>31</sup> In Arizona, as the managed care entities implemented their models and case managers gained experience, the state was able to cut back on some of its initial requirements. As discussed in Chapter 4, this evolution of Medicaid managed care programs is common and to be expected in the launching of a new and complex program.

In short, strong state oversight of health plans is critical.<sup>32,33</sup> It will be even more critical as the many states now beginning to implement Medicaid managed long-term care progress and as the resources of health plans, other vendors and advisors are spread among the many states in the midst of implementation. During contract negotiations and contractor readiness review, setting and reinforcing clear expectations and requirements will be critical to Georgia's success. Georgia can also consider creative approaches to assessing health plans' capacity to provide the full scope of services. For example, it could conduct a request for information process to solicit information from potential bidders, then use that information to shape its program design and procurement strategy. Georgia could also consider shaping its health plan procurement to offer bidders the option to bid to serve the Medicaid managed LTC population only, to serve the acute care population or to serve both, and to offer evaluation bonus points to those offering to serve both populations.

Georgia should also consider the implications of contracting with health plans that are Medicare Advantage Special Needs Plans (SNPs). SNPs used to offer states one of the only viable options for consolidating Medicare and Medicaid financing, but, as described in *Chapter 3, National Environmental Scan*, last year's developments in CMS's Medicare-Medicaid Coordination Office present alternative approaches to integrate financing. Nonetheless, if seeking to contract for LTC services, contracting with health plans that are SNPs might offer some advantages:

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<sup>30</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>31</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at: <http://www.kff.org/medicaid/upload/8243.pdf>

<sup>32</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>33</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

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- Experienced SNPs have subject matter experts in coordinated care and care management, which will offer the potential for consumers to remain stable, avoid inpatient admissions and serious complications and maintain quality of life
- SNPs may have already established contracts with LTC and HCBS providers
- SNP infrastructure, staffing and information systems are equipped to track all member needs and integrate LTC, physical health and behavioral health services, coordinate with treatment team members and have dedicated staff to follow up if providers are not meeting member needs and sharing information

If selected health plans are not already SNPs, requiring them to become SNPs might also offer the advantage of assuring that the health plan has necessary structures and processes in place to support serving members with complex needs, so that DCH could consider a somewhat reduced oversight role for SNPs.

While risk-based managed care offers potential for Georgia to achieve its Medicaid redesign goals, achieving these goals by simply implementing managed long-term care is not a given. Medicaid managed long-term care programs must be designed and implemented using a deliberate and rational approach. The decision to implement Medicaid managed long-term care should not be taken lightly: designing and implementing a managed long-term care delivery system is not as straightforward as designing and implementing a traditional Medicaid managed care program. The intricate decisions made during the program design and planning process will influence the degree to which the managed long-term care program is able to achieve its potential. Georgia will need to consider the issues below in its design of a managed long-term care program for Medicaid.

- It is important for planning and start-up periods to be long enough to allow state agencies to collaborate to make complex program design choices, to work with CMS to obtain the authority to operate new programs, and to consult with stakeholders, including consumers, providers, and MCOs.<sup>34</sup>

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<sup>34</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at: <http://www.kff.org/medicaid/upload/8243.pdf>

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- Consider requiring person-centered planning,<sup>35,36</sup> specifying who will work with beneficiaries to develop service plans, and specifying the required elements of service plans.<sup>37</sup>
- Emphasize HCBS rather than institutional care;<sup>38</sup> structure benefits to appropriately incentivize the right care in the right setting at the right time;<sup>39</sup> establish a direct linkage between primary care and other clinical, behavioral and supportive services;<sup>40</sup> and aim to cover a broad range of services in the benefit package to promote a shift to more community-based and better coordinated care.<sup>41,42, 43</sup> The array of services for which health plans are responsible and at risk may affect their ability to coordinate services effectively or achieve diversions from institutions or transitions from institutions back to the community. Including attendant care and/or paid family caregivers in the benefit package is of particular importance.<sup>44</sup> Flexibility to provide a broad service package, autonomy for MCO service coordinators, and clear state expectations regarding options for consumers to direct their own services, along with detailed requirements for plans' roles in facilitating these options, can improve care coordination and make plans more aware of the full range of services and supports that consumers may need. In this discussion, consider

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<sup>35</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>36</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>37</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>38</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>39</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>40</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>41</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>42</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>43</sup> United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term. April 2009

<sup>44</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

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- which party – the health plan or the state and, if the state, which state agency or agencies – is responsible for addressing provider and housing shortages that might exist, since these create barriers to serving people in the community.<sup>45</sup>
- In the spirit of covering a broad range of services in the benefit package and to reduce the potential for “dumping”, consider pursuing options to integrate Medicare and Medicaid financing using Special Needs Plans or, ideally, one of the shared savings models first offered by CMS in 2011.
  - Also, emphasize hands-on care coordination.<sup>46</sup> Case managers generally provide more active or “hands-on” care coordination than do PCPs/gatekeepers.<sup>47</sup> Furthermore, establish clear guidelines about expectations for care management services; a strategy for ensuring that the professionals who perform this important role have appropriate skills, training, and supervision; and a strategy for regularly monitoring and evaluating the effectiveness of care management services.<sup>48</sup>
  - To test the feasibility of successfully emphasizing HCBS rather than institutional care as outlined above, assess the provider supply to determine whether provider capacity is sufficient to accommodate the transition to the community. Doing so is particularly important in light of the provider shortages in Georgia and across the nation.
  - Communicate a clear vision for managed long-term care to promote program goals.<sup>49</sup> These program goals should be reflected in the performance measures selected and should drive the public discussion about the approach to program design and implementations.

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<sup>45</sup>Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at: <http://www.kff.org/medicaid/upload/8243.pdf>

<sup>46</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at: [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>47</sup> Kaiser Commission on Medicaid and the Uninsured. Medicaid Managed Care for Dual Eligibles. Case Studies of Programs in Georgia, Minnesota and Pennsylvania. July 2001. Available at: <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14051>

<sup>48</sup> United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term April 2009

<sup>49</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

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- Use a uniform assessment tool to ensure consistent access to necessary LTC services.<sup>50</sup> A uniform assessment tool can also provide meaningful and critical data to inform the rate setting process and to serve as a basis for capitation rates.
- Consider how performance will be measured, reported and linked to payment. Meaningful quality measures are needed and must be used to measure plans' performance, to incent plans' behavior and to hold plans accountable.<sup>51</sup> A major challenge is that few quality measures for long-term care services have been developed or tested, though particular states and plans have data and experience that could help inform efforts to create national standards.<sup>52, 53</sup>
- Carefully consider risk adjustment and other financial incentives for health plans and providers to incentivize appropriate care.<sup>54,55</sup> For example, in order for states to expand HCBS availability under a managed care initiative, a financial incentive ideally should be provided for health plans. One approach is to base capitated payments on the mix of institutional and home-based care.<sup>56</sup>
- Consider the role of community-based organizations in the managed long-term care system. These entities often have long-standing ties with consumers by making long-term care referrals or by providing services.<sup>57</sup> Careful consideration should also be given to reform solutions that would narrow gaps in the availability of local services<sup>58</sup> and to the role of sister agencies.

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<sup>50</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>51</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>52</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>53</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>54</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>55</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>56</sup> Center for Healthcare Strategies, Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options. May 2010. Available at: [http://www.chcs.org/usr\\_doc/LTSS\\_Policy\\_Brief\\_.pdf](http://www.chcs.org/usr_doc/LTSS_Policy_Brief_.pdf)

<sup>57</sup> Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>58</sup> United Hospital Fund and Auerbach Consulting, Inc, Medicaid Managed Long-Term. April 2009

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- Engage stakeholders to achieve buy-in and foster smooth program implementation.<sup>59</sup> The involvement of stakeholders must be considered carefully in terms of timing and content, so that the state's goals are clearly and accurately communicated to stakeholders. Stakeholders, particularly participants and/or their families, can also help the State to monitor their health plan's performance. Such stakeholder involvement can help stakeholders to gain more confidence in the new delivery system and, to some extent, to influence its design and implementation.
- The impact of advocacy from the aging network is clearly visible in a few of the programs.<sup>60</sup> For example, after lengthy negotiations, Texas carved out nursing home care when it implemented the STAR+PLUS Medicaid LTC managed care program in the mid-1990s, and, despite extensive efforts, the state was not able to expand the benefit package to include nursing home care even 10 years later. As noted by the Center for Health Care Strategies:

"These states' experiences underscore another important lesson for states pursuing MLTC programs — if possible, states should include all desired benefits and/or program design elements at the start of an MLTS program. Hawaii's leadership was emphatic about this as well, saying that if they had implemented acute care only, "we would still be here two years later planning to include long-term care benefits." State experience demonstrates that it can be more difficult to add program elements or make substantial changes to existing MLTS programs. This may mean taking more time during the planning stage to work with relevant stakeholders or to develop systems for implementation, but it is usually time well-spent that will save states resources in the long-run."<sup>61</sup>

- Consider approaches to ease the transition for consumers and providers other than phasing the enrollment of subpopulations. For example, often, consumers are concerned about continuity of care and want assurances that provider networks in managed care plans will have the expertise and capacity to provide the broad array of services and supports that people with disabilities often need. Some states that

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<sup>59</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>60</sup> US Dept. of Health and Human Services, The Past, Present and Future of Managed Long-Term Care. April 2005. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

<sup>61</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

## Appendix M: Long-term Care Services

have implemented Medicaid managed long-term care have suggested transition periods of 30 to 90 days or more during which enrollees would be permitted to see any provider, regardless of whether that provider is in the health plan's network.<sup>62</sup> Other possible approaches are to require plans to enroll any willing provider during, for example, the first year of the implementation.

- Recognize that moving from a 1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTC financing and plan accordingly.<sup>63</sup> Consider conducting extensive outreach to educate, for example, traditional LTC providers about how to demonstrate their value in the new delivery system, about how to approach negotiations with a health plan, and the like. Such outreach can and should begin months before program implementation, to allow time for providers to prepare for contract negotiations.
- Consider the diverse needs of the people being served.<sup>64, 65</sup> Just as the many HCBS waiver programs serve people with a wide variety of needs, so must the Medicaid managed LTC health plans. For example, some considerations in serving people with developmental disabilities in Medicaid managed long-term care, as set forth by are outlined below:<sup>66</sup>
  - The presence of a carve in, which will allow disabled clients of the department to receive physical health care and mental health services from the same providers.
  - A defined role for specialty provider networks for acute care, mental health, and dental services.

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<sup>62</sup>Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider. October 2011. Available at:

<http://www.kff.org/medicaid/upload/8243.pdf>

<sup>63</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>64</sup> Center for Healthcare Strategies, Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. November 2011. Available at: [http://www.chcs.org/usr\\_doc/MLTS\\_Roadmap\\_112210.pdf](http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf)

<sup>65</sup> CHCS Testimony, Making the Case for Improving Long Term Care Services. Senate Special Committee on Aging Hearing- Wednesday, March 4, 2009. Available at:

[http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=844520](http://www.chcs.org/publications3960/publications_show.htm?doc_id=844520)

<sup>66</sup> Richard W. Ronder, Theodore Kastner, Steven J. Parker, Kevin Walsh. Serving People with Developmental Disabilities in Medicaid Managed Care, *Managed Care Quarterly* 1999; 7(2): 23–30. Available at:

<http://www.aspenpublishers.com/books/kongstvedt/Readings/Chapter%2031/MCQ%207-2.p23-30.pdf>

## Appendix M: Long-term Care Services

- The ability of specialists to be identified as primary care providers.
- Requirements for the provision of care coordination and case management services.
- The requirement for an annual individualized health care plan.
- Descriptions of disability-specific quality measurement programs.
- Requirements in regard to ADA accessibility.
- Requirements in regard to preparation of written materials and other communication-related accommodations.
- Disability-specific education programs.
- Defined linkages with state agencies and community organizations.
- Capitation rates that are risk adjusted.

As it considers options for Medicaid managed LTC program design – and the Medicaid design strategy overall – DCH should inventory its Medicaid population to identify the various subgroups, and this inventory should be based not just on eligibility codes but should also be based on the care seeking characteristics of the people served. This information can aid DCH in defining the needs of the population to be served and to identify subgroups that might not be well served through managed care, so that DCH can then carefully consider options for handling such subgroups. Some recipients, such as people who become eligible via spend-down and emergency eligibility, might not easily be included in a risk-based managed care program. Creative options can be considered for such subgroups. For example, Tennessee Medicaid proposed elimination of its medically needy program and instead proposed an expansion to cover those who would have otherwise become eligible through the medically needy rules.<sup>67</sup> While such an expansion might, on the surface, appear to be more costly, it could generate savings by eliminating the need for the Medicaid agency to maintain a separate administrative infrastructure to operate the medically needy program. For such subgroups,

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<sup>67</sup>Tennessee Statewide Healthcare Reform Demonstration Fact Sheet. Available at: <https://www.cms.gov/MedicaidStWaivProgDemoPGI/downloads/Tennessee%20TennCare%20Fact%20Sheet.pdf>

## Appendix M: Long-term Care Services

DCH could evaluate the implications of the various options using the same framework used for the purposes of this independent assessment.

While risk-based managed LTC poses opportunities for DCH to overcome many of the challenges with its current LTC delivery system, it poses some challenges, as outlined above. Addressing these challenges is not possible but will require a deliberate and rational approach to decision-making, design and implementation.

# Appendix M: Long-term Care Services

**Figure M.2: Advantages and Disadvantages for Carving In Or Carving Out Long-term Care Services**

	Carve In	Population Carve Out: Based on Specified Eligibility Categories <sup>68</sup>	Current Provision of Services <sup>69</sup>
<b>Advantages</b>	<ul style="list-style-type: none"> <li>• Intensive and coordinated clinical case management and care coordination offer potential to improve outcomes and significantly decrease cost of physical health care, especially for members receiving LTC services who also have chronic diseases</li> <li>• Eliminates potential conflicting business interests of current model where some organizations making authorization decisions are also providers</li> <li>• Offers budget predictability, as is a capitated payment structure</li> <li>• Potential for meaningful quality oversight and quality management through use of quality measures and pay-for-performance measures in provider contracts, once appropriate and meaningful measures and benchmarks are available</li> <li>• Potential to hold providers accountable for meeting quality targets</li> <li>• One blended capitated rate for all LTC and physical health services for all enrollees (those who use LTC and those who do not), which could be further enhanced via consolidation of Medicare and Medicaid funding</li> <li>• Care for whole person managed by one vendor that contracts with all levels of providers to deliver the full scope of</li> </ul>	<ul style="list-style-type: none"> <li>• Intensive and coordinated clinical case management and care coordination offers potential to improve outcomes and decrease physical health care costs, especially for members receiving LTC services who also have chronic diseases</li> <li>• Eliminates potential conflicting business interests of current model where some organizations making authorization decisions are also providers</li> <li>• Offers budget predictability, as is a capitated payment structure</li> <li>• Potential for meaningful quality oversight and quality management through use of quality measures and pay-for-performance measures in provider contracts, once appropriate and meaningful measures and benchmarks are available</li> <li>• Potential to hold providers accountable for meeting quality targets</li> <li>• One blended capitated rate for all LTC and physical health services for enrollees who use LTC services, which could be further enhanced via consolidation of Medicare and Medicaid funding</li> <li>• Care for whole person managed by one vendor that contracts with all levels of providers to deliver the full scope of Medicaid services so members will receive coordinated care and care management,</li> </ul>	<ul style="list-style-type: none"> <li>• No or minimal learning curve for current network of SNFs and HCBS providers</li> <li>• Providers have the resources in place to provide care and services</li> <li>• Current provider network for LTC services and the ABD population are strong</li> <li>• Stakeholders are comfortable with status quo</li> </ul>

<sup>68</sup> LTC services provided in a SNF or HCBS setting under a FFS arrangement.

<sup>69</sup> Long-term and acute care services would be provided through the carve out delivery system to individuals falling into certain eligibility categories where use of LTC services is highest (e.g., duals, ABD, etc.).

# Appendix M: Long-term Care Services

	Carve In	Population Carve Out: Based on Specified Eligibility Categories <sup>68</sup>	Current Provision of Services <sup>69</sup>
	<p>Medicaid services so members will receive coordinated care and care management, which offers potential to help them remain stable, avoid inpatient admissions and serious complications and maintain quality of life</p> <ul style="list-style-type: none"> <li>• Vendor infrastructure, staffing and information systems are well positioned to track member needs and integrate LTC, physical health and behavioral health services, coordinate with treatment team members and have dedicated staff to follow up if providers are not meeting member needs and sharing information</li> <li>• Limits DCH administrative oversight and monitoring burden by contracting with a single vendor to serve the “whole” person</li> </ul>	<p>which offers potential to help them remain stable, avoid inpatient admissions and serious complications and maintain quality of life</p> <ul style="list-style-type: none"> <li>• Vendor infrastructure, staffing and information systems are well positioned to track member needs and integrate LTC, physical health and behavioral health services, coordinate with treatment team members and have dedicated staff to follow up if providers are not meeting member needs and sharing information</li> </ul>	
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>• Time needed for CMOs to contract with SNFs and HCBS providers and to build infrastructure</li> <li>• Stakeholder concern regarding transition to a new system</li> <li>• CMO learning curve may be steep</li> <li>• Model is largely untested, and so findings to date regarding the impact of such a model are somewhat inconclusive, particularly as they relate to cost</li> <li>• DCH would have the increased burden of oversight and monitoring over a broader scope of vendor responsibilities, and oversight for this population is critical to success</li> </ul>	<ul style="list-style-type: none"> <li>• Time needed for CMOs to contract with SNFs and HCBS providers and to build infrastructure</li> <li>• Stakeholder concern regarding transition to a new system</li> <li>• CMO learning curve might be steep, but not as steep as it would be if CMO were covering the full range of populations</li> <li>• Model is largely untested, and so findings to date regarding the impact of such a model are somewhat inconclusive, particularly as they relate to cost</li> <li>• DCH would have the burden of oversight and monitoring over additional vendors, , and oversight for this population is critical to success</li> </ul>	<ul style="list-style-type: none"> <li>• Financing of one individual by two separate entities disincentivizes each entity from focusing on the care that is most cost effective overall (e.g., entities that pay for primary care and acute inpatient services are not incentivized to seek HCBS rather than SNF upon discharge because another entity will then be responsible for payment, and, conversely, entities responsible for nursing facility care are not incentivized to avoid inpatient admissions)</li> <li>• Presents potential for fragmented care coordination and duplication of care management</li> <li>• May create confusion for HCBS providers in coordinating with separate entities for authorizations of some services</li> <li>• Makes service authorization more challenging due to limited availability of</li> </ul>

# Appendix M: Long-term Care Services

	Carve In	Population Carve Out: Based on Specified Eligibility Categories <sup>68</sup>	Current Provision of Services <sup>69</sup>
			<p>information and clinical and disease management and special care coordination needs</p> <ul style="list-style-type: none"> <li>• Current HCBS waiver programs have been challenged to meet some CMS goals for rebalancing</li> <li>• Reporting to DCH from several entities versus a limited number of CMOs poses substantial DCH administrative oversight and monitoring burden</li> <li>• SNF and HCBS provider information systems are less equipped to track all member needs and integrate LTC, physical health and behavioral health services, coordinate with treatment team members and share information with hospital and specialty providers, especially for consumers receiving LTC services who also have chronic diseases and, in turn, may increase cost of physical healthcare</li> <li>• Fragmented responsibility among various state and local agencies makes coordinated oversight and program integrity initiatives more challenging</li> </ul>

# Appendix N: Children in Foster Care

## *Statement of the Issues*

Children in foster care present unique challenges to Medicaid programs in delivering their health care services. Many children in foster care require care for chronic physical and behavioral health problems as well as psychosocial services; providing the necessary services and coordinating care without duplicating services and efforts is challenging. A recently released study of five states by the U.S. Government Accounting Office (GAO) found that children in foster care were prescribed psychotropic drugs at higher rates than other children. They found this difference could be due to several factors, such as:<sup>1</sup>

- More mental health needs
- Increased exposure to traumatic experiences
- Challenges of coordinating their medical care

As discussed in our national scan, another challenge of managing children in foster care is their environmental instability. Care is at times disjointed and sporadic because these children are moved throughout the state and are in a variety of different custody arrangements. Shifting guardianship from birth parents, foster parents, guardians or adoptive families makes it difficult to coordinate necessary health care services, screenings and follow-ups. There is no central repository for their records. Lack of coordination between physical health and behavioral health providers as well as state agencies intensifies these issues.

The Georgia Department of Human Services Division of Family and Children Services (DFCS) is responsible for assuring that children who cannot remain with their birth families be placed in safe and nurturing homes. The Georgia Department of Community Health (DCH) is responsible for coordinating the delivery of health care services for children in foster care. As of fiscal year 2010, an estimated 26,845 children were in foster care in Georgia.<sup>2</sup> Children in Georgia's foster care system receive health care services through Georgia's Medicaid fee-for-service (FFS) delivery system.

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<sup>1</sup> Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions. GAO-12-270T. December 1, 2011. <http://www.gao.gov/products/GAO-12-270T>

<sup>2</sup> SFY 2010 Data and Thomson Reuters Commissioners Reports.

# Appendix N: Children in Foster Care

## *Redesign Options and Recommendations for Children in Foster Care*

A variety of approaches should be considered for children in foster care. These approaches are described in the following narrative, and the advantages and disadvantages of each are outlined in Figure N.1 at the end of this Appendix:

- **Carve-in services for foster care children.** In this risk-based managed care delivery system, foster children and all other Medicaid and PeachCare for Kids® members would be enrolled in the same managed care delivery system, and the cost of the benefit would be included in the capitation rate.
- **Carve out services for foster care children to the FFS delivery system.** This FFS delivery system would operate like the current Georgia Medicaid FFS pharmacy benefit, as described above.
- **Carve out foster care children and provide services under a separate care management organization (CMO).** In this risk-based managed care delivery system, foster children and all other Medicaid and PeachCare for Kids® members would *not* be enrolled in the same managed care delivery system; instead, they would be enrolled in a separate health plan that specializes in managing care for foster children.

Children are at risk for duplication of care management and services if DFCS case workers do not have results from medical and behavioral health evaluations to meet court system due dates and requirements. Due to the current eligibility guidelines, children may transition from FFS to Georgia Families and back again based on moving in and out of foster care. At times, providers are not reimbursed because case workers refer to providers who are not in a CMO's network while the child is still enrolled with a CMO. Consequently, DFCS and the Department of Juvenile Justice reimburse the provider out of a separate fund. This leads to unnecessary and duplicative payments.

Some other states, such as Texas, use managed care delivery systems as a way to coordinate continuous care for children in foster care. Any managed care program must meet the unique needs of children in foster care. Screenings and assessments for physical, behavioral and oral health must be included in standard Medicaid managed care contracts.

# Appendix N: Children in Foster Care

In light of the considerations discussed above, we include in our assessment of options a carve in to cover foster children through the managed care delivery system.<sup>3</sup> Keeping these design issues in mind, Figure N.1 below provides advantages and disadvantages of carving in management of health care services for children in foster care.

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<sup>3</sup> Should the State of Georgia decide to move forward with a foster care carve out, then the scores in the evaluation of options in Chapter 5 must be updated, and the results of the evaluation may change.

# Appendix N: Children in Foster Care

**Figure N.1: Advantages and Disadvantages for Carving In or Carving Out Children in Foster Care**

	Carve In <sup>4</sup>	Carve Out Population to FFS	Carve Out Population to Separate CMO <sup>5</sup>
<b>Advantages</b>	<ul style="list-style-type: none"> <li>• Maintain continuity of clinical care management regardless of child’s custody arrangement</li> <li>• Streamlined and continuous care coordination</li> <li>• Health plans are accountable for making sure members receive required services</li> <li>• Avoids potential duplication of services and contradictory care plans</li> <li>• Allows availability of clinical information due to one or linked information systems when authorizing services and for considering coordination of physical and behavioral health care needs</li> <li>• May reduce costs due to decreased service duplication</li> <li>• Allows leverage with providers to enforce coordination of care requirements and to hold them accountable for outcomes using pay-for-performance and value-based purchasing</li> <li>• Streamlines DCH’s administrative oversight and monitoring burden by including in one delivery system, especially when children transition in and out of foster care</li> <li>• Transition to a different delivery system when transitioning out of foster care is not necessary</li> </ul>	<ul style="list-style-type: none"> <li>• More flexibility with a broader array of providers to provide services without concern over providers being out-of-network</li> <li>• Prior authorization requirements may be more limited and thus, services can be provided as soon as appointments can be scheduled</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain continuity of clinical care management regardless of child’s custody arrangement</li> <li>• Streamlined and continuous care coordination</li> <li>• Health plans are accountable for making sure members receive required services</li> <li>• Avoids potential duplication of services and contradictory care plans</li> <li>• Allows availability of clinical information due to one or linked information systems when authorizing services and for considering coordination of physical and behavioral health care needs</li> <li>• May reduce costs due to decreased service duplication</li> <li>• CMO focus would be on meeting the needs of children in foster care so is ideal to develop a customized program which includes contract requirements specific to children in foster care services and requires coordination among caregivers, state staff, guardian, attorneys, etc.</li> <li>• CMO network likely to be focused on providers with expertise in serving children in foster care and children with special needs</li> <li>• Some administrative efficiencies would be gained at the health plan level, since children in foster care would all be enrolled in the same health plan</li> </ul>

<sup>4</sup> Advantages and disadvantages assume a CMO would have statewide coverage to maintain contact with enrolled children in foster care as they move around the State.

<sup>5</sup> Advantages and disadvantages assume a CMO would have statewide coverage to maintain contact with enrolled children in foster care as they move around the State.

# Appendix N: Children in Foster Care

	Carve In <sup>4</sup>	Carve Out Population to FFS	Carve Out Population to Separate CMO <sup>5</sup>
			<ul style="list-style-type: none"> <li>• Could create some opportunities to leverage providers to enforce coordination of care requirements and to hold them accountable for outcomes using pay-for-performance and value-based purchasing, depending upon program design, but leverage would not be as great as that under the carve-in model, since the number of children in foster care is so small relative to the general Medicaid population</li> </ul>

# Appendix N: Children in Foster Care

	Carve In <sup>4</sup>	Carve Out Population to FFS	Carve Out Population to Separate CMO <sup>5</sup>
<p><b>Disadvantages</b></p>	<ul style="list-style-type: none"> <li>• Health plans may face challenges focusing network development to recruit providers experienced with managing care for and delivering services to children in foster care</li> <li>• Because foster children will be spread among the contracted health plans, the foster care population will be diluted and, as a result, health plans might not be incented to build the infrastructure necessary to address the unique needs of this population</li> <li>• Because all of the contracted plans need to build infrastructure to serve the foster care population, introduces some administrative inefficiencies at the health plan level</li> <li>• Must address challenges in determining responsible entity for payment of some services or medications during transition between managed care entities</li> </ul>	<ul style="list-style-type: none"> <li>• Continuity of care would be challenging given the frequent changes in child’s custody arrangement and location</li> <li>• Difficulty sharing clinical information real-time when child transitions from one delivery system to another</li> <li>• Difficulty maintaining continuity in clinical case management and care coordination</li> <li>• Likely to have duplication of services and contradictory care plans</li> <li>• Costs may increase due to duplication of services</li> <li>• Difficulty negotiating with providers unless FFS is able to implement pay-for-performance and enforce coordination of care requirements to hold providers accountable for outcomes</li> <li>• DCH must assume the responsibility of administrative oversight and monitoring separate delivery and payment systems</li> <li>• Must address challenges in determining responsible entity for payment of some services or medications during transition between delivery systems</li> <li>• Must navigate two different delivery systems: impacts timely delivery of care and services</li> </ul>	<ul style="list-style-type: none"> <li>• Need for transition to a different delivery system when transitioning out of foster care</li> <li>• May experience limited leverage with providers because of small covered population</li> <li>• Frequent transitions make it challenging to require and enforce pay-for-performance and coordination of care and hold CMOs accountable for outcomes when children in foster care are the health plan’s only covered population</li> <li>• DCH must assume administrative oversight and monitoring of at least two separate delivery systems – one for children in foster care and one for other Medicaid enrollees</li> <li>• Must address challenges in determining responsible entity for payment of some services or medications during transition between delivery systems upon entry into or aging out of the foster care system</li> </ul>

# Appendix O: Dental Services

## *Statement of the Issues*

Access to and utilization of dental care are among the most chronic challenges for Medicaid programs nationally, and children in families with low incomes have higher rates of dental caries. Children's access to dental services in Medicaid and Children's Health Insurance Programs (CHIP) has improved since 2000. Approximately 40 percent of children received a dental service in federal fiscal year 2009 compared with 27 percent of children in 2000.<sup>1</sup> The three most common reasons that dentists give for not participating in Medicaid are low reimbursement rates, administrative burden and patient behavior.<sup>2</sup> In addition, the dental workforce has been decreasing creating even more challenges for Medicaid populations.

The Georgia Department of Community Health (DCH) carved in the dental benefit for Georgia Families, and provides the benefit through the fee-for-service (FFS) delivery system for all other populations. Under Georgia Families, adult members may receive the following additional benefits depending on the care management organization (CMO) in which they are enrolled: semi-annual cleaning, exam and x-rays; preventive dental hygiene supplies; and simple extractions.<sup>3</sup> In 2010, DCH added requirements to the CMO contracts specific to timeliness of dental appointments. CMOs must ensure wait times of no more than 21 calendar days for routine dental visits and 48 hours for urgent needs.<sup>4</sup> Additionally, CMOs have made improvements each year on dental Healthcare Effectiveness Data and Information Set (HEDIS®) rates, and as shown in Figure 5.11, are above the national average and the 90<sup>th</sup> percentile with regard to annual dental visits.

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<sup>1</sup> The Department of Health and Human Services Children's Health Insurance Program Reauthorization Act, 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP. 2011.

<sup>2</sup> Borchgrevink, A., Snyder, A., and Geshan, S. The Effects of Medicaid Reimbursement Rates on Access to Dental Care. National Academy for State Health Policy. March 2008.  
[http://nashp.org/sites/default/files/CHCF\\_dental\\_rates.pdf?q=Files/CHCF\\_dental\\_rates.pdf](http://nashp.org/sites/default/files/CHCF_dental_rates.pdf?q=Files/CHCF_dental_rates.pdf)

<sup>3</sup> Medicaid Managed Care in Georgia. Presentation by AmeriGroup Community Care, Peach State Health Plan and WellCare of Georgia. August 2011.

<sup>4</sup> Department of Community Health. Georgia Families Quality Strategic Plan. Updated March 26, 2010.  
[http://dch.georgia.gov/vgn/images/portal/cit\\_1210/6/27/1037642292010UpdatetoQualityStrategicPlan.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/6/27/1037642292010UpdatetoQualityStrategicPlan.pdf)

# Appendix O: Dental Services

**Figure O.1: HEDIS® Rates for Annual Dental Visits, Ages 2-21**

Yearly Dental Visits for Individuals Ages 2 to 21	Percentiles <sup>5,6,7</sup>	
	2009	2010
National Average - 90 <sup>th</sup> percentile	59.83	64.08
Amerigroup	66.73	69.09
Peach State Health Plan	60.15	63.58
WellCare	65.21	67.48

*Redesign Options and Recommendations for Dental Services*

A variety of approaches should be considered for administering dental services. These approaches are described in the following narrative, and the advantages and disadvantages of each are outlined in Figure O.2 at the end of this Appendix:

- Carve in dental services.** In a risk-based managed care delivery system, dental services would be included in the benefit package, along with physical health services, and the cost of the benefit would be included in the capitation rate. The health plan would be responsible for managing the dental benefit for its enrolled population, either through a subcapitated arrangement or by developing its own dental provider network, payment rates and policies governing the dental benefit.
- Carve out dental services and provide under FFS.** This FFS delivery system would operate like the current Georgia Medicaid FFS dental benefit, as described above.
- Carve out dental services and provide through a risk-based dental benefit administrator.** In this risk-based managed care delivery system, the state would contract with one set of health plans for physical health services and a dental benefit administrator for dental services. All Medicaid and Peachcare for Kids® members would be enrolled in the dental plan. The dental benefit administrator would be responsible for managing the dental benefit for its enrolled population, either

<sup>5</sup> National Committee for Quality Assurance. HEDIS® 2009 Percentiles.  
<sup>6</sup> National Committee for Quality Assurance. HEDIS® 2010 Percentiles.  
<sup>7</sup> Performance Measure1 Report for Georgia Medicaid2 and PeachCare for Kids

## Appendix O: Dental Services

through a subcapitated arrangement or by developing its own dental provider network, payment rates and policies governing the dental benefit.

Dental care is the benefit most commonly carved out of Medicaid managed care contracts. Of states that have managed care programs and participated in a recent Kaiser survey, 25 reported carving out dental services and 5 of these states contract with a pre-paid health plan to administer the benefit.<sup>8</sup> However, some states have had successes in contracting with managed care plans or dental benefit administrators – they may have more opportunities to conduct initiatives that states would be more limited in conducting through FFS delivery systems. For example, in Pennsylvania, managed care organizations (MCOs) provide dental coverage and four contracted with a specialized dental practice for care for enrollees with severe disabilities using a global budgeting payment arrangement.

The results of the Georgia-specific scan outlined in Chapter 4 indicate that a carve in approach is likely to be preferable for Georgia because, relative to the two carve out approaches, the carve in approach poses a greater likelihood of enabling Georgia to achieve its goals:

- **May increase opportunities to improve coordination and quality of care.** Carving in dental and physical health services to one delivery system allows enhanced coordination of care, particularly related to EPSDT services and for individuals with chronic diseases that may impact dental care (e.g., heart disease). Incentives are aligned to treat the “whole person” from a clinical and cost perspective.
- **Poses a lesser administrative burden on DCH so is more likely to achieve operational feasibility from a fiscal and administrative oversight perspective.** Since the carve out model would require DCH to contract with two sets of vendors, DCH would need to procure, negotiate contracts with providers and potentially monitor the activities of two sets of vendors.

In light of the considerations discussed above, we include in our assessment of options a carve-in to cover dental services through the managed care delivery system.<sup>9</sup> Figure O.2 below provides the advantages and disadvantages of carving in dental services for health plans to administer through a managed care delivery system versus managing the benefit through the FFS delivery system versus managing the benefit through a single dental benefit administrator.

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<sup>8</sup> Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

<sup>9</sup> Should the State of Georgia decide to move forward with a dental care carve-out, then the scores in the evaluation of options in Chapter 5 must be updated, and the results of the evaluation may change.

# Appendix O: Dental Services

**Figure O.2: Advantages and Disadvantages for Carving In or Carving Out Dental Services**

	Carve In	Carve Out: FFS	Carve Out: Risk-based Dental Benefit Administrator
<b>Advantages</b>	<ul style="list-style-type: none"> <li>• Allows enhanced coordination of care by having health and dental services provided through one entity, particularly related to EPSDT services</li> <li>• Aligns incentives to treat the “whole person” from a clinical and cost perspective</li> <li>• Allows access to dental and medical claims data for care coordination purposes and for identifying quality initiatives</li> <li>• Prior authorization of complicated procedures and monitoring of utilization patterns may reduce unnecessary utilization</li> <li>• Health plans have more resources for conducting ongoing provider and member education</li> <li>• Responsible for creating an adequate network of dentists, conducting rigorous credentialing and screening of providers and monitoring provider performance</li> <li>• Allows budget predictability through capitated payment arrangement</li> <li>• Provides options to negotiate payments for specialty dental services<sup>10</sup></li> <li>• Provides options to pay for services (such as</li> </ul>	<ul style="list-style-type: none"> <li>• Streamlines administrative procedures for providers due to use of one set of policies and prior authorization criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Places burden on vendor for creating an adequate network of dentists, and monitoring provider performance</li> <li>• Prior authorization of complicated procedures and monitoring of utilization patterns may reduce unnecessary utilization</li> <li>• Vendors have more resources for conducting ongoing provider and member education</li> <li>• Vendors focus solely on dentals services and are able to gain expertise and experience</li> <li>• Streamlines administrative activities for dentists when contracting with one vendor</li> <li>• Allows budget predictability through capitated payment arrangement</li> <li>• Provides options to negotiate payments for specialty dental services</li> <li>• Provides options to pay for services (such as oral health supplies) that may not be reimbursed through Medicaid</li> <li>• May use commercial relationships and</li> </ul>

<sup>10</sup> Snyder,A. Increasing Access to Dental Care In Medicaid: Targeted Programs for Four Populations. National Academy for State Health Policy. March 2009. [http://www.vfc-oh.org/cms/resource\\_library/files/02e970cafdbec983/increasing\\_access\\_to\\_dental\\_care.pdf](http://www.vfc-oh.org/cms/resource_library/files/02e970cafdbec983/increasing_access_to_dental_care.pdf)

# Appendix O: Dental Services

	Carve In	Carve Out: FFS	Carve Out: Risk-based Dental Benefit Administrator
	<p>oral health supplies) that may not be reimbursed through Medicaid</p> <ul style="list-style-type: none"> <li>• Benefits administrated by one entity may be less confusing to members</li> <li>• May use commercial relationships and leverage more freely when contracting with dental providers</li> </ul>		<p>leverage more freely when contracting with dental providers</p>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>• Complicated procedures may require prior authorization, which may delay treatment</li> <li>• May create some administrative burden for dentists participating in multiple health plans</li> <li>• Dentists may view prior authorization requirements as a method to deny or delay payments</li> </ul>	<ul style="list-style-type: none"> <li>• Health and dental services provided through multiple delivery systems may result in difficulties in coordinating care</li> <li>• May provide less care management to those in need of assistance</li> <li>• Does not provide budget predictability as providers are paid on a FFS basis</li> <li>• Does not allow opportunities to use creative payment strategies to encourage provider participation</li> <li>• Multiple administrators of benefits may lead to member confusion</li> <li>• Resources may not be available to provide patient education</li> </ul>	<ul style="list-style-type: none"> <li>• Coordination of care may be challenging when health and dental services are provided through multiple delivery systems</li> <li>• Complicated procedures may require prior authorization, which may delay treatment</li> <li>• Multiple administrators of benefits may lead to member confusion</li> <li>• Dentists may view prior authorization requirements as a method to deny or delay payments</li> <li>• One dental vendor may lead to increased costs to the state due to vendor having more negotiating leverage</li> </ul>

# Appendix P: Non-emergency Transportation Services

## *Statement of the Issues*

Historically, states have delivered non-emergency medical transportation (NET) services on a FFS basis or through a brokerage arrangement. Of 36 states that responded to a recent Kaiser Commission study, almost half the states (17) with managed care delivery systems provide non-emergency transportation outside of their MCO contracts, usually on a FFS basis or through a brokerage arrangement.<sup>1</sup> States that have implemented transportation brokerage models have found that these models can:

- Streamline program administration, reduce costs and increase economies of scale
- Offer increased opportunity to improve efficiency and standardize services for clients
- Reduce fraud and abuse which decreases costs
- Improve client access to medical services by developing a coordinated network of transportation providers
- Place responsibility for managing client transport with an entity that specializes in transportation
- Simplify collection of standardized data, program monitoring and oversight of client access to care
- Facilitate collection and reporting of utilization and cost data
- Provide opportunity for greater cost-certainty through negotiated agreement(s) or competitive contract(s)

Medicaid NET services are estimated to have cost Georgia almost \$80.9 million for FY 2010.<sup>2</sup> DCH has had a regional transportation brokerage system in place since 1997 for its Medicaid

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<sup>1</sup> Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

<sup>2</sup> A Primer on Rural and Human Services Transportation in Georgia. Prepared for the Governor's Office of Planning and Budget. Governor's Developmental Council and the Georgia Coordinating Council for Rural and Human Services Transportation. August 2011.

# Appendix P: Non-emergency Transportation Services

population. PeachCare for Kids® consumers are not served through this system, and some of the Georgia Families CMOs subcontract with a broker to provide their transportation. For the brokerage system, DCH contracts with brokers for each of five regions of the State. At the time of this report, DCH held contracts with the brokers listed below. However, DCH is in process of reprocurring these contracts.

- Logisticare: East region
- Southeastrans, Inc.: Atlanta, North and Central regions
- Southwest Georgia Regional Development Center: Southwest region

DCH staff report that fraud and abuse was a problem prior to the brokerage program, but decreased after implementation leading to significant cost savings. The brokers are better able to serve the rural areas than when the program was administered internally; however, stakeholders indicated a variety of continuing concerns, such as:

- Availability of transportation to appointments is still an issue, particularly in the Southeast region. Some CMOs indicated they have had to implement alternate contracts with cab services to get their members to the care they need, and bear the transportation costs 100 percent in the southeast. This access contributes to challenges with coordination of care.
- DCH has one broker per region, which does not allow consumers a choice of brokers. Additionally, one broker per region may limit DCH's ability to negotiate with the brokers.
- Concern with the ability of some of the current vendors to effectively manage the program. Stakeholders voiced concern that some transportation providers are more focused on regularly scheduled monthly transportation than the "one off" trips that are also important.

## *Redesign Option and Recommendations for Non-emergency Transportation Services*

The approaches to consider for NET services are described in the following narrative, and the advantages and disadvantages of each are outlined in Figure P.1 at the end of this Appendix. In short, states have two options to handle pharmacy services:

## Appendix P: Non-emergency Transportation Services

- **Carve NET services in to the selected delivery system.** In a risk-based managed care delivery system, NET services would be included in the benefit package along with physical health services, and the cost of the benefit would be included in the capitation rate. The health plan would be responsible for managing the NET benefit for its enrolled population, negotiating contracts with transportation brokers and monitoring the broker to ensure access to transportation for the enrolled population.
- **Carve NET services out to the transportation brokerage system.** This transportation brokerage system would operate like the current Georgia Medicaid brokerage system, as described above.

Recommendations from stakeholders included considering a system that recognizes the point is not transportation in and of itself – it is delivering full services to members so they receive the service they need and to obtain the right level of care. Interconnectivity is needed to design services to meet the needs of members.

DCH may be better positioned to achieve even more successes with its NET program by carving NET services into the delivery system. Health plans that administer transportation services often contract with the same brokers that states use, as is the case with the health plans providing transportation for PeachCare for Kids® members. By carving in the services, health plans would have increased opportunity to improve care coordination through working directly with the transportation brokers. The capitated rate would include transportation costs, and the health plans would be responsible for assuring that consumers receive appropriate NET services. Health plans would have a vested interest in improving access to transportation services due to the impact lack of transportation has on missed appointments, appropriate utilization and continuity of care.

Given the contractual relationships they would have with the transportation brokers, the health plans would have more control over transportation vendors and making sure that they are working together to meet the needs of the “whole person”. Additionally, they would be contracting for both the Medicaid and PeachCare for Kids® populations which may improve their ability to negotiate with transportation brokers given the increased number of covered lives. They would also have increased flexibility in the choice of vendor given they would not be subject to state procurement requirements.

# Appendix P: Non-emergency Transportation Services

In light of the considerations discussed above, we include in our assessment of options a NET services carve-in to cover the NET benefit through the managed care delivery system.<sup>3</sup>

Figure P.1 below provides the advantages and disadvantages of carving in NET to a managed delivery system versus managing the benefit through a transportation brokerage system.

Note: House Bill 277 calls for a study that identifies means to increase the coordination of Georgia's rural and human services transportation (RHST) system. The purpose of the legislation and the resulting report is to ensure the most cost-effective delivery of RHST services in Georgia, and to best serve the clients utilizing the system.<sup>4</sup> As decisions have not been made about the recommendations from this report, we have not considered the impact of potential changes in statewide transportation services

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<sup>3</sup> Should the State of Georgia decide to move forward with a NET carve-out, then the scores in the evaluation of options in Chapter 5 must be updated, and the results of the evaluation may change.

<sup>4</sup> A Primer on Rural and Human Services Transportation in Georgia. Prepared for the Governor's Office of Planning and Budget. Governor's Developmental Council and the Georgia Coordinating Council for Rural and Human Services Transportation. August 2011.

# Appendix P: Non-emergency Transportation Services

**Figure P.1: Advantages and Disadvantages for Carving In and Carving Out Non-emergency Transportation Services**

	Carve In	Carve Out
<b>Advantages</b>	<p>In addition to the advantages listed under “Carve Out”:</p> <ul style="list-style-type: none"> <li>• Lack of access to transportation may continue to exist in some areas, but health plans would have more “stake” in increasing transportation availability to impact service utilization and continuity of care</li> <li>• Allows coordination of care, so that the plans may more fully meet the care needs of the member</li> <li>• Allows health plans to monitor broker, which enhances opportunities to identify inappropriate utilization</li> <li>• Allows health plans’ to work directly with a broker to improve coordination</li> <li>• Health plans’ have sole responsibility for helping members to access services</li> <li>• Combining Medicaid and CHIP populations increases the number of covered lives which may improve cost negotiations</li> <li>• Serving Medicaid and CHIP populations through one system minimizes confusion when members “churn” among programs</li> <li>• Allows broker choice as procurement rules do not apply</li> <li>• Streamlines the number of contracts for which DCH must provide administration and oversight</li> </ul>	<ul style="list-style-type: none"> <li>• May effectively contain fraud and abuse and contains costs</li> <li>• Fixed rate per trip helps manage costs and utilization, leading to budget predictability</li> <li>• Provides a single point of contact for patients to schedule transportation</li> <li>• Streamlines program administration and increases economies of scale</li> <li>• Clients may be able to access medical services more easily by developing a coordinated network of transportation providers</li> <li>• Places responsibility for managing client transport with entities that specialize in transportation</li> <li>• Facilitates collection and reporting of utilization and cost data</li> <li>• Provides opportunity for greater cost-certainty through negotiated agreement(s) or competitive contract(s)</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>• May create additional administrative costs because transportation providers must contract with multiple health plans</li> <li>• Lack of access to transportation services still exists in some areas</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of access to transportation services still exists in some areas</li> <li>• Current system does not offer member choice of broker</li> <li>• DCH is required to administer and provide oversight to multiple plans</li> </ul>

# Appendix Q: Pharmacy Services

## *Statement of the Issues*

States that contract with health plans for their Medicaid programs either include prescription drug coverage in the contract or carve out coverage and administer services through the fee-for-service (FFS) delivery system. In the past, some states chose to carve out coverage to qualify for the federal drug rebate program, for which drugs covered under managed care organization (MCO) contracts did not qualify. Implementation of the Affordable Care Act (ACA) changes that program to allow states to collect federal drug rebates for prescription drugs reimbursed under capitated Medicaid managed care contracts. MCOs that administer the prescription drug benefit for Medicaid programs must now provide prescription drug encounter information to the states. The states are now permitted to collect federal rebates from manufacturers for those drugs, which lowers prescription drug costs for the state. MCOs are finding that manufacturers are less willing to begin new or maintain current rebate agreements with MCOs or their pharmacy benefit managers due to states being able to collect the federal rebates. As the rebates MCOs were receiving from manufacturers continue to decrease, MCOs are paying more for prescription drugs.<sup>1</sup>

The Georgia Department of Community Health (DCH) carves in the prescription drug benefit for Georgia Families and provides the benefit through the fee-for-service (FFS) delivery system for all other populations. For the FFS delivery system, DCH has a contracted pharmacy benefit manager to help with administration of the program, including the preferred drug list. In federal fiscal year 2009, DCH spent \$270,276,141 (after rebates) for prescription drugs through the FFS delivery system.<sup>2</sup> On average, DCH's monthly payment for the first quarter of 2011 was \$41.6 million for an average of 418,957 eligibles per month.<sup>3</sup>

## *Redesign Options and Recommendations for Pharmacy Services*

The approaches to consider for pharmacy services are described in the following narrative, and the advantages and disadvantages of each are outlined in Figure 1 at the end of this Appendix. In short, states have two options to handle pharmacy services:

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<sup>1</sup> Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available at:

[http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid\\_Prescription\\_Drug\\_Rebate\\_Policy\\_Brief.pdf](http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf)

<sup>2</sup> Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available at:

[http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid\\_Prescription\\_Drug\\_Rebate\\_Policy\\_Brief.pdf](http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf).

<sup>3</sup> Quarterly Utilization and Performance Review Report. SXC Health Solutions report to the Department of Community Health. May 10, 2011.

## Appendix Q: Pharmacy Services

- **Carve pharmacy services in to the selected delivery system.** In a risk-based managed care delivery system, pharmacy would be included in the benefit package along with physical health services, and the cost of the benefit would be included in the capitation rate. The health plan would be responsible for managing the pharmacy benefit for its enrolled population, negotiating and administering discounts and rebates with suppliers and negotiating payment rates with pharmacies.
- **Carve pharmacy services out to the FFS delivery system with a pharmacy benefit manager.** This FFS delivery system would operate like the current Georgia Medicaid FFS pharmacy benefit, as described above.

Studies have shown that managed care delivery systems are able to provide “drug coverage in a more cost-effective manner than FFS delivery systems via formulary management, high generic fill rates, comprehensive drug utilization, and coordination of care.”<sup>4</sup> States that have carved out the benefit are now proposing or planning to carve pharmacy benefits into their managed care contracts given the ACA changes now allowing for collection of rebates. They report doing so “to improve coordination and integration of care.” For example, New York, Ohio and Texas all plan to carve in the pharmacy benefit in 2011 or 2012.<sup>5</sup>

Additionally, studies show that Medicaid MCOs achieve higher savings than FFS delivery systems through a variety of mechanisms. For example, a March 2011 study comparing MCOs serving Medicaid populations to FFS systems found the following:<sup>6</sup>

- Dispensing fees paid to pharmacists tend to be higher in FFS delivery systems than for most other payers, including commercial payers. MCOs serving Medicaid populations have dispensing fees that are more comparable to those paid by Medicare Part D plans and other commercial insurers.
- MCOs on average “pay slightly less for the ingredient component of medications”
- MCOs have much higher dispensing rates for generic drugs and low-cost brands

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<sup>4</sup> Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available at:

[http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid\\_Prescription\\_Drug\\_Rebate\\_Policy\\_Brief.pdf](http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf)

<sup>5</sup> Kaiser Commission of Medicaid and the Uninsured. A Profile of Medicaid Managed Care Programs in 2010. A Summary from a 50 state survey. September 2011.

<sup>6</sup> The Lewin Group. Projected Impacts of Adopting a Pharmacy Carve-In Approach Within Medicaid Capitation Programs. March 2011. Available at: [http://www.mhpa.org/upload/MHPA\\_Paper\\_on\\_Pharmacy\\_Carve-In.pdf](http://www.mhpa.org/upload/MHPA_Paper_on_Pharmacy_Carve-In.pdf)

## Appendix Q: Pharmacy Services

- Fewer medications are prescribed, most likely due to MCOs' effectiveness at "identifying unnecessary or even fraudulent prescriptions"

One challenge that providers have noted is the administrative burden of having multiple formularies to manage when participating in the FFS delivery system and multiple CMOs within Georgia Families. One study finds this to be the one "lone programmatic advantage of the carve-out approach, but indicates it is "often over-emphasized given that physician practices must typically deal with dozens of drug coverage programs regardless as to how the Medicaid pharmacy benefit is administered"<sup>7</sup>

In light of the considerations discussed above, we include in our assessment of options a pharmacy carve-in to cover the pharmacy benefit through the managed care delivery system.<sup>8</sup>

Figure Q.1 below provides the advantages and disadvantages of carving in pharmacy to a managed delivery system versus managing the benefit through the FFS delivery system using a pharmacy benefit manager.

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<sup>7</sup> The Lewin Group. Projected Impacts of Adopting a Pharmacy Carve-In Approach Within Medicaid Capitation Programs. March 2011. Available at: [http://www.mhpa.org/upload/MHPA\\_Paper\\_on\\_Pharmacy\\_Carve-In.pdf](http://www.mhpa.org/upload/MHPA_Paper_on_Pharmacy_Carve-In.pdf)

<sup>8</sup> Should the State of Georgia decide to move forward with a pharmacy carve-out, then the scores in the evaluation of options in Chapter 5 must be updated, and the results of the evaluation may change.

# Appendix Q: Pharmacy Services

**Figure Q.1: Advantages and Disadvantages for Carving In Or Carving Out Pharmacy Services**

	Carve In	Carve Out
<b>Advantages</b>	<ul style="list-style-type: none"> <li>• Allows coordination of care by having health services and prescription drugs provided through one entity, allowing health plan to more closely monitor drug utilization to identify and outreach to members who have high or inappropriate utilization patterns and to identify those needing care management</li> <li>• Aligns incentives to treat the “whole person” from a clinical and cost perspective<sup>9</sup></li> <li>• Allows access to real-time pharmacy and medical claims data for care coordination purposes and for identifying quality initiatives from a member health outcomes perspective and physician prescribing pattern perspective<sup>10</sup></li> <li>• Allows budget predictability as payment is included in capitation payments</li> <li>• Although prescription drug costs for MCOs are higher with implementation of the ACA, states receive rebates that may more than offset increases in capitation rates<sup>11</sup></li> <li>• Benefits administered by one entity may be less confusing to members than when administrated by multiple plans</li> </ul>	<ul style="list-style-type: none"> <li>• Providers must use only one formulary</li> </ul>

<sup>9</sup> The Lewin Group. Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs. October 2007.

<sup>10</sup> The Lewin Group. Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs. October 2007.

<sup>11</sup> Molina Healthcare. Healthcare Reform Policy Brief. Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief. January 2011. Available at: [http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid\\_Prescription\\_Drug\\_Rebate\\_Policy\\_Brief.pdf](http://c0410201.cdn.cloudfiles.rackspacecloud.com/Medicaid_Prescription_Drug_Rebate_Policy_Brief.pdf).

# Appendix Q: Pharmacy Services

	Carve In	Carve Out
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>Administrative burden for providers may increase due to potential for multiple formularies</li> </ul>	<ul style="list-style-type: none"> <li>Coordination of care may be challenging when health services and prescription drugs are provided through multiple delivery systems</li> <li>Difficulty in predicting budgets</li> <li>Pharmacy data provided to health plans by state programs is typically challenging to use as part of care coordination<sup>12</sup></li> <li>Administering benefits by a variety of entities could lead to member confusion.</li> <li>One drug formulary may lead to higher costs due to manufacturers having more leverage</li> </ul>

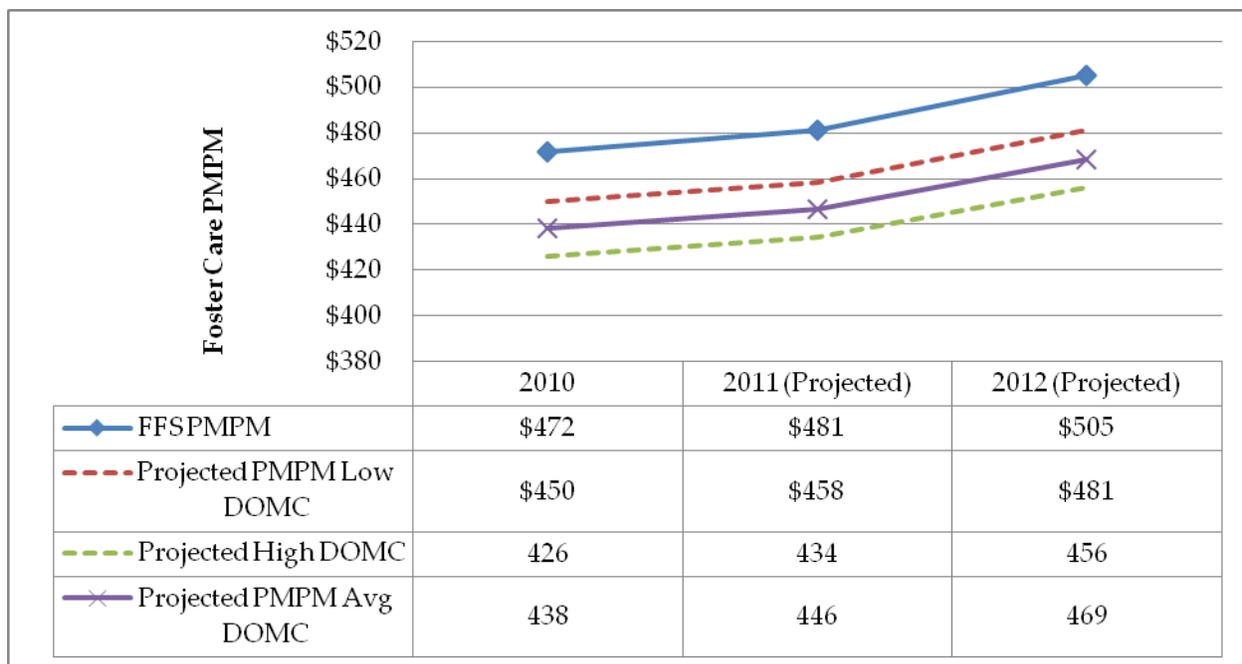
<sup>12</sup> The Lewin Group. Projected Impacts of Adopting a Pharmacy Carve-In Approach Within Medicaid Capitation Programs. March 2011. Available at: [http://www.mhpa.org/upload/MHPA\\_Paper\\_on\\_Pharmacy\\_Carve-In.pdf](http://www.mhpa.org/upload/MHPA_Paper_on_Pharmacy_Carve-In.pdf)

# Appendix R: Projected Managed Care Savings

All of the following graphs were developed based on analysis performed by Aon Hewitt Consulting on behalf of the Georgia Department of Community Health. This analysis attempts to project the savings incurred from carving into managed care the groups currently operating under a fee-for-service arrangement within Georgia Medicaid. Managed care savings opportunities are split into scenarios with a high degree of managed care (High DOMC) and a low degree of managed care (Low DOMC). Managed care savings projections are offset by the associated administrative costs which would apply to each scenario. An average of High DOMC and Low DOMC scenarios is also shown in each of the graphs below.

Following the charts, please find Aon Hewitt Consulting’s comments to their analysis.

**Figure R.1: Projected Savings from Managed Care Carve-In, Foster Care<sup>1</sup>**



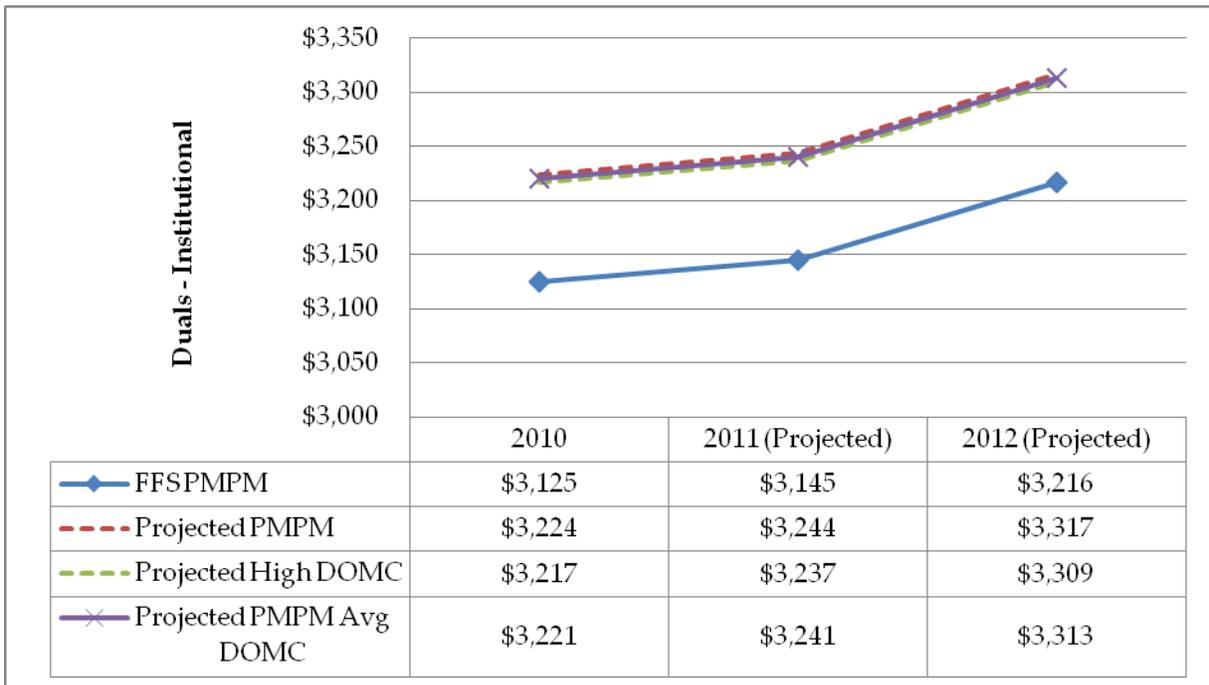
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>1</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.2: Projected Savings from Managed Care Carve-In, Dual Eligibles in Institutional Care<sup>2</sup>**



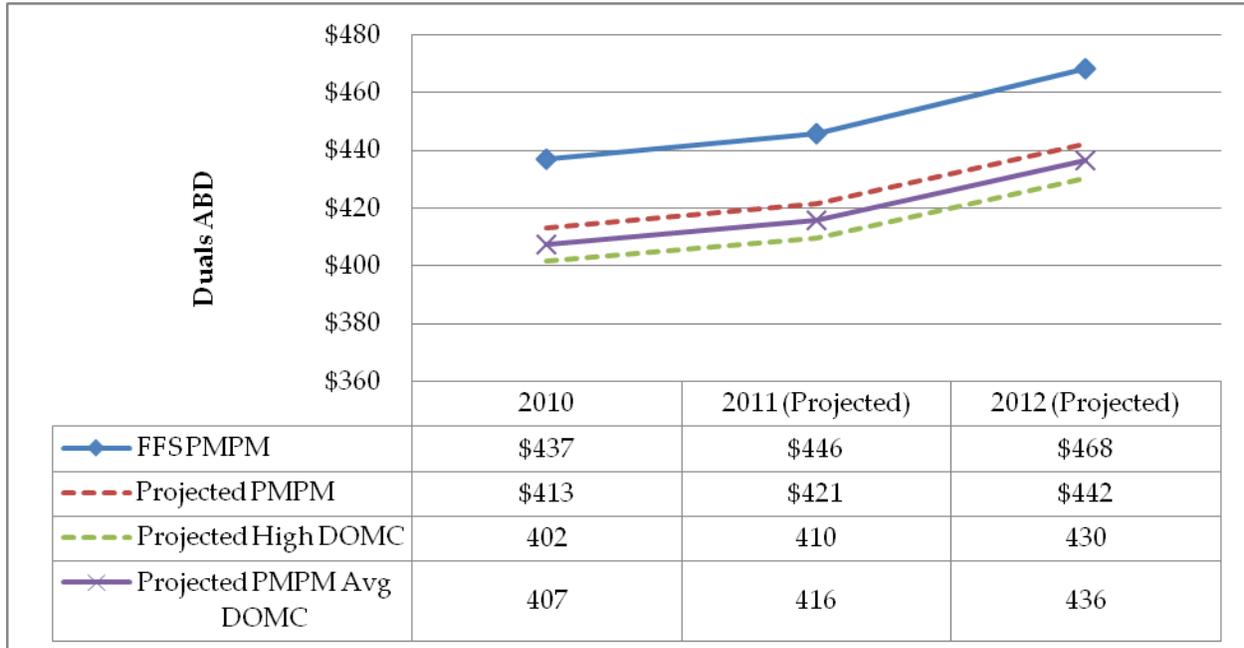
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>2</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.3: Projected Savings from Managed Care Carve-In, Dual Eligibles – Aged, Blind and Disabled<sup>3</sup>**



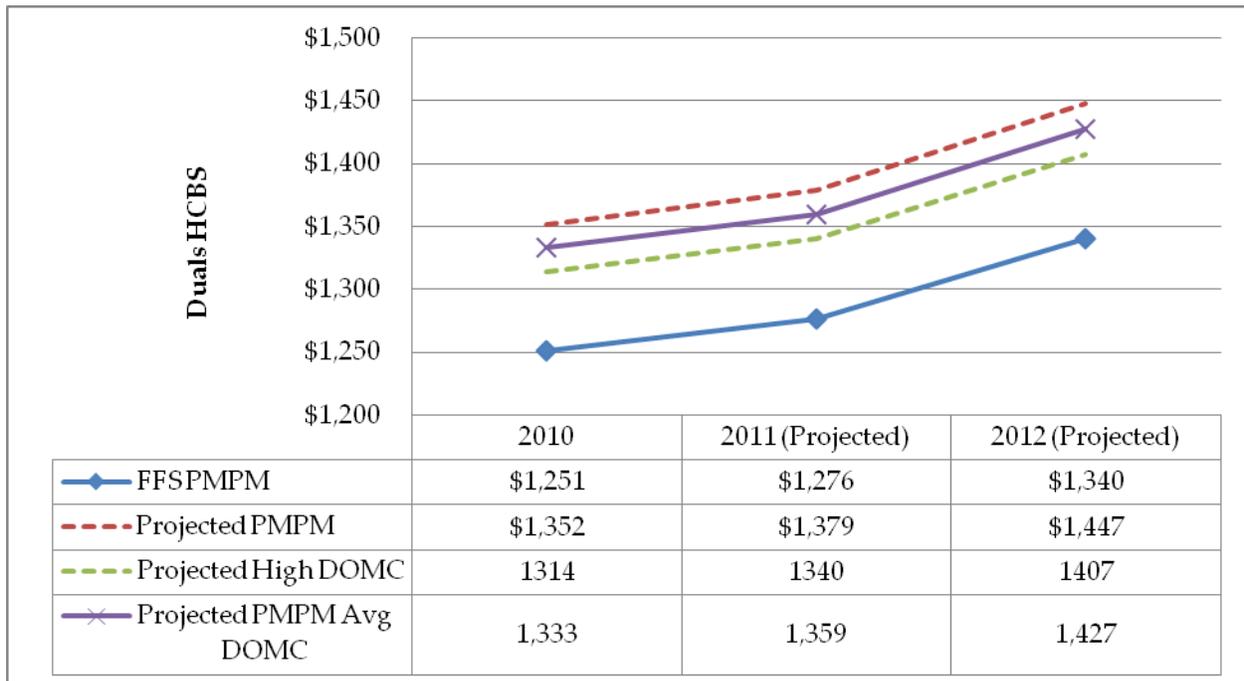
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>3</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.4: Projected Savings from Managed Care Carve-In, Dual Eligibles – Home- and Community-based Services<sup>4</sup>**



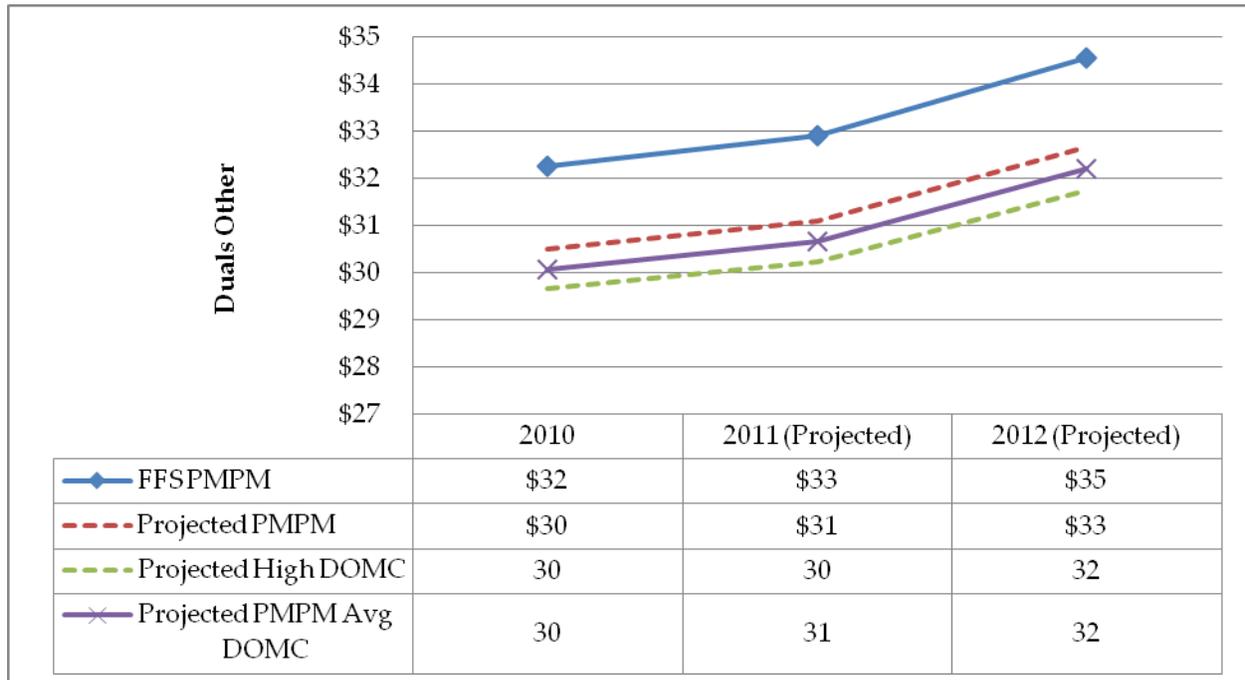
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>4</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.5: Projected Savings from Managed Care Carve-In, Dual Eligibles – Other<sup>5</sup>**



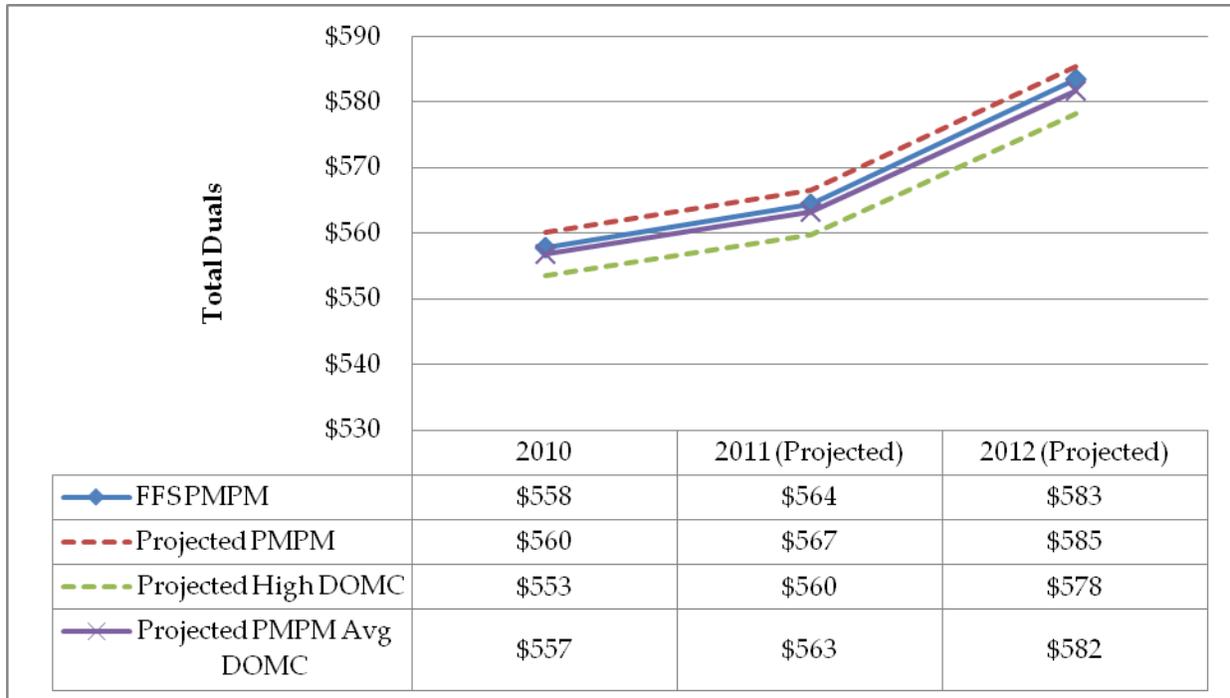
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>5</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.6: Projected Savings from Managed Care Carve-In, Dual Eligibles – Total<sup>6</sup>**



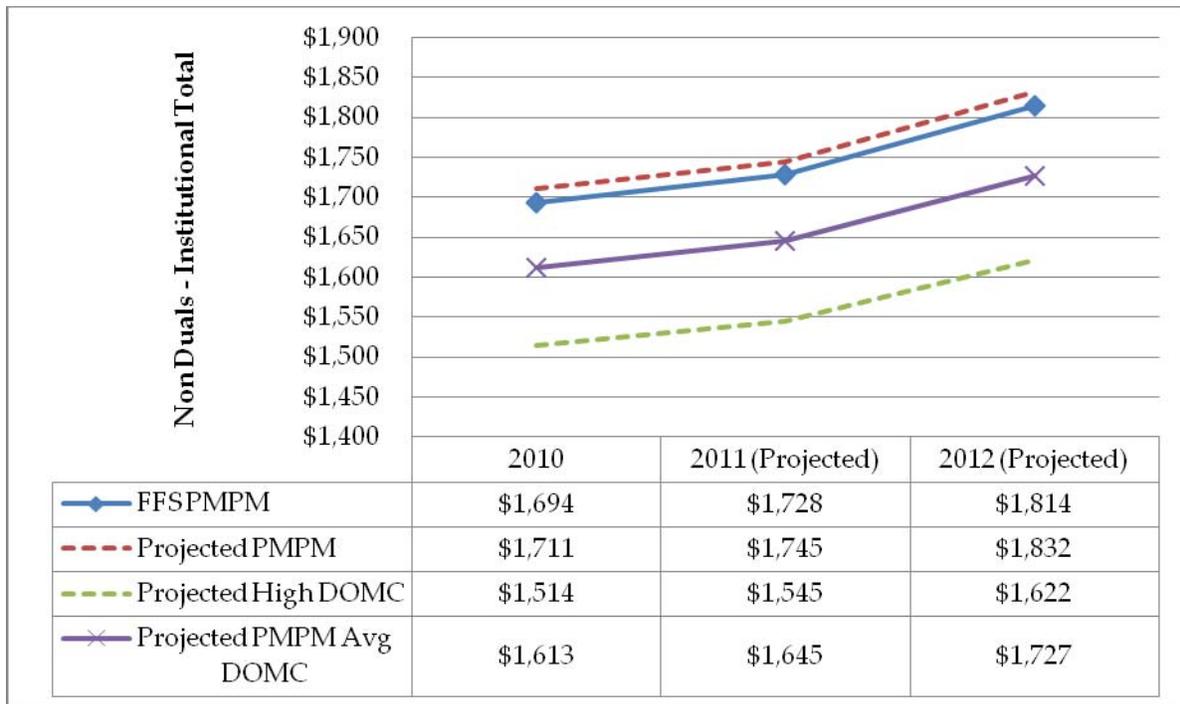
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>6</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.7: Projected Savings from Managed Care Carve-In, Non-Dual Eligibles – Institutional Care<sup>7</sup>**



**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>7</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.8: Projected Savings from Managed Care Carve-In, Non-Dual Eligibles – Aged, Blind and Disabled<sup>8</sup>**



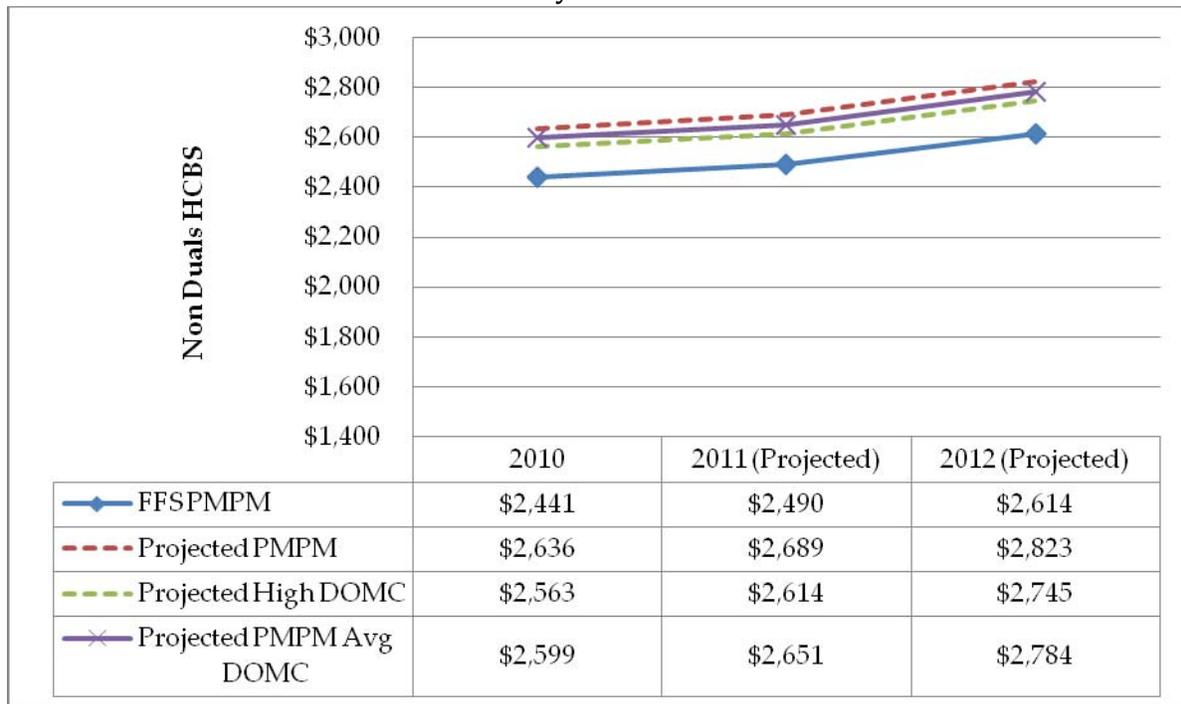
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>8</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.9: Projected Savings from Managed Care Carve-In, Non-Dual Eligibles – Home- and Community-based Services<sup>9</sup>**



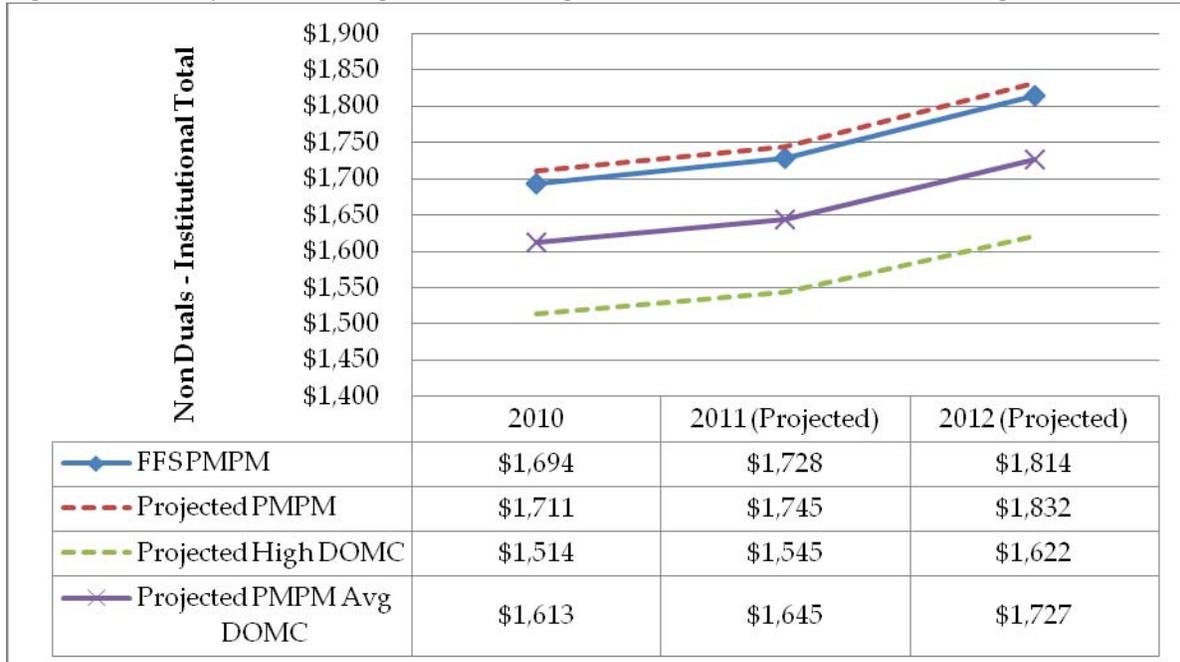
**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>9</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

**Figure R.10: Projected Savings from Managed Care Carve-In, Non-Dual Eligibles – Total<sup>10</sup>**



**Notes and Assumptions:**

1. HCBS Waiver includes Independent Waiver and Community Care Waiver Populations.
2. SFY 2010 PMPM costs provided by the Georgia Department of Community Health.
3. The Impact of Healthcare Reform Impact is not considered in this analysis.
4. Future trends based on "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary.
5. Weighted average PMPM costs based on SFY2010 membership.
6. Administrative Costs do not include premium tax.

<sup>10</sup> Aon Hewitt Consulting on behalf Georgia Department of Community Health – Potential Managed Care Opportunities

# Appendix R: Projected Managed Care Savings

Below are Aon Hewitt Consulting's comments to their analysis that Navigant used to develop the above charts.

## **Background and Scope**

The Georgia Department of Community Health (DCH) requested that Aon Hewitt Consulting (Aon Hewitt) develop managed care savings estimates for SFY 2015 through SFY 2017 for members served by DCH who are not currently covered under managed care contracts. At this time, the future managed care program has not been clearly defined. The detailed claim data needed to develop expected managed care savings for any proposed managed care program are also not readily available. The problem is further confounded by the uncertain impacts of Health Care Reform (HCR) which is scheduled to begin implementation before the projection period.

With the issues identified above, a thorough actuarial analysis of expected managed care savings is not possible. However, with the data available and not taking into account the impacts of HCR, illustrative managed care savings can be developed. While these estimates are not appropriate for budgetary purposes, they may be helpful with identifying future managed care savings opportunities.

## **Data**

DCH provided per member per month (PMPM) claim costs and membership by various categories of aid (COA) for SFY 2010. The claims were incurred from July 1, 2009 through June 30, 2010 and paid through August 2011. DCH also previously provided lag triangles by several COA and claim types (inpatient, outpatient, home health, physician, etc.) from July 2005 through August 2010 along with monthly membership by COA.

## **Assumptions, Methods, and Results**

The average, long-term, claim trend assumptions by COA used in this report are based on the aggregate future trends listed in the "2010 Actuarial Report on the Financial Outlook for Medicaid" from the Office of the Actuary, historical trends experienced by the Georgia Medicaid Program and our professional judgment.

DCH provided PMPM claim costs for several COA's by high level service category. Using this claim detail, Aon Hewitt developed a range of managed care savings estimates by COA. Part of the savings resulted from case management fees historically paid for these members that were assumed to be covered in the future by the administrative costs paid to a managed care organization (MCO).

Total future costs will depend upon the number and mix of members covered. SF 2010 membership levels were assumed in our analysis. An additional source of savings is potentially

# Appendix R: Projected Managed Care Savings

available for institutionalized and Home and Community Based Services (HCBS) waiver members. Managed care savings for long term care (LTC) members – members receiving nursing home (NH) or HCBS benefits – are generally achieved by shifting the distribution of members by service setting so that more members receive services in the HCBS setting. The number of LTC members who leave the institutional setting is limited. The shift in the member mix distribution develops over time as LTC members in the HCBS setting delay entry into the NH. [The analysis] illustrates the impact of a 10 percent shift of NH members to the HCBS setting. Naturally, an instantaneous 10 percent shift is not realistic. [The analysis] does, however, illustrate the level of member mix shift needed to make MLTC financially viable for the assumed projected claim costs.

## **Reliances and Limitations**

Aon Hewitt relied upon data provided by DCH. Aon Hewitt did not audit the data beyond general tests of reasonableness. Errors in the data provided may have an impact on the results of this report. The results presented in this report are contingent upon future events. As such, actual results will vary from the projections provided in this report. This report is intended for the internal use of DCH. Aon Hewitt Consulting realizes that this report may be a public record and subject to disclosure to third parties. Aon Hewitt does not intend to benefit from, and assumes no duty or liability to, any third parties who receive this report. This report should only be reviewed in its entirety. Users of this report should possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.