Directions for Change: Recommendations for Medicaid Reform in Georgia January 1997

GEORGIA COALITION
FOR HEALTH, INC.

DIRECTIONS FOR CHANGE

Recommendations for Medicaid Reform in Georgia

January 1997

GEORGIA
HEALTH POLICY
CENTER

DIRECTIONS FOR CHANGE
RECOMMENDATIONS FOR MEDICAID REFORM IN GEORGIA

Submitted to

The Department of Medical Assistance

and

Governor Zell Miller

By

The Georgia Coalition for Health, Inc.

This report was prepared by the Georgia Health Policy Center, School of Policy Studies, Georgia State University. The Coalition supports and governs the Georgia Health Policy Center, which is under the direction of James G. Ledbetter, PhD.

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January 3, 1997

GEORGIA COALITION FOR HEALTH

Honorable Zell Miller
Governor
State of Georgia
State Capitol
Atlanta, Georgia 30334

Dear Governor Miller:

On behalf of the Georgia Coalition for Health, Inc., I am pleased to submit this report, *Directions for Change: Recommendations for Medicaid Reform in Georgia.* The recommendations in this report have been approved by the Board of the Coalition and also endorsed by the Board of Medical Assistance.

As you know, the Coalition launched this comprehensive study in response to your request to examine approaches for reforming Medicaid and to make recommendations that would lead to greater budget stability and predictability. I believe that this report reflects a unique process of garnering scientific and financial data, listening to more than 1200 Georgia citizens as they expressed their views about health care, and working to resolve differences represented in the Coalition. The Board kept focused on the vision of creating reform that would hold down Medicaid costs while at the same time providing basic health care to all qualified recipients. The result was consensus on the major recommendations contained in this report - a remarkable achievement, considering the complexity of the Medicaid program and the range of views represented by members of the Coalition.

I would like to commend the Board members and staff who worked to achieve this consensus. They took their charge seriously, worked diligently to learn about this complicated topic, and grappled with the tough issue of balancing fiscal responsibility and concern for people and their health needs. Each constituency represented in the Coalition brought its own unique perspective to the process, contributing to the rich and lively quality of the discussions. The task of reaching consensus was a challenge, but one that the Board met with commitment and creativity.

Thank you for the opportunity to help shape the necessary changes in Georgia's health care system. We support you and members of the General Assembly as you prepare to make these reforms.

Sincerely,

Allen Franklin
Chairman, Georgia Coalition for Health, Inc.

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DIRECTIONS FOR CHANGE

RECOMMENDATIONS FOR MEDICAID REFORM IN GEORGIA

The Georgia Coalition for Health, Inc.

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EXECUTIVE SUMMARY

The Medicaid program is in the process of undergoing significant change, with the major responsibility for financing shifting from the federal government to the states. To prepare for this shift, Governor Zell Miller has determined that Georgia needs to make long term changes in the system to achieve greater stability and budget predictability. The Georgia Coalition for Health, Inc., a nonpartisan, nonprofit organization formed to develop public consensus on healthcare issues, was asked to study the issue and recommend appropriate Medicaid reforms to the Department of Medical Assistance (DMA) Board, and, ultimately, to the Governor and the Legislature. Subsequently, the Governor also requested that all state agencies meet an ambitious short term goal of no budget increases for the next two years.

The Coalition Board has worked for the past year on the Governor's charge. The Georgia Health Policy Center at Georgia State University, the staff arm of the Coalition, provided research and administrative support for the endeavor. A wide spectrum of Georgia's citizens and interested groups contributed to this critical discussion about changes to the Medicaid system.

At the outset, the Board set five key objectives for the reform effort:

- To achieve the greatest access possible within the limited resources of the Medicaid budget
- To make sure that eligible Medicaid beneficiaries receive appropriate services
- To protect the healthcare safety net that helps people without adequate private health insurance
- To strengthen the healthcare infrastructure that serves all Georgians

- To ensure long term cost efficiency and budget predictability

The Board is pleased to report that it achieved consensus among the four constituencies represented by the Coalition: citizens, the business sector, government, and healthcare providers.

The Board is pleased to report that it achieved consensus among the four constituencies represented by the Coalition: citizens, the business sector, government, and healthcare providers. The results are recommendations for changes to the current Medicaid system that will move toward achieving the Governor's goal of long term budget stability. However, it will be impossible to achieve the short term budget goal of zero increases for the next two years through Medicaid reform.

The Board also recommends several other public policy initiatives that affect not only Medicaid reform but also other public and private healthcare programs. Some of these initiatives would require legislative change; others could be accomplished by state agencies or would require private sector participation.

THE RECOMMENDATIONS

Medicaid services typically are provided in three separate categories:

- Physical health (treatment of disease and illness, and preventive care)
- Long term care (health care, nursing home care, and social services to people with chronic care problems)
- Behavioral health (treatment of mental illness and substance abuse and services to individuals with developmental disabilities)

The Board concentrated its efforts on developing separate recommendations for two of these three categories: physical health and long term care. Behavioral health was not included in the mandate to the Coalition. The Behavioral Health Planning Unit within the Department of Human Resources has already begun to implement a new state law on behavioral health that is expected to lead to significant changes. The Board expects that behavioral health program

changes will achieve comparable cost efficiencies to those recommended for physical health and long term care.

The recommendations for physical health and long term care reflect the Board's overall vision about the way Medicaid beneficiaries receive care, the way healthcare providers are reimbursed for care, and the way the Department of Medical Assistance ensures that care is appropriate, high quality, and cost-effective. The Board has taken pains to anticipate and minimize any adverse side effects of these changes, to make sure that the safety net of the healthcare infrastructure is not damaged, and to minimize any negative impact on healthcare providers.

Physical Health. The Board recommends that Medicaid set a long term objective of using various approaches to better control the cost and quality of health care. Examples include enrolling beneficiaries in provider-sponsored health care corporations (PSHCCs) or health maintenance organizations (HMOs) or incorporating more vigorous care management techniques within the existing Georgia Better Health Care Program.

This recommendation builds upon several programs already in effect. A voluntary HMO, already available to Medicaid beneficiaries in Atlanta, is scheduled for expansion to additional urban areas in the state in 1997. Georgia Better Health Care, a program that matches Medicaid beneficiaries with primary care physicians who coordinate their health care, is already performing some care management. It, too, is scheduled for expansion throughout the state in 1997.

The Board discussed, but ultimately rejected, the approach of requiring all Medicaid beneficiaries to enroll in managed care plans where providers or health plans would accept full risk. Although that approach would come closer to achieving the five-year budget targets, the Board was concerned about the potential disruption to the healthcare delivery system. The recommended alternative is a less stringent approach that comprises several different kinds and levels of managed care. If an evaluation of the cost,

quality, access, and outcomes of the program indicates that this interim approach has not been successful by July 1999, then DMA would be expected to use other strategies, which might include mandatory, full-risk managed care for all beneficiaries. The process of obtaining a waiver should begin now, although it should not be implemented unless the evaluation indicates it is necessary.

Long Term Care. The Board recommends that over the next five years, the state gradually shift the balance of long term care services from nursing homes to other settings, such as homes or community-based programs like adult day care. Such a shift does not mean that patients now in nursing homes would be discharged, but rather that people who need long term care would be given more alternatives to institutions.

To support this shift away from nursing homes, prevention programs would focus on keeping people healthy enough to stay at home. The state would control the number of nursing home beds and also institute a case placement and management system in which individual cases are reviewed to make sure that the care provided is both high-quality and cost-effective.

PUBLIC POLICY INITIATIVES

During the course of the work on Medicaid reform, the Georgia Coalition for Health received many helpful suggestions about the healthcare needs of Georgians. The stakeholder process, public testimony, and Board committees all provided a rich forum for ideas and suggestions for improving the Medicaid program. The central ideas that emanated from this process are included as public policy initiatives, three of which require legislative action by the 1997 General Assembly: establishing a trust fund to support graduate medical education, establishing a long term care commission to develop a strategic plan for service needs and incentives, and implementing a temporary moratorium on the increase of nursing home beds.

CONCLUSION

This project to examine options for fundamental changes in Georgia's Medicaid program, including the process and the resultant recommendations, has been remarkable in several aspects.

A central part of the process was the inclusive participation of a large number of Georgians.

- *The process itself was unique.* No other state has carried out such a comprehensive and inclusive effort to incorporate both scientific and public input. The project team provided information about the experience of Medicaid reform in other states and developed financial models to show the likely cost impact of various reform options. A central part of the process was the inclusive participation of a large number of Georgians. More than 1,200 people contributed their views about Medicaid reform in structured community dialogues, focus groups, and at the open Board meetings. An additional 5,000 Georgians had an opportunity to address Medicaid reform in community forums held throughout the state.

- *The Board achieved consensus.* Despite representing varied constituencies, all 32 Board members endorsed the recommendations, signifying broad support for the changes. Each constituency brought its own unique concerns to the deliberations, and discussion was lively and far ranging. At the end, the vision for improved health care and better financial stability brought the Board members together in consensus.

- *Recommendations for long term care represent a paradigm change in the way services are provided.* The changes endorse a shift away from institutional care and toward home- and community-based care, a change long sought by many healthcare advocates.

- *Physical health recommendations focus on improved management of health care.* The recommendation supports a gradual transition toward a reformed system that builds on the existing Medicaid structure and helps support traditional Medicaid providers.

The changes are not short term "fixes," but rather are steps to pave the way for major system changes that will position the state to achieve financial stability in the next century.

- *Recommendations reflect the importance of the Medicaid program as a central element of the state's healthcare safety net.* The recommendations acknowledge the impact of change on other components of the healthcare system and attempt to ameliorate those changes.

- *The changes are not short term "fixes," but rather are steps to pave the way for major system changes that will position the state to achieve financial stability in the next century.* As with any major organizational system shift, these changes will involve an up-front investment of resources to achieve the desired goal.

In summary, the Georgia Coalition for Health, Inc., has set a direction for Medicaid reform that attempts to balance cost containment and assurance of quality health care for all Georgians. The Board thanks the Governor for the opportunity to contribute to this important process and supports him and the General Assembly as they prepare to address these reforms.

Chapter 1

BACKGROUND: GEORGIA'S MEDICAID PROGRAM

Medicaid is a federal program that pays for:

- Long term or chronic care for people with disabilities
- Long term or chronic care for low-income elderly people
- Medical care for low-income families

In state fiscal year (FY) 1996, Georgia's Medicaid total budget was $3.7 billion; $2.3 billion came from the federal government; $1.4 billion came from the state.

Here's how that spending was allocated among different groups:

	All Beneficiaries (%)	Total Dollars Spent (%)
AFDC (welfare) families	42	20
Low-income pregnant women and children	32	21
People with disabilities	18	41
Low-income elderly	8	18

In state FY 1996, Medicaid provided benefits to 1,181,092 people in Georgia—more than one in seven people in the state. Medicaid pays for about 14% of all healthcare spending in the state and 85% of all nursing home care costs.

In the early part of this decade, Medicaid spending grew rapidly, up 116% in five years.

Medicaid primarily covers children: 59% of beneficiaries are under 21, and almost 40% of all preschool children in Georgia are Medicaid beneficiaries. Medicaid pays for more than half of all births in the state. It covers about 28,000 children with disabilities, most of whom would probably be rejected by private insurers no matter what their family income.

In the early part of this decade, Medicaid spending grew rapidly, up 116% in five years. That's mainly because more people became eligible for benefits: eligibility rose 106% in five years. During that same time period, Medicaid spending grew from 9.6% of the state budget to 12.2%.

Partly as a response to these cost increases, the Department of Medical Assistance (DMA) has taken steps to more tightly manage the care of Medicaid beneficiaries. For example, a voluntary health maintenance organization (HMO) is available to beneficiaries in Atlanta; as of December 1996, 16,000 individuals were enrolled in the five core metropolitan Atlanta counties. Another program that performs some care management is Georgia Better Health Care (GBHC),which matches Medicaid beneficiaries with primary care physicians who coordinate their health care. As of December 1996, 426,000 people were enrolled in 71 counties.

By the end of calendar year 1997, the voluntary HMO program will be expanded to all counties where HMO or provider-sponsored health care corporation (PSHCC) networks and contracts are available. By that same date, GBHC will be expanded statewide. At that time, all Medicaid recipients will be required to enroll in GBHC unless they choose an HMO or a PSHCC. In addition, the Department has contracts to conduct utilization review of services, review requests for coverage of selected drugs, and precertify admissions to hospitals or nursing homes for medical necessity or appropriateness of level of care.

Georgia Medicaid has four home- and community-based programs for which the federal government has waived certain provisions of the Medicaid law. These waivers allow

the state to offer noninstitutional care to recipients who would otherwise qualify for nursing home care or other institutionalization. Waiver programs include the Community Care Services Program, with several options for home- and community-based care of the frail elderly; the Independent Care program, which serves disabled adults in their own homes and communities; the Mental Retardation waiver program, which services recipients with special needs, and the Independent Care program for Traumatic Brain Injuries, which serves a small population with very particular medical requirements. In FY 1996, more than $87 million was budgeted for this program, and $26 million more was appropriated for FY 1997. In 1996, approximately 25% of Georgians in the long term care system were served in home- and community based programs.

As a result of these changes—and as a consequence of declining welfare rolls—Medicaid spending growth has slowed to about 3% to 5%. State budget pressures have reduced the growth rates even more for fiscal years 1997 and 1998. Nonetheless, there is still concern about the ability of the Medicaid program to cope with rising healthcare costs.

Chapter 2

THE PUBLIC POLICY PROCESS: RESEARCH AND DECISION-MAKING

The Medicaid program is in the process of undergoing significant change, with the major responsibility for financing shifting from the federal government to the states. To prepare for this shift, Governor Zell Miller has determined that Georgia needs to make long term changes in the system to achieve greater stability and budget predictability. The Georgia Coalition for Health, Inc., a nonpartisan, nonprofit organization formed to develop public consensus on healthcare issues, was asked to study the issue and recommend appropriate Medicaid reforms to the Department of Medical Assistance (DMA) Board, and, ultimately, to the Governor and the Legislature (see Appendix A). Subsequently, the Governor also requested that all state agencies meet an ambitious short term goal of no budget increases for the next two years.

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At the outset, the Board set five key objectives for the reform effort:

- To achieve the greatest access possible within the limited resources of the Medicaid budget
- To make sure that eligible Medicaid beneficiaries receive appropriate services

The Coalition sponsored extensive research on the views of healthcare providers, Medicaid beneficiaries, and Georgia citizens – the stakeholders in the state's Medicaid system.

- To protect the healthcare "safety net" that helps people without adequate private health insurance
- To strengthen the healthcare infrastructure that serves all Georgians
- To ensure long term cost efficiency and budget predictability

STAKEHOLDER INPUT AND BACKGROUND RESEARCH

In preparation for its deliberations on Medicaid reform, the Coalition sponsored extensive research on the views of healthcare providers, Medicaid beneficiaries, and Georgia citizens—the stakeholders in the state's Medicaid system. More than 6,000 Georgians expressed their views as a part of this process. The Coalition also studied the experience of other states as they tackled Medicaid reforms.

Citizen input was gathered through focus groups in all areas of the state, with almost 500 people participating. Focus group participants were randomly chosen to represent all socio-economic segments of Georgia's population. Several of the focus groups were composed of Medicaid beneficiaries, and others were made up of healthcare providers. In addition, about 700 healthcare providers, Medicaid beneficiaries, and advocates participated in a series of 14 community dialogues throughout the state. Whereas each focus group was made up of people with similar socio-economic backgrounds, the community dialogues brought together individuals representing diverse groups to participate in open, spirited discussions. Further, Georgia Health Decisions conducted 200 community forums throughout the state in which 5,000 Georgians had the opportunity to express their concerns about Medicaid reform.

Detailed reports on all the citizen input are available from the Georgia Health Policy Center. The main themes are summarized on the following pages.

Citizens. The citizens, both Medicaid beneficiaries and members of the general public, expressed a wide variety of views but agreed on a few basic themes.

- Vulnerable people should be protected. Citizens generally believe in the concept of a healthcare safety net and are willing to pay taxes to provide healthcare to people who need help.

- Only truly needy individuals should qualify for Medicaid. Citizens want to make sure that eligibility is strictly defined and enforced to stop abuse. In particular, they want to limit asset transfers to family members that enable older people to qualify for Medicaid.

- Nothing should be free. Citizens want all adult Medicaid beneficiaries to make some financial contribution toward their care, generally favoring a sliding scale based on income. They believe welfare recipients should work. They also want to make sure that families contribute to the cost of caring for disabled children and, perhaps, for elderly parents.

- Health care should be accessible to all Georgians. Citizens worry about rising healthcare costs and their own ability to get affordable coverage; even if they now have health benefits, they worry about losing them. People are also concerned about the uninsured and would like to broaden Medicaid reform to offer affordable coverage for this group.

- In general, citizens do not understand the concept of a managed care health plan. People tend to base their opinions about managed care on what they learn through the media. However, when they receive accurate information and hear from others with experience in managed care plans, citizens often agree that Medicaid beneficiaries should be required to participate in capitated managed care plans as a cost cutting measure.

- Citizens strongly support shifting long term care dollars from institutional care to more community and home-based care. They maintain that beneficiaries and their families should have more options in the type of long term care they receive, where they receive that care, and who provides the care to them. They believe the key to the success of this change is shifting some of the responsibility for monitoring quality of care from the Medicaid system to families.

Medicaid Beneficiaries. In the community dialogues, Medicaid beneficiaries generally shared the opinions of the general population, as described above, but also expressed some specific concerns.

- Medicaid costs should not be cut by reducing eligibility, since not enough truly needy people are covered even today.

- There should be no stigma attached to receiving Medicaid, and any managed care plans used in the program should serve both Medicaid beneficiaries and non-Medicaid patients.

- Especially in cases of complicated disabilities, beneficiaries should have flexibility to choose the most appropriate providers and services, and they believe that they would be able to select services cost-effectively.

- More home- and community-based services should be made available. Support services such as transportation, outreach, and follow-up should be strengthened, especially in rural areas.

- Efforts to detect and eliminate fraud, waste, and abuse should be enhanced.

- Prevention and education should be integral components of any benefits package.

Providers. In addition to participating in the focus groups and community dialogues, many healthcare providers were

interviewed for a separate study as part of a detailed analysis of the current healthcare delivery system in Georgia. Key findings from that research are summarized below.

- The delivery system is in rapid transition. Organized health plans are widespread in the state, displacing traditional fee-for-service reimbursement plans. Hospitals and other providers are restructuring, merging, and forming networks to compete with insurer-sponsored managed care organizations.

- A quick-budget-fix approach to Medicaid reform could harm public health and actually raise costs in the long run. Providers would support a serious, well-reasoned reform effort, developed through a fair process that listens to providers' concerns, and includes realistic transition periods.

- Any reform plan should include performance standards, outcome measures, accountability, competition, and choice (for both beneficiaries and providers). Providers should be able to at least break even financially if they participate in Medicaid, and a small profit would be appropriate as recompense for taking risk.

- Providers who have traditionally served the Medicaid population with demonstrated quality should be included in a managed care system or any other delivery system.

Experience in Other States. Finally, research focused on seven states that have carried out extensive Medicaid reform: Arizona, California, Florida, Minnesota, Oregon, Tennessee, and Washington. The Board was interested both in the methods these states chose to change Medicaid and in the effect of the changes on cost, access, and quality of care.

The other states' experience indicates:

- For AFDC families, managed care generally leads to lower costs, better access, and equivalent quality of care compared to traditional fee-for-service systems.

- Primary care case management generally leads to lower costs, and many physicians have been positive about participating in such programs.

- Managed care is more successful when different structures are available for different types of beneficiaries, types of service, or geographic areas.

- Managed care delivers the greatest savings when mandatory full-risk programs are used, and when providers and the state both share in the savings.

The comparison states have used various types of care management for their Medicaid physical health programs for as long as 13 years. Nationwide, about 8% of all Medicaid recipients in 31 states were enrolled in primary care case management (such as Georgia Better Health Care) during 1994; 15% of all recipients in 27 states were in full-risk managed care, and 2% of all recipients in 10 states were in partial-risk managed care. In 1996, 25% of all Medicaid recipients nationwide were enrolled in primary care case management or more structured managed care plans.

For long term care, the other states' experience with alternative structures is much less extensive than it is with physical health; most efforts cover only a small number of people in demonstration programs. Because so little has been done in this area by other states, there's little experience to guide Georgia in its deliberations about long term care reform.

THE BOARD'S DECISION-MAKING PROCESS

The Georgia Coalition for Health is governed by a 32-member Board representing four constituencies:

- Citizens are represented by Georgia Health Decisions, a nonprofit, nonpartisan research organization.
- Business is represented by the Georgia Business Forum on Health, an affiliate of the Georgia Chamber of Commerce.
- Health care providers are represented by the Georgia Healthcare Providers Council, which, in turn, represents eight major provider organizations and other associate members.
- The public sector is represented by eight individuals from state and local governments and health agencies and institutions.

Under the rules of the Coalition, decisions must be approved by a majority of each of the four constituencies, not simply a majority of the entire Board.

Three options that represented three distinct styles of Medicaid reform were defined.

Because the Coalition Board does not include any Medicaid beneficiaries, members were extremely conscious of the need to understand and listen to the concerns of the people whose healthcare system is under scrutiny. In addition to the extensive research and citizen input from Medicaid beneficiaries described above, the Board included time for public comment at each of its eight meetings before making decisions. Many Medicaid beneficiaries and advocates took the opportunity of open Board meetings to express their concerns.

Early in the process, three options that represented three distinct styles of Medicaid reform were defined. Examining each option allowed the Board to understand better what that style of reform might mean to Georgia's Medicaid program.

A Medicaid reform project team, which included staff of the Georgia Health Policy Center and economic and financial consultants, provided extensive analyses of each option. (Appendix B lists the project team members.) Financial modeling was performed for each option, including the potential effects on the healthcare safety net. In addition, each option was evaluated for quality issues.

The Financial Models. Two key financial models were used to project the effect of proposed changes.

Medicaid costs. Using an actuarial model, the project team sorted historical claims and eligibility data by type of assistance (e.g., blind, disabled, or AFDC), type of service (e.g., inpatient hospital, pharmacy, or primary care physician), geographic region, age, and sex. They projected costs under the current program, reflecting population changes, inflation, and already enacted changes in the Medicaid program. They then were able to predict the state's total costs under different proposals over the next 5 years.

The model takes into consideration the subtle interaction of changes in the rules and actual patient and provider behavior. For instance, imposing a $50 patient co-payment for inpatient hospital care will not only reduce the state's cost for hospitalization but reduce admission rates. At the same time, it will increase outpatient utilization, because patients will still need treatment.

Any financial projection model, no matter how powerful, has limitations. Whereas such models produce specific dollar figures, they should not be taken as exact estimates, especially for several years into the future. What's important is the direction of trends and the general magnitude of the figures, especially in comparison to the projections for other options.

Market effects. The project team was able to determine the extent to which different providers rely on Medicaid revenue and how this might vary under managed care. They were also able to segment these effects by geographical

area. The basis for this analysis included data on population, Medicaid claims, number of physicians, utilization and revenues of hospitals and nursing homes, and prescriptions and revenues of pharmacies.

The project team also defined criteria for determining that a given subset of providers would be financially "at risk"—that is, heavily reliant on Medicaid revenue and already under pressure from other market forces. If two or more types of providers were at risk in a geographical area, they classified the entire area as being at risk from changes in Medicaid.

As with the actuarial models, the economic models are not intended as exact predictions of what will occur over the next 5 years. In all cases, revenue effects are projected under the assumption that nothing else will change. In reality, of course, other marketplace trends not related to Medicaid will affect healthcare providers, and they may well begin to offer different services or different service mixes.

Chapter 3

HEALTHCARE DELIVERY MODELS AND TERMS

The rising cost of health care has been an issue of serious concern for many years, both for employee populations and in public programs. But so far, employers have acted much more aggressively to manage costs than either Medicaid or Medicare.

Any discussion of healthcare costs requires an understanding of the two components of overall cost: utilization and unit cost. Utilization is the rate at which people receive care—for instance, the number of primary care physician visits or CT scans or hospital inpatient days per thousand covered members. Unit cost is the price paid for the individual services. It's impossible to control overall costs unless both utilization and unit cost are controlled. Otherwise, as one component is clamped down upon, the other one tends to go up in compensation.

It's also necessary to understand the concept of risk—the potential for financial harm if utilization or unit cost are too high. In the traditional healthcare delivery model, described as a "fee-for-service" or "indemnity" plan, this risk lies entirely with the payer—in this case, the State of Georgia. Providers receive their fees no matter what happens. It's also possible for risk to be shifted entirely to the provider. In such a system, described as a "full-risk," "capitated," or "prospective payment" arrangement, the provider receives a set amount per patient or per procedure and is expected to deliver all needed care for that amount. The payer is responsible only for that amount, no matter what happens. Finally, there can be approaches in between these two extremes, in which risk is shared between payer and provider.

Additional risk may be placed upon providers in a full-risk Medicaid plan. Normally, full-risk plans require patients to pay small fees or "co-payments" each time they seek care. That tends to hold down utilization because patients think twice before they seek treatment. But federal law does not allow providers to deny care to a Medicaid beneficiary who is unable to pay, and Medicaid beneficiaries are often unable to pay. Thus, providers may have to deliver more treatment to a Medicaid population than they would to a private population that has co-payments because the utilization of services by the Medicaid population is not moderated by individual financial responsibility. Co-payments have not proven effective for the Medicaid population because, in reality, they are passed on to the providers.

Discussion of any reform efforts incorporates specific terms that are important to a full understanding of this issue. The glossary on the following pages defines some of these terms.

GLOSSARY OF TERMS

Capitation: contracting with a health plan to provide all needed services for a set amount per patient per month.

Case management: reviewing cases individually to draw up an appropriate and cost-efficient treatment plan. For instance, a catastrophically ill patient might be better cared for at home than in the hospital, or in a specialized facility rather than a general hospital.

Case mix reimbursement: reimbursing hospitals or nursing homes a set amount for each type of case or admission, according to the diagnosis or level of care required.

Drug formulary: a list of specific drugs, compiled for efficacy and cost, from which physicians are generally required to prescribe.

Home- and community-based services: providing long term care outside nursing homes, using services such as home health care, adult day care, assisted living facilities, personal

care assistants, respite care, or caregiver education and support groups.

Long term care services: a systematic array of medical, social, and support services that provide assistance over time to individuals who cannot independently care for themselves.

Managed care: an umbrella term used to describe many different variations on the general concept of simultaneously controlling both utilization and unit cost. Common to all these variations are these four factors: individuals are formally enrolled; providers and payers have formal contracts to cover the enrolled population; treatment is coordinated, usually by the primary care physician, rather than received from whichever provider the patient chooses to visit; and providers or health plans usually assume some or all financial risk.

Partial-risk contracting: shifting some but not all financial risk to providers. For instance, they could receive a capitated rate, but at the end of the year, financial records would be examined. If the provider's actual cost exceeded the set payment, the provider would receive an additional payment for a percentage of the excess; if actual cost was lower than the set payment, the provider would repay a percentage of the difference. Partial-risk contracting might be used for the entire package of Medicaid services, or for only a portion (perhaps as an interim measure before a provider network is fully assembled).

Pharmacy benefit management: making one organization responsible for the delivery and utilization management of all prescription drugs.

Preadmission screening: evaluating each potential long term care recipient in advance to determine the needed level of service and the most cost-efficient setting of care.

Primary care case management: making the primary care physician responsible for coordinating the care of each beneficiary, presumably looking for the most cost-effective

treatment. Such efforts are usually more successful when financial incentives are provided to the physician to encourage cost-effective care or quality outcomes.

Prospective payment: setting the unit cost for a given service in advance, thus placing the provider at risk. For example, under the current Medicare program, hospitals receive a single set payment for any diagnosis-related group (DRG), no matter what treatment or services are provided. As another example, doctors receive a set fee for a given service, determined under a methodology that gauges the time, difficulty, and overhead involved in each procedure. The methodology is called the Resource-Based Relative Value System, or RBRVS.

Rebasing: updating the prospective payment fee schedule to keep up with inflation or other marketplace changes; usually done each year. Cutting the frequency of rebasing in effect lowers unit cost.

Safety net providers: a network comprised largely of traditional, institutionally based Medicaid providers or services, including public health departments, community-based health centers, regional health services, and disproportionate share hospitals, which also includes some teaching hospitals.

Selective contracting: limiting the number of providers for certain services (for instance, dialysis, bypass surgery, or maternity care) and encouraging cost-effective treatment by offering financial incentives and penalties to those providers.

Traditional Medicaid providers: institutions and individuals that have been historically involved with Medicaid and for whom Medicaid patients form a disproportionate share of their patient load.

Utilization review: evaluating whether patients really need hospitalization or surgery, before unnecessary care is provided. This may occur by requiring advance approval before the patient enters the hospital or surgery is scheduled. It may also occur by reviewing the situations of patients

already in the hospital, to see when they can safely be discharged.

Chapter 4

THE HEALTHCARE SAFETY NET

One of the major objectives of the Coalition was preservation of the healthcare safety net—the network of providers, agencies, and payment arrangements that seeks to protect the almost 40% of Georgians who have public, non-employment-based insurance, inadequate health insurance, or no insurance. In addition, certain safety net services, such as trauma centers, neonatal care centers, and public health services, benefit *all* Georgians, no matter what their income level. The safety net includes such elements as:

- Providers who are required by federal or state law to provide free or reduced-fee care to people who cannot afford to pay
- "Disproportionate-share hospitals," those that serve more than their share of Medicaid beneficiaries
- Public, non-employment-based insurance, such as Medicare, Medicaid, and other initiatives
- Public agencies such as public health departments
- Community health centers
- Charitable organizations

The elements of the safety net are tightly interdependent. A shift in services or payment from one source will have ripples throughout the net. Cost-shifting occurs when financial resources supporting one population are also used, in part, to support services for another, usually indigent, population. Specifically, if Medicaid payments are reduced, it could have severe consequences on every part of the net. For instance, if a hospital loses too much Medicaid revenue,

it might become financially unable to provide free care, it might have to discontinue some services, or, in the worst case, it might have to close.

One of the ways Medicaid supports disproportionate-share hospitals is through the Indigent Care Trust Fund. Certain hospitals that serve a disproportionately large number of Medicaid recipients and other indigent individuals are eligible to participate in this program by contributing limited amounts of funds that are matched by federal dollars. This contribution, plus a share of the federal match, is then returned to hospitals to help them offset the cost of providing care. In federal FY 1995, the total trust fund was approximately $400,000,000. However, this was only a partial reimbursement for uncompensated care.

The Board's concern for preserving the healthcare safety net was inherent in its recommendations and all its deliberations.

As the Board evaluated each of the options for Medicaid reform, they had as a primary concern the effect on the safety net. Although protecting individual providers from financial loss was not an objective, the Board did make it a major priority to minimize overall disruption to the healthcare delivery system and to ensure that financial losses would not lead to the disappearance of essential services from the safety net.

The Board's concern for preserving the healthcare safety net was inherent in its recommendations and all its deliberations. For example, many thought that DMA should assure that traditional providers have the opportunity to participate in primary care case management of HMO-type provider networks, and that DMA should address the issue of assuring critical functions of some safety net providers, such as provision of indigent care and protection against communicable disease transmission. Special concern for traditional Medicaid providers led to recommendations in two areas: (1) technical assistance to safety net providers to help them adjust to Medicaid changes (see pages 38-40) and (2) specific safety net public policy initiatives to the Governor and the Legislature (see pages 47-49, Items 1, 5, and 6).

Finally, a related issue deserves mention. Although the Coalition's charge of Medicaid reform did not explicitly include addressing the needs of Georgia's uninsured population, that issue is intricately intertwined with changes in Medicaid. Citizens said emphatically at forums and focus groups that they wanted to reduce the number of people without private coverage, and the Coalition strongly endorses this goal. In particular, the Board wants to make sure that cost-cutting measures for Medicaid do not increase the number of uninsured.

One way to accomplish that goal might be to allow uninsured people to buy into a program that offered a standard benefits package. The project team has performed preliminary financial projections of the cost if all eligible people bought into such a program. However, experience in other states indicates that, if the system is voluntary, many people choose not to buy in (either because they cannot afford to or they have identified other priorities for spending their money). And, in fact, those who do buy in are the individuals with the greatest healthcare needs. Given that there are fewer people in a system and these people need more health care, the cost for providing care per individual could be two to three times higher than if all eligible people bought into such a program. It is apparent that a substantial subsidy would be required to achieve effective levels of participation. This would clearly be difficult in a time of budget-cutting, but the matter deserves further study, and the Coalition plans to pursue it.

Chapter 5

RECOMMENDATIONS

CONSIDERING THE OPTIONS

Any proposal for reforming Medicaid must focus on four essential program elements: benefits, eligibility, provider payment, and the delivery system. Many variations of modification are possible in each of these four categories. Because it was impractical to model every possible combination, three specific options were defined to represent three distinct styles of Medicaid reform. Modeling these distinctive styles showed the Coalition Board the impact each would have on the Medicaid program. Each option is summarized below to explain the range of possibilities the Board considered before making its final recommendation.

Option 1. Option 1 represents a continuation of the current Medicaid program using traditional methods of cutting provider reimbursement, benefits, and eligibility to achieve significant savings. Under this option, the current fee-for-service delivery system remains in place. However, to illustrate the possible impact of this approach to reform, reductions in certain service and eligibility categories are assumed.

For the physical health program, the inpatient hospital reimbursement system remains largely unchanged except that rates are rebated every three years instead of every year. The current physician fee schedule is reduced from 90% of the Medicare Resource-Based Relative Value Scale (RBRVS) to 80%. Pharmacy benefits are also reduced by limiting the number of prescriptions to four per month instead of the five previously allowed. Eligibility for Supplemental Security Income (SSI) is reduced from 300% to 200% of the SSI income level.

For long term care, the current nursing home rates are reduced, nursing home days are limited to a maximum of 300 per year, and eligibility for SSI is reduced from 300% to 200% of the SSI income level.

Option 2. This second option assumes that the Department of Medical Assistance (DMA) takes on the role of a managed care organization. The basic fee-for-service reimbursement mechanism is maintained, but several managed care techniques are employed by DMA (or its designated contractor) to improve its control of nonmedically necessary care or to take advantage of its buying power in the marketplace.

For physical health care, these changes include changing the hospital payment methodology from the current case rate system to a case-mix adjusted system (e.g., DRGS), moving to a 3-year hospital rate rebasing system, strengthening the role of utilization managers through enhanced utilization review, requiring prior authorization and concurrent review, carving out the pharmacy benefit, and retaining a pharmacy benefit manager. Other changes include the implementation of selective contracting with centers of excellence for specialized services (e.g., cardiac care centers, neonatal centers, specialized children's services, obstetrical services, and other high-volume services) and early intervention in potentially large claims. No changes in benefits or eligibility are assumed.

For the long term care program, a more restrictive preadmission screening tool is adopted, the current nursing home reimbursement system is changed to a case-mix approach, and home- and community-based services are expanded. The role of case managers is expanded and strengthened to allow them to develop and authorize service plans, approve services, and reassess beneficiaries. Additionally, selective contracting for waivered services is implemented. The combination of these changes is assumed to encourage the use of home- and community-based services as an alternative to institutionalized care.

Option 3. Option 3 represents a Medicaid program using a capitated managed care delivery system for both physical health care and long term care. Under this system, risk is passed through to managed care organizations (MCOs) that are selected through a competitive bidding process. Although the MCOs are capitated for all services, they can contract with providers under any payment system they are able to negotiate. Enrollment in an MCO is mandatory for all Medicaid beneficiaries; those who do not enroll in a capitated MCO are automatically assigned to one. Managed care contracts with MCOs cover 2 years.

APPLYING THE MEDICAID REFORM STYLES TO GEORGIA

The Board, using information developed by the project team, carefully examined each of the three styles of Medicaid reform for physical health and long term care. Board members considered the short- and long term financial implications of each option, as well as the impact on consumers, providers, markets, and the safety net. Lessons learned from considering what each of the three styles of reform would mean for Georgia helped guide the Board toward its final recommendations.

Lessons Learned from Option 1. As the Board considered Option 1, which cut eligibility, reduced services, and decreased payments to providers as ways to decrease Medicaid expenditures, it explored all eligibility categories and services that were either optional or above minimum federal requirements.

It became apparent that, in most cases, cutting eligibility and services did not generate the desired savings in the short or long term. Also, cutting eligibility would present logistic—and possibly, legal—problems because cutting services to potential new recipients is only possible if services to current recipients are discontinued. The eligibility cut considered in Option 1 would decrease the income level from 300% of SSI to 100% of SSI and would

result in 3,200 people being dropped from Medicaid. Those in nursing homes would be most affected by this cut in eligibility.

Just as serious, reducing the number of people with Medicaid coverage would shift the provision of care of those individuals to providers who offer charity care to the uninsured. Whereas the total volume of care would stay about the same, state and local governments would no longer receive federal Medicaid matching funds and thus would have less money available to provide the same services.

Early in the exploration process, some Board members thought that there might be opportunity for substantial savings from paring back what some believed was a rich benefit package. However, many of the optional services offered by Medicaid in Georgia are preventive in nature, so that eliminating those services could result in higher expenditures over time. Further, the services considered for elimination would result in little savings to the overall Medicaid program. Also, it became clear that the Medicaid population has special needs, differing from the typical employer-insured population, and the Medicaid package is needed to provide special benefits important to this group of poor and often sicker individuals. An example of such a benefit is nonemergency transportation to get to a primary care practitioner.

Cutting payments might be a disincentive for some providers to serve Medicaid patients, which could compromise access in certain areas of the state and perhaps prevent people from obtaining needed care. Or, it could force people to go to the emergency room instead of the doctor's office, thus increasing the cost of treating a given condition. The Board concluded that, to assure people's access to care, providers should be compensated adequately no matter what style of reform is chosen.

Because of such negative implications, Option 1 was never seriously considered as a recommendation, but served mostly as a benchmark for cost comparisons.

Lessons Learned from Option 2. In Option 2, DMA would become a managed care agency, monitoring and intervening in patient care, choosing providers, negotiating contracts for certain services, and taking advantage of its purchasing power. This option achieves savings through changing the system rather than cutting eligibility, benefits, or provider payments. However, up-front administrative costs would be incurred as part of the effort of re-engineering the system.

The Board had two major concerns about whether DMA can effectively function as a managed care overseer and contractor. First, the level of salaries that DMA can pay may not be adequate to retain skilled and experienced staff in an extremely competitive field, especially when for-profit entities will be bidding for the same talent. Second, it may be difficult for a state agency operating in a political environment to be sufficiently firm and objective in the negotiation and competitive bidding process among providers. This would limit the savings that could be achieved with this option.

As the Board considered Option 2, concerns about impact on the markets and providers began to emerge. For example, implementing a pharmacy management program would result in a double-or-nothing effect for pharmacies. That is, those affiliated with the pharmacy benefit management entity (probably one of the existing drug chains) might have revenue gains, but those not affiliated would lose their entire Medicaid business.

Lessons Learned from Option 3. Option 3, serving all Medicaid beneficiaries through a "capitated system", received the most attention, partly because it was the only model to deliver long term financial stability and partly because it involved such a dramatic change in the health delivery system. The implementation of this option would require major up-front investments of time and money. Based on its consideration of Option 3, the Board identified important concerns for any recommendation it might make:

- The healthcare infrastructure (providers, markets, and the safety net) must be protected from potential instability caused by a too-rapid transition to a new delivery system. This is especially important for traditional Medicaid providers.

- Because so little is known about the impact of managed care on people with disabilities, they deserve special consideration in any reformed system.

- Paying large administrative fees to managed care organizations might mean that less money will be spent on direct patient care.

- As with any major organizational re-engineering effort, up-front administrative costs would be required to achieve the desired outcomes.

FINANCIAL IMPACT OF OPTIONS 1, 2, AND 3

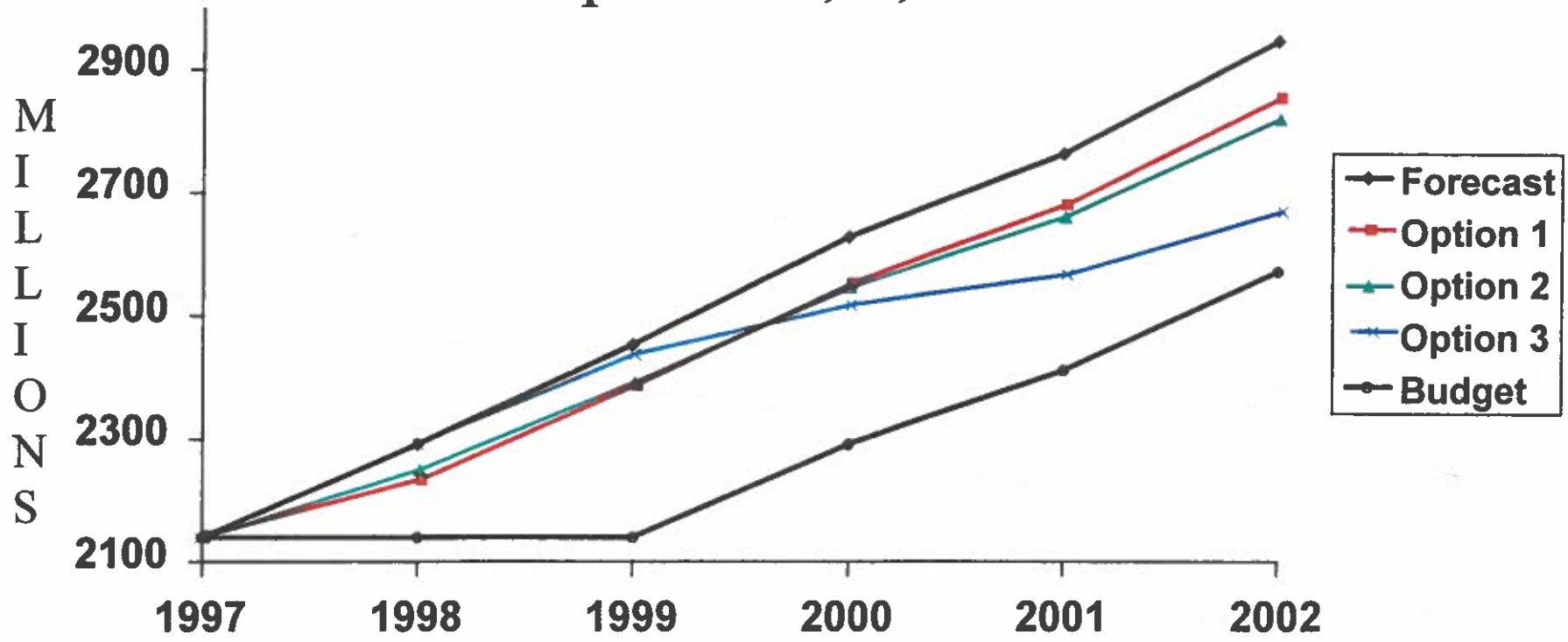
Graphs A and B on pages 31 and 32 compare the financial impacts of each of the three styles of Medicaid reform for both physical and long term care. For physical health (Graph A), Option 1 achieves some short term savings, but in the long run does little to change the pattern or trend of Medicaid spending. Option 2 has much the same financial impact as Option 1. Option 3 produces no short term savings but does cut the overall trend of expenditures by 50% by reducing both unit cost and utilization.

The Board collectively preferred restructuring the system over cutting eligibility, benefits, or payments to providers.

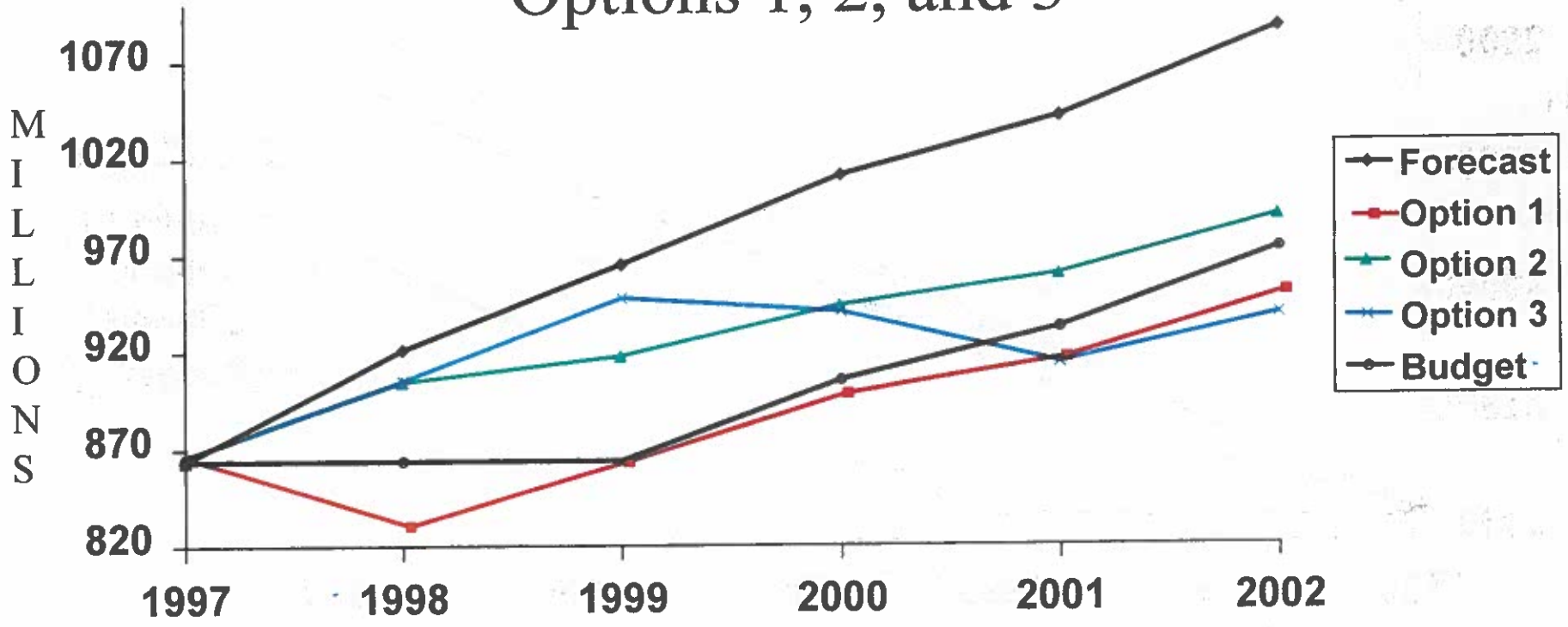
For long term care (Graph B), Option 1 achieves the most dramatic short term savings, principally because of the cuts in eligibility. However, as in physical health, Option 1 does not moderate the long term trends. Option 3 produces little short term savings but has the largest long term savings. Option 2 has neither the short term savings of Option 1 nor the lasting benefits of Option 3.

After careful examination of all the options, the Board collectively preferred restructuring the system over cutting eligibility, benefits, or payments to providers. However, the

Graph A
PHYSICAL HEALTH EXPENDITURES
Options 1, 2, and 3



Graph B
LONG TERM CARE EXPENDITURES
Options 1, 2, and 3



Board was concerned that a too-rapid restructure of the system would not be in the best interest of the consumers or of Georgia's healthcare infrastructure. The Board believed that providing sufficient time and technical assistance could help the infrastructure, especially traditional Medicaid providers, make a successful transition to managed care.

Despite concern about the administrative burden placed on DMA, the Board preferred that DMA attempt to tighten the management of care and only fully transfer risk and responsibility (mandatory capitation) if adequate financial savings are not forthcoming.

The Board developed consensus on two approaches – one for physical health and one for long term care – that blended the best aspects of earlier options.

For long term care, it became apparent that the basic source of savings was the shift in the percentage of recipients from nursing home settings to home- and community-based settings. Capitation may or may not be necessary to achieve the desired level of savings. This reinforced the Board's decision that DMA attempt to tighten the management of care itself.

After a series of straw votes, it was apparent that none of the initial three options could achieve the necessary majority approval from each constituency. Instead, the Board developed consensus on two approaches – one for physical health and one for long term care – that blended the best aspects of earlier options. After financial modeling was performed, the Board reiterated its approval of these two recommendations.

Option 4 [has] the goal of moving toward a more tightly managed system of care with minimal disruption to beneficiaries, providers, and the safety net.

PHYSICAL HEALTH RECOMMENDATION: OPTION 4

Realizing that Option 3 would create such dramatic change in the healthcare delivery system, the Board modified that option for its recommendation for physical health (referred to as Option 4), with the goal of moving toward a more tightly managed system of care with minimal disruption to beneficiaries, providers, and the safety net. The recommendation scaled back Option 3's commitment to universal capitation, envisioning that mandatory capitation,

along with any new approaches, would be considered only if voluntary measures failed to achieve adequate cost reductions by July 1999.

Option 4 sets Georgia on the right track toward meaningful Medicaid reform.

Graph C on page 35 highlights the projected cost of Option 4, as compared to the three original options, the budget target, and the status quo (the current program, reflecting anticipated population growth and inflation). In all graphs and financial analyses, the state's fiscal years are used. The 1997 fiscal year, for example, ends on June 30, 1997.

The financial projections show that the recommendation may not deliver the possible long term savings of Option 3. Nevertheless, the Board believes that this recommendation is the best approach. Further, although it does not meet short term budget targets, Option 4 sets Georgia on the right track toward meaningful Medicaid reform that will eventually accomplish those goals. It does so without creating serious disruption to the healthcare delivery system or the healthcare safety net, and it offers as much help as possible to communities and providers, including the "traditional providers" who have not joined managed care networks, in adjusting to market changes.

Option 4 is politically achievable. It has received endorsement from each of the Coalition's four constituencies.

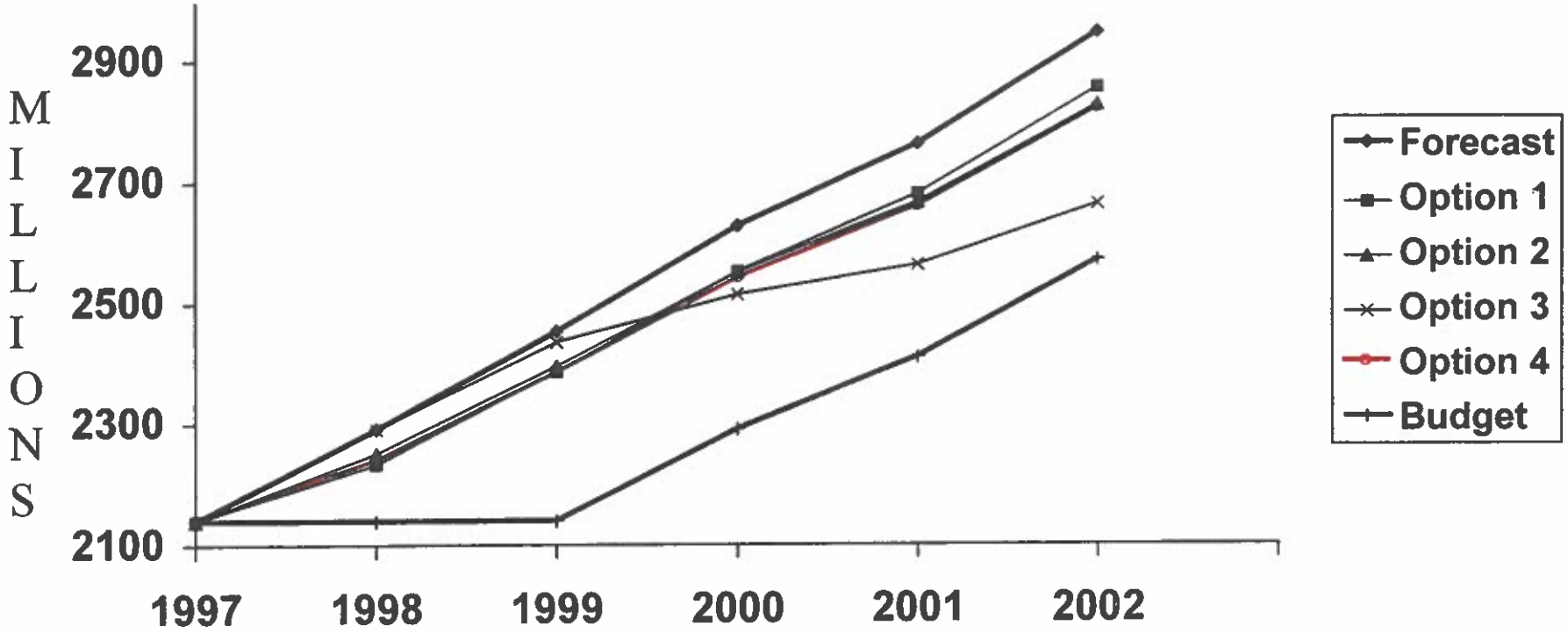
Perhaps most important, Option 4 is politically achievable. It has received endorsement from each of the Coalition's four constituencies, an accomplishment that many thought would be impossible. The Board believes that this option will be accepted by the public and the legislature, which, of course, is the prerequisite for any kind of Medicaid reform.

The Board's recommendation for Option 4 for physical health has four major components:

1. Strengthening Georgia Better Health Care as a framework for better care management and new disease management activities;

2. Offering voluntary HMO membership as an option for more Medicaid beneficiaries;

Graph C
PHYSICAL HEALTH EXPENDITURES
Option 4



3. Contracting with providers to accept partial risk, as a transition to full capitation; and

4. Offering technical assistance to existing Medicaid providers to help them restructure the delivery system to achieve the efficiency required to participate in a managed care environment.

Each of these components is discussed below.

1. Strengthening Georgia Better Health Care. DMA has scheduled the expansion of Georgia Better Health Care (GBHC) to cover all areas of the state by the end of 1997. That would place all Medicaid beneficiaries under the responsibility of a primary care physician who would coordinate care and seek the most cost-effective treatment plan for each person. Under Option 4, the strengthening of GBHC would begin to provide additional financial incentives to primary care physicians to manage successfully the services they deliver and, ultimately, the costs of those services. Hospitals might also share in such incentives. The goal is to treat patients in the most cost-effective setting, thus reducing the inappropriate use of inpatient hospitalization, emergency room visits, and specialist treatment. This approach may be seen as a beginning step toward managed care.

GBHC would also expand its disease management and prevention activities to keep the Medicaid population as healthy as possible.

GBHC would also expand its disease management and prevention activities to keep the Medicaid population as healthy as possible, rather than simply treating people after they get sick. Primary care physicians would assess each patient's health status, provide needed checkups and preventive care, educate patients on healthy lifestyles, detect illness at an early stage, and make sure chronic illnesses are properly managed. In the long run, this is the best way to control costs, because people will need fewer services and diseases will be treated earlier at lower cost. This focus on disease management also would serve as a mechanism to preserve the system of care for children with special health needs, as well as people with HIV/AIDS, sexually transmitted diseases, and tuberculosis.

2. Continue Expanding Voluntary HMO Coverage. Voluntary HMO coverage, now available to Atlanta beneficiaries, is scheduled to be offered in other urban areas as soon as possible as an alternative to GBHC. Wherever possible, DMA would contract with HMOs, and eventually all Medicaid beneficiaries in urban areas would be served by HMOs or by GBHC. Competitive bids could be submitted by an HMO or network meeting the participation criteria. The target date for full participation in Atlanta would be late 1996 as scheduled; for other urban areas, the implementation will be in calendar year 1997.

3. Contracting with Providers. The Board is interested in assisting traditional Medicaid providers, including those components of the safety net, with the transition to managed care. For a provider, the shift from fee-for-service reimbursement to capitation is a profound change in the business environment. It requires significant changes in practice patterns, and, if not given careful attention, can have severe financial consequences and a severe impact on the quality and delivery of service. For that reason, many providers look on such a shift with great trepidation.

One way to ease the transition is to foster a middle ground whereby providers become accustomed to accepting risk, and change their practice patterns accordingly, thus avoiding a dramatic shift to full risk. Currently, DMA enters into two types of contracts with providers: full risk and non-risk. Option 4 contains a provision for adding a third type of contract: partial risk.

Each of these three types of contracting is described below to clarify the significance of this facet of the recommendation.

Full risk — used for the voluntary HMO coverage. DMA can enter into full-risk contracts with HMOs or licensed provider-sponsored health care corporations (PSHCCs), either statewide or in smaller areas. DMA will limit the number of contracts in any area, based on the number of Medicaid recipients; too many contracts would spread the number of members too thinly among plans to give any

single plan enough covered lives for plan solvency. Competitive bidding should be used to select contractors if too many plans seek the business.

Partial risk — used as an interim step toward development of a network that could accept full risk contracts. DMA would prefer to offer such contracts only in geographic areas where no full-risk contracts could be developed.

Partial-risk contracting serves as an interim step for providers who cannot immediately assemble a network that offers the full package of Medicaid health services. For example, a hospital might assemble a network of physicians and other providers, but be unable to contract with an acceptable home health agency. It could contract with DMA to provide everything but home health, at a set rate per member, per month. At the end of the year, financial records would be examined and if the network's actual costs exceeded the set payment, it would receive a percentage of the excess. If actual costs were lower than the set payment, the network would repay DMA for a percentage of the difference.

DMA can enter into partial-risk contracts with licensed HMOs and PSHCCs; it must offer such contracts to any qualified provider. One drawback: if DMA makes a partial-risk contract available in a given area, it may be more attractive to a provider than a full risk contract, even if that provider was otherwise willing and able to assume full risk. So partial-risk contracts could tend to drive out full risk contracts and limit potential savings.

No risk — used for Georgia Better Health Care and in areas where no organized health plans are available. Providers are reimbursed for each service provided. In addition, DMA can pay a monthly case management fee to primary care physicians, varying by the degree of case management responsibility assumed by the provider.

4. Providing Technical Assistance. Dramatic changes to the healthcare marketplace, which would be hastened by Medicaid reform, could have devastating financial

consequences, especially in rural areas and other under-served locations. If key facilities were to fail, it could place the entire healthcare infrastructure at risk, harming the entire community.

The Board recommends several kinds of technical assistance to help local communities chart an appropriate course.

Although it is not the role or the intention of the Coalition to ensure survival of any particular healthcare provider, the Board wants to help communities intelligently anticipate and respond to market changes resulting from Medicaid reform. Some communities may need to protect themselves against potentially adverse effects to healthcare institutions. Others will simply be eager to take an active role in planning the most efficient way to meet their communities' healthcare needs.

The Board recommends several kinds of technical assistance to help local communities chart an appropriate course. The strategy builds on the success of local health planning coordinated by the state's Division of Public Health and the community decision-making program of the Georgia Hospital Association.

The Board recommends a planning process that would enable local communities to assess their overall health status and analyze how changes in the health delivery system could enhance that health status. The process should include all "stakeholders" in the healthcare infrastructure and should follow carefully chosen steps to ensure objectivity and confidence in the recommendations.

The Board believes that a statewide consortium is the most appropriate mechanism to support such planning. It should be assisted by a nonpartisan facilitator who understands the unique problems and opportunities in Georgia and is committed to improving the health status of all citizens of the state. The consortium would help local providers and governments determine the appropriate geographic areas or natural health markets that should be considered in planning. It would inventory available sources of advice and funding and help communities apply for grants.

A serious concern is whether the appropriate stakeholders at the local level will agree to participate. The Board recommends that DMA require hospitals and health departments to participate in local health planning efforts and report annually on their efforts to meet community health needs.

5. Evaluating the Impact of Recommended Changes. The Board recommends that the changes recommended for Medicaid reform in the area of physical health should be completed as soon as possible. Further, the program should be scientifically evaluated to determine if the recommended changes have the desired effect of realizing the desired cost savings, access, improved health outcomes, and quality of care by July 1, 1999. In the interim, DMA will begin the process of obtaining a waiver, which will be implemented only if the evaluation finds that these changes have not successfully achieved the objective of reducing costs.

LONG TERM CARE RECOMMENDATION: OPTION 4

Many people who receive Medicaid benefits have chronic health problems that require long term care, in contrast to episodic health care. Such services include medical, social, and support services for people who cannot care for themselves without such help. For convenience in this report, the term "long term care" embraces the term "chronic care."

As with physical health, the Board defined three options that represented three broad styles of Medicaid reform, analyzed them in detail, and eventually evolved consensus on a fourth option. Although the first three options were rejected, the process of examining them was useful in identifying the important lessons discussed earlier.

The Board's process of evaluating long term options differed somewhat from the similar process for physical health, for three reasons.

- For two decades, physical health purchasers and providers have been aggressively seeking greater efficiencies through a wide variety of marketplace mechanisms and management techniques. But the same attention has not been paid to long term care. That means there's far more opportunity for improvement in long term care, using less complicated techniques and with fewer potentially harmful consequences.

- Because there has been little incentive for change in long term care, there have been few experiments with changing service delivery patterns, provider organization, and payment alternatives. Therefore, decision-makers have little quantitative or qualitative information about the potential outcomes of such changes.

People who begin to need long term care will be given more alternatives.

- The Board benefitted from the advice of the Coalition's technical advisory committee on long term care (see Appendix C). The committee's extensive experience in this field was valuable in the process of studying the three options and formulating the final recommendation.

Option 1 was not regarded as a reasonable approach, Option 2 was intended merely as an interim step, and there were also concerns about Option 3. The recommendation for long term care—or, Option 4— calls for a plan to gradually shift the ratio at which long term care is divided between nursing homes and other settings—at home or in community-based programs such as adult day care. Medicaid has traditionally supported institutional care, but many participants in this process argued that people with chronic care needs can more appropriately be cared for at home or in noninstitutional, community-based settings. Often, such settings have the potential to be less expensive. It is not anticipated that patients now in nursing homes would be discharged. Instead, people who begin to need long term care will be given more alternatives that allow them to stay out of institutions. To support this shift away from nursing homes, aggressive programs to manage chronic diseases would try to keep people healthy enough to stay at home.

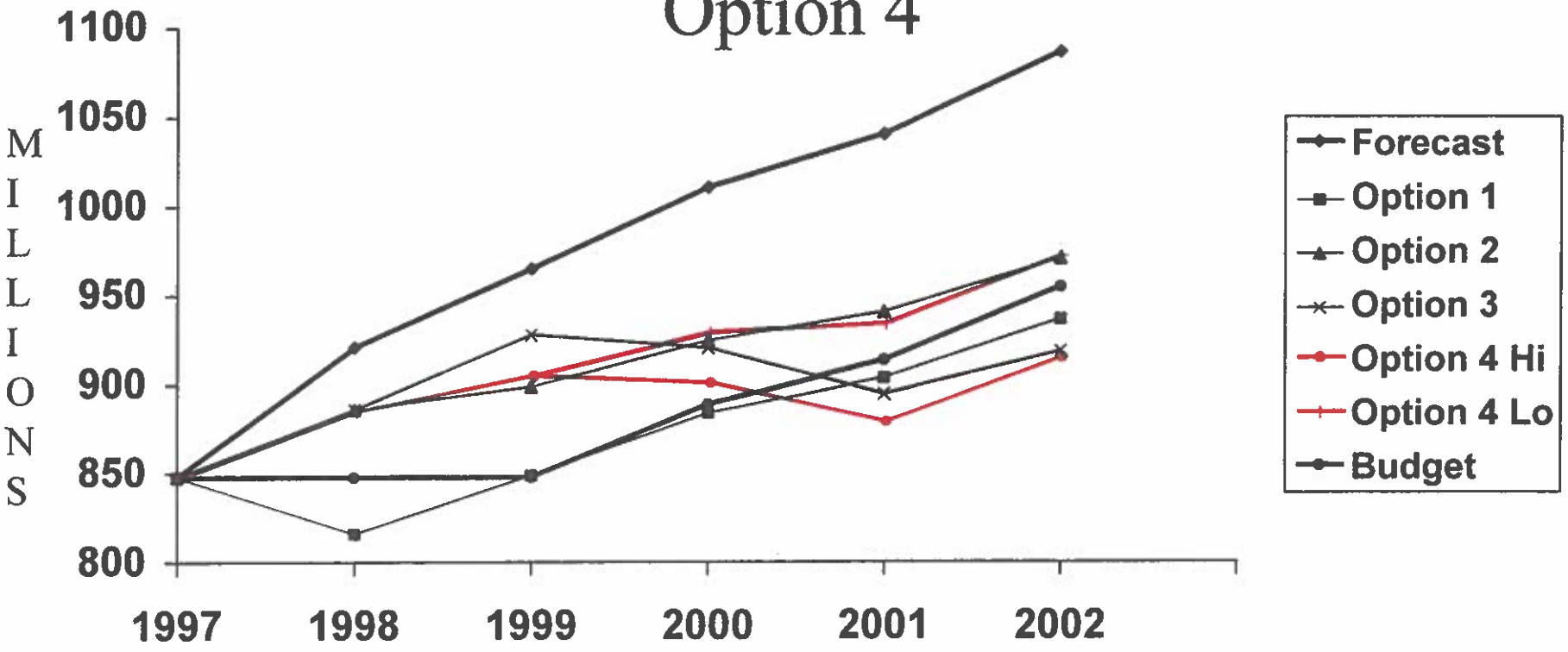
The Board felt it was inappropriate to project specific rates at which the long term care population would shift away from nursing homes. Graph D on page 43 highlights the projected cost of Option 4 as compared to the original three options, the budget target, and the status quo (the current program, reflecting anticipated population growth and inflation). The graph shows two projections for Option 4: one optimistic, assuming high use of nonnursing-home alternatives, and one conservative, assuming low use. Under the optimistic "high savings" projection, assuming that alternative services are developed as quickly as possible and used enthusiastically by patients, the number of beneficiaries using nonnursing-home alternatives would increase by 2.5% in 1998 and 1999 and would increase by 6% in 2000 and 2001. That would achieve the short term budget target by 2001. Under the more conservative "low savings" projection, the trend would remain at 2.5% throughout the five-year period. This would come close to achieving the short term budget target. It is expected that the recommendation for long term care will result in savings that fall somewhere between these two cost-savings projections of 2.5% and 6%.

If the desired budget changes cannot be achieved under the voluntary approach of Option 4 by July 1, 1999, the state would have to request a waiver from the Health Care Financing Administration to develop a home- and community-based shift and to move to a capitated managed care arrangement. Because it would probably take about two years for such a waiver to be approved, DMA should begin to develop the waiver now. However, the waiver would only be put into effect after evaluating the impact of changes recommended in Option 4 and determining that a waiver is needed to effect additional system changes. The two-year window of opportunity will allow DMA to test and put into operation a series of efforts that should significantly control long term care costs and increase the acceptability and delivery of these services.

Graph D

LONG TERM CARE EXPENDITURES

Option 4



Such steps to better manage the system include the following:

- Controlling the number of nursing home beds by freezing the current capacity until an assessment has been conducted

- Conducting stronger preadmission screening to assess people who first apply for long term care, to place them in an appropriate setting, with patient choice a major factor in the decision

- Continuing the monitoring of long term care beneficiaries, to check their progress and oversee quality of care in all settings, and to shift the level of care as necessary

- Monitoring performance, cost, and changes in health status

- Providing better information and education for consumers to help them evaluate their options for long term care

- Developing an information system to support system management and provide oversight of the performance

The Board also recommends that the state sponsor pilot projects to study alternative methods of delivering long term care services and offer technical assistance to communities to help them develop an appropriate mix of such services.

One potential drawback to these recommended changes is what has been called the "woodwork effect," that is, when better home- and community-based services are made available, people who had previously been managing on their own will come out of the woodwork to request these services. Unless this effect is controlled—which should happen with strict preadmission screening—costs will soar. Many of those who come out of the woodwork cannot be served by Medicaid. The problem of how to serve those

people will have to be resolved by the community, not by DMA.

Nursing homes will face significant changes in their business, and, to succeed, probably will need to diversify their services and improve efficiencies. Although they will lose revenue from skilled nursing care, they may well decide to expand into home- and community-based or other alternative services, for which demand will grow. Technical assistance from the state will be needed to help guide nursing homes and providers of home- and community based services through this transition.

Option 4 will create a major change in the way that long term care is delivered to Medicaid beneficiaries.

Because Option 4 anticipates a gradual shift, it allows transition time to plan for marketplace changes. Nursing home revenue loss in 1998, compared to current figures, will be less than 4% in almost all markets. It rises to 10%-15% under the low savings projection, and about 20% under the high savings projection. The state already enjoys a good geographic distribution of community-based healthcare services, which provides a foundation for expansion.

In summary, Option 4 will create a major change in the way that long term care is delivered to Medicaid beneficiaries. The recommendation reflects a philosophical and public policy shift in reconfiguring the balance of service choices for long term care. The hope is that the marketplace can respond by developing and expanding high-quality home- and community-based services to care for people with chronic health problems.

Chapter 6

PUBLIC POLICY INITIATIVES

The Georgia Coalition for Health received many recommendations during the course of its examination of options for Medicaid reform. Contributions that emerged from the stakeholder process, public testimony, and several subcommittees all provided a rich forum for ideas about improving the Medicaid program. Although it was not possible to model or quantify the potential savings of these suggestions, many were important in the Board's deliberations. This section highlights suggested legislation, recommendations for DMA, and possible policy directions.

LEGISLATIVE ACTION

1. Graduate Medical Education (GME). Hospital-based graduate medical education has been built on reimbursement-based calculations for both private and public sector groups. In fiscal year 1996, Medicaid reimbursed approximately $24 million dollars for GME. The Graduate Medical Education Committee reaffirmed that public and private sector graduate medical education support should continue. However, the current reimbursement mechanism should not be a vehicle for continued funding. To replace that mechanism, a Graduate Medical Education Trust Fund should be established. The oversight of the Trust could be governed by a nonpartisan board, representing medical education, hospital-based providers, and the public sector.

Allocation of Trust Fund revenues could be based on teaching institutions' performance toward achieving the nonpartisan board's recommendations concerning future graduate medical service personnel demands.

2. Long Term Care Commission. A comprehensive, long range plan should be developed to enable the state to prepare for the increased demands for long term care. Currently, planning for these services is shared by four state agencies—the Department of Human Resources, the Department of Medical Assistance, the Office of the Commissioner of Insurance, and the State Health Planning Agency. A Long Term Care Commission composed of representatives of these state agencies, as well as representatives of the consumer and provider communities, should be established. This Commission should be authorized to develop a strategic plan that details the service needs of the population, determines mechanisms to address these needs, and identifies incentives that would enable individuals and families to meet their long term care needs, e.g., incentives to purchase long term care insurance.

3. Temporary Moratorium on the Increase of Nursing Home Beds. The existing certificate-of-need legislation in Georgia has resulted in an annual average increase of 323 nursing home beds for the past five years. This increase has raised nursing home expenditures, exclusive of healthcare inflation, for the Medicaid program by approximately $7 million. Consideration should be given to implementing a moratorium, either legislatively or administratively, on the expansion of nursing home beds until a determination of market needs for the defined population can be made.

POLICY RECOMMENDATIONS FOR DMA

4. Fraud and Abuse. One of the strongest messages heard from all stakeholders is that efforts to detect and eliminate fraud and abuse should be significantly enhanced. The Innovations Committee recommended that DMA contract with private companies to perform the auditing services necessary to detect fraud and abuse. The Committee felt that by allowing companies to retain 10%-15% of what is recovered, DMA will not have to pay for the services. However, legal barriers to such contingency contracts must be addressed. DMA has identified several additional strategies for enhancing the state's ability to prevent and

detect fraud and abuse, and will continue to explore paths for improvement. The Coalition supports the efforts initiated by DMA and the forfeiture legislation proposed by the State Health Fraud Control Unit.

5. Technical Assistance to Traditional Medicaid Providers. A significant component of the transition strategy is technical assistance to traditional healthcare providers to help them remain competitive in a reformed healthcare market. Implementing an enhanced primary care case management system and developing provider sponsored health care corporations are two approaches toward that goal. The Commissioner of Insurance has recently developed rules and regulations allowing such organizations to assume risk and contract directly with payers for the care of a covered population. These rules and regulations establish the solvency and operating standards necessary to protect the public and those individuals who subscribe to such plans. This protection is crucial for the State, the Medicaid program, and Medicaid beneficiaries. This arrangement will help providers in both urban and rural areas to create a restructured healthcare delivery system to preserve access for the citizens in their communities. The Coalition pledges support to the Insurance Commissioner on this initiative to be responsive to organizations seeking such licensure. The goal must be the protection of the state and consumers while encouraging healthcare providers to achieve greater efficiencies and increased capacity to deliver health care to the citizens of the state.

6. Regional Medical Services. The Regional Medical Services Committee recommended that regional medical services include neonatal intensive care units, burn units, and trauma centers. The Committee also recommended establishing a regionalized plan for trauma and burn units similar to the current plan for neonatal intensive care units. To ensure quality, "state designated facilities" should be required to maintain performance standards and use outcome measures. It was also recommended that managed care organizations be required to subcontract regionalized

services to a designated subcontractor within a defined geographical area.

7. Concerns about Provider Payment Under Fee-for-Service and Capitated Systems of Care. Discussions held in the community dialogues and research conducted by the project team indicated that some Medicaid providers are receiving inadequate payment. The Board is concerned that inadequate payment may have a negative impact on people's access to care. Although this concern about payment was specifically identified with providers of dental care, actuarial data suggest that there may be additional providers who are inadequately compensated. The Board considered, but decided against, "carving out" dental benefits from the Medicaid package. (Under a carve out, DMA would separately reimburse dentists under a fee-for-service system, even for beneficiaries who were covered under a managed care plan.) This issue of adequate payment/access to care is associated with a fee-for-service system as well as a capitated system. Thus, whatever type of payment system is implemented by DMA, adequate provider compensation will be a major factor in assuring access to care.

8. Approaches to Achieve Cost Savings and Greater Efficiencies. DMA must be assured that it is being reasonably charged for the services that are provided to Medicaid recipients. The Innovations Committee recognized that cost-based reimbursement is not an efficient payment mechanism, and recommended that, wherever possible, DMA should move from a cost-based system of reimbursement toward other more efficient methods of payment. Examples include selective contracting for services and the DRG payment system for hospitals.

9. Scope of Services. Participants involved in the community dialogues and individuals providing comments at the Coalition Board meetings emphasized that prevention and education should be integral components of any benefit package. They also recommended that DMA should strengthen supportive services such as outreach, follow-up, and transportation (especially in rural areas). Community

dialogue participants also stressed the importance of increasing the use of mid-level practitioners to provide care to Medicaid consumers.

10. Health Plans and Networks that Provide Flexibility to Plan Members. Participants in the community dialogues, focus groups, and Coalition Board meetings described a desire for flexibility to explore alternative, cost-effective methods for the provision of care. Many people shared stories about their personal situations and their beliefs that savings could be realized without jeopardizing quality if individuals and families were allowed to more aggressively manage their own care. They also expressed a willingness to accept responsibility for personal care decisions. The Innovations Committee recommended that DMA conduct a pilot project that allows a specified number of individuals in the Deeming Waiver Program and other home- and community-based waivers to choose providers of the services who best meet their needs.

11. Asset Transfer Provisions. Before passage of *The Kennedy-Kassebaum Insurance Portability Act of 1996*, Georgia allowed the transfer of assets if the transfer was performed three or more years before the individual became eligible for Medicaid. As of January 1, 1997, the practice of asset transfer will no longer be legal. Given that the Coalition Board has expressed a desire to tighten the practice of asset transfer, they express agreement with the policy, and encourage the state to tightly enforce the law.

12. Administration of the Medicaid Program. Throughout the stakeholder involvement process, people made suggestions about the administration of the Medicaid program. Some of the more frequently mentioned suggestions included maximizing the use of the electronic claims process, updating the databank of all Medicaid providers, ensuring that user-friendly information is provided to Medicaid consumers and providers, developing and implementing quality assessment tools, improving and accelerating the eligibility determination process, and linking payer functions with regulatory functions.

13. Monitoring Role for DMA. The Coalition recognized that DMA should have a significant role in monitoring health outcomes and health status of Medicaid recipients. It is recognized that in the existing Medicaid program (fee-for-service environment) it is difficult to collect and analyze the data that will assure provision of quality care. However, the Board encourages a greater emphasis on collecting and analyzing the necessary data to reflect this focus. DMA should have a greater responsibility to monitor health plans and assure quality of care is provided to the Medicaid population in a cost-effective manner, no matter what the payment mechanism. The Coalition Board recommends that DMA be given sufficient resources to successfully carry out the administrative functions associated with this monitoring role.

POTENTIAL POLICY DIRECTIONS

14. Concern about the Uninsured – Allowance of Buy In with Available Funds. Many people involved in this process expressed serious concern about the growing number of Georgians who have no form of health insurance, private or public. (In 1995, approximately 20% of Georgia's nonelderly population were uninsured). In addition, many voiced concern that limiting Medicaid expenditures may increase the number of uninsured individuals. Members of the Coalition have expressed the desire that individuals not currently eligible for Medicaid be allowed to buy into the program on a sliding scale basis. A preliminary study is currently being undertaken to determine the cost of a sliding scale buy in program. When additional information is obtained from this study, the Coalition may want to recommend that a buy in be implemented with available funds, or, that the Coalition should continue to address methods of extending coverage to individuals who are uninsured and not eligible for Medicaid.

15. Encouraging Individuals to Work. Discussions held throughout the focus groups and the community dialogues emphasized the importance of allowing individuals to work and not risk losing healthcare benefits. One solution

identified by focus group participants was the decoupling of Medicaid and welfare so that low income individuals could receive Medicaid. Participants strongly articulated society's responsibility to respect their dignity and their contribution by allowing them to work and thereby give back to the tax base and the Medicaid system. One of the recommendations of the Innovations Committee was to have DMA conduct a pilot project for a specified group of individuals falling into a certain income category who are making the transition from Medicaid to the work force. These individuals would buy into a more restricted benefits program using a sliding scale co-payment. The Committee also recommended that the criteria used to determine eligibility should ensure that Right from the Start Medicaid (RSM) recipients do not drop private insurance coverage to be eligible for Medicaid. DMA should continue its efforts to identify recipients for whom it is cheaper for DMA to pay their insurance premiums than to pay for their Medicaid benefits.

16. Medical Ethics Commission. Participants in the community dialogues and focus groups suggested that consumers, providers, and citizens recognize that a concerted effort is required to develop a state consensus on prioritizing services for population groups. An important conviction expressed in the stakeholder process was that this issue is a larger societal concern for all Georgians and should not be applied solely to Medicaid beneficiaries. A commission could develop a process to identify services that could be withheld or placed in a lower priority; this process would apply to all health plans in the state. Additionally, such efforts could begin the public discussion with citizens to prepare them for understanding the rationale for service limitation, as well as ways they can direct their medical care through durable powers of attorney and living wills. A commission of citizens, healthcare experts, policy makers, ethicists, and faith leaders could guide such a process, assure public involvement, and create the necessary public support to move forward.

Chapter 7

CONCLUSION

This project to examine options for fundamental changes in Georgia's Medicaid program, including the process and the resultant recommendations, has been remarkable in several aspects.

- *The process itself was unique.* No other state has carried out such a comprehensive and inclusive effort to incorporate both scientific and public input. The project team provided information about the experience of Medicaid reform in other states and developed financial models to show the likely cost impact of various reform options. A central part of the process was the inclusive participation of a large number of Georgians. More than 1,200 people contributed their views about Medicaid reform in structured community dialogues, focus groups, and at the open Board meetings. An additional 5,000 Georgians had an opportunity to address Medicaid reform in community forums held throughout the state.

- *The Board achieved consensus.* Despite representing varied constituencies, all 32 Board members endorsed the recommendations, signifying broad support for the changes. Each constituency brought its own unique concerns to the deliberations, and discussion was lively and far ranging. At the end, the vision for improved health care and better financial stability brought the Board members together in consensus.

- *Recommendations for long term care represent a paradigm change in the way services are provided.* The changes endorse a shift away from institutional care and toward home- and community-based care, a change long sought by many healthcare advocates.

- *Physical health recommendations focus on improved management of health care.* The recommendation supports a gradual transition toward a reformed system that builds on the existing Medicaid structure and helps support traditional Medicaid providers.

- *Recommendations reflect the importance of the Medicaid program as a central element of the state's healthcare safety net.* The recommendations acknowledge the impact of change on other components of the healthcare system and attempt to ameliorate those changes.

- *The changes are not short term "fixes," but rather are steps to pave the way for major system changes that will position the state to achieve financial stability in the next century.* As with any major organizational system shift, these changes will involve an up-front investment of resources to achieve the desired goal.

In summary, the Georgia Coalition for Health, Inc., has set a direction for Medicaid reform that attempts to balance cost containment and assurance of quality health care for all Georgians. The Board thanks the Governor for the opportunity to contribute to this important process and supports him and the General Assembly as they prepare to address these reforms.

Chapter 8

VIEWS OF THE FOUR CONSTITUENCIES

As noted previously in this report, the Board of the Georgia Coalition for Health, Inc., arrived at consensus on the major recommendations for reform of the state's Medicaid system. That achievement reflected a significant commitment to keep focused on the vision of ensuring long term cost efficiency and budget predictability while maintaining access to health care for Medicaid recipients. Naturally, members of the Coalition brought their own perspectives to the process, representing the views of their constituencies: business, citizens, healthcare providers, and the public sector. Each constituency was invited to contribute to this report a summary of their key views, and those are included below. Despite some differences in emphasis and detail, however, the entire Board approved the recommendations in this report. That consensus signifies an important base of support for the recommended approaches to Medicaid reform.

GEORGIA BUSINESS FORUM ON HEALTH

Representatives of business supported movement to a mandatory program for beneficiaries to choose from among competing systems of health care. These systems would be "at risk" through a capitation arrangement from DMA. Since this approach was most like the managed-care arrangements in place for many employer-sponsored health benefit plans, it was seen as the appropriate evolutionary step for Medicaid.

Alternatives that proposed cutting benefits and/or eligibility or promoted creation of a managed care company within DMA were not supported.

While the business representatives favored a more rapid movement to a mandatory, capitated arrangement, other constituencies' issues related to readiness of the provider communities, concerns about the cost/quality dynamic and the inability of any approach to meet the immediate budget concerns, resulted in business agreeing to a more deliberate pace. Key elements include expansion and evaluation of GBHC and initial preparation for a mandatory capitated arrangement in the future, if deemed appropriate. Preparation will include both support for emerging integrated healthcare systems, emphasizing traditional Medicaid providers, and submission of a waiver request from HCFA.

GEORGIA HEALTH DECISIONS

Georgia Health Decisions sits on the Georgia Coalition for Health as the voice of Georgia's citizens. To understand the public's perspective on Medicaid reform, GHD conducted extensive research, including 55 focus groups, 2 citizens' panels, 200 community forums, and a random sample phone survey. Through this process, GHD heard the concerns of more than 5,000 Georgians.

In responding to the findings of this research, the Georgia Health Decisions' delegation to the Coalition unanimously supported Option 4 for Physical Health for the following reasons:

- Medicaid eligibility would not be randomly reduced for the sole purpose of cost savings. Not only do Georgians not support a reduction in eligibility, removing poor and low income families from Medicaid coverage would merely place these individuals—largely women and children—in the ranks of the uninsured. Costs for their health care would then be shifted to some other publicly funded program or the insured population through increased premiums.

- The scope of services provided to Medicaid beneficiaries would not be altered. Georgians included in GHD's

research do support reasonable controls on Medicaid coverage, such as the current limits on the number of prescription drugs covered. However, they would not eliminate coverage for any particular service, recognizing that Medicaid benefits have been designed for those who are chronically ill or have little money to pay for services not covered.

- Data provided by the Health Policy Center did not indicate sufficient savings could be generated to justify reducing either eligibility or covered services.

- To achieve cost savings, Georgians supported the mandatory participation of Medicaid beneficiaries in managed care plans. Option 4 moves beneficiaries into such plans, either through Georgia Better Health Care or HMOs. While Option 4 provides for a gradual movement into managed care, it also establishes a deadline for evaluating Medicaid's progress toward achieving budget predictability.

The GHD delegation also unanimously supported Option 3, the mandatory participation of Medicaid beneficiaries in managed care plans. However, it was recognized that the statewide provider capabilities to prepare for such a change and the security of safety net providers could not be assured. Option 4 includes time for these adjustments and technical assistance for safety net providers prior to the transition.

Georgia Health Decisions unanimously supported Option 4 for Long Term Care. Throughout the research process, Georgians expressed strong support for shifting dollars for long term care from institutions to more home- and community-based care. Not only do citizens believe such a shift would be cost effective, they want more options that would allow them and their family members to remain at home or stay within their own community. Option 4 provides for immediate steps to be taken to achieving these goals, through the waiver application as well as the development of evaluation tools and assessment training.

There are other issues of concern to Georgians, however, that were outside the scope of work undertaken by the Coalition and therefore not included in the Coalition's recommendations. Throughout our conversations with Georgians across the state, we heard frustrations with how people currently become eligible for Medicaid. Georgians call for a fundamental reshaping of eligibility that would:

- Decouple eligibility for Medicaid from eligibility for any other government program (such as AFDC and SSI)
- Eliminate the current disincentives to work for those who can work (AFDC mothers, and some adults with disabilities)
- Require all beneficiaries to contribute financially to their health care on a sliding scale
- Allow the working uninsured to buy health coverage through Medicaid on a sliding scale with a subsidy.

Each of these issues is covered in detail in the report prepared by Georgia Health Decisions for the Coalition.

Finally, Georgia Health Decisions is extremely concerned about the impact of changes within both the Medicaid and private systems on the uninsured. Movements to capitated managed care plans have a strong potential to adversely impact the safety net and the state's ability to provide care to the uninsured. At the request of GHD, the Georgia Health Policy Center has conducted a cost analysis for covering Georgia's 1 million+ uninsured. We strongly urge further study and action to address this issue, which is critical to the health of our population.

GEORGIA HEALTHCARE PROVIDERS COUNCIL

Position. The Georgia Healthcare Providers Council recognizes that healthcare delivery is in a state of transition. The Council also recognizes that budget constraints and cost containment necessitate reform efforts in the delivery of

Medicaid services. The study process and reform recommendations must be guided by core principles - fairness, quality, and access, not by budget considerations alone.

Concerns. The Providers Council is gravely concerned that the core principles enumerated above will be sacrificed as a result of the impending Medicaid budget reductions and by the ultimate implementation of a fully capitated payment system.

1. *The Process.* The Providers Council does not believe, despite considerable effort, that the Medicaid reform process undertaken by the Georgia Coalition for Health has been comprehensive in scope. Significant programs, such as behavioral health, have been carved out even though they represent an appreciable part of the Medicaid budget. Adequate consideration has not been given to important issues such as eligibility, choice, and scope of coverage. Underlying assumptions haven't been adequately explained. It has been necessary for the Coalition to set aside many important issues in an attempt to meet budget reduction targets and to do so in a very short time period.

2. *Modeling*

- The capitation model based on Arizona has several fallacies as it pertains to Georgia: Arizona had no Medicaid program prior to their existing managed care program; eligibility requirements are much greater in Arizona; and population and geography are dramatically different. No data were presented to show the satisfaction of the patients and providers in the Arizona program.

- Reform effort and options are not comprehensive. Eligibility and scope of coverage were not considered in the reform solutions.

- Pursuit of a "one size fits all" capitation approach in spite of the recent studies from the Florida and Tennessee

programs and the impact on care for the poor and elderly.

- Reform option does not appear to account for the fact that Georgia's Medicaid system already exhibits certain efficiencies (i.e., low administrative fees, prescription limitations).

- Provider resistance to capitation model is viewed by business as "self-serving" and a reluctance to "do their share." It should be viewed in the same way that businesses view reducing healthcare costs as a part of improving the overall financial viability of their businesses.

- Assumption by Georgia Policy Center staff and others that mandated managed care capitation is the best approach when other coalition members believe otherwise.

3. *Patient impact*

- Underfunded capitation plans may create access problems.

- Quality of care may be compromised through underfunded capitation plans.

- Patients lose freedom to choose provider because plans limit the number of providers accepted. This means that even if providers are willing to adhere to the reimbursement schedule and meet the credentialing requirements, they will not necessarily be accepted in the plan.

- Choice of provider will be limited in capitated plans. This could create more of a tiered system since Medicaid patients will not have the freedom to change providers if unsatisfied with the plan as private sector patients have.

4. *Economic impact*

- Many of Georgia's small rural communities and inner-city areas could be adversely affected (loss of jobs, tax revenue, and access to health care).

- A mandated managed care capitated program is likely to increase overall Medicaid costs. In the short term, it results in a projected $200 million increase in administrative costs at the expense of current services.

- In the event of failure, such a radical and rapid change in the delivery system could place the financial burden on county tax payers and private payers and leave a dismantled healthcare delivery system in many areas.

- Inadequate provider reimbursement has adverse small business implications as well as access implications.

- No option considered came close to meeting budget targets. Continued reductions in provider payments will reduce access to beneficiaries and will result in a decrease in participating providers.

Guiding Principles. Even though the Providers Council has concerns about the Coalition's process and recommendations for reform, the group agrees that reform must take place and must be guided by principles which build on the existing system of private healthcare providers. Such a system should:

1. Provide for accessible and affordable health care.

2. Provide for a gradual transition based on appropriate pilot implementation.

3. Not inhibit the easy movement of patients between providers and levels of service.

4. Ensure that the case management is performed in conjunction with adequate consultation between the service provider and the patient.

5. Compensate providers fairly for services with incentives for efficiencies.

6. Incorporate acuity-based payments where appropriate.

7. Allow for a blend of payment options.

8. Adjust the supply of nursing home beds in response to the long term care population's needs.

9. Take into account the special relationships between minority providers and their patients.

10. Allow for capitation in specific situations.

11. Include a privatized fraud and abuse program.

12. Define a benefits package comparable to that which is available to average working Georgians.

13. Be based on carefully delimited eligibility requirements.

14. Earmark the Medicaid funds being redirected to education for health related educational activities and programs.

GEORGIA PUBLIC SECTOR

Coalition Board members representing the public sector expressed particular concerns about preserving the healthcare safety net for people who are uninsured as well as for Medicaid recipients. The safety net includes both public and private providers who ensure access to services, particularly in rural and other underserved areas. Many public sector providers depend significantly on Medicaid reimbursement for their services, and would be in jeopardy if they are not included in managed care networks.

Also, county and municipal governments provide support for, and depend on, local hospitals and have concerns about maintaining access to services if Medicaid and other healthcare market reforms result in closures of some small rural hospitals. Attention should be given to the impact of changes on local bond issues for hospitals. Emergency transportation should receive special attention, because many local hospitals are the primary providers of these services.

Public sector representatives urged development of a collaborative regional planning effort in which all healthcare entities in a geographic area plan together to address the health needs of the community. They also suggested that incentives be developed in Medicaid managed care contracts for inclusion of safety net providers and demonstrated accessibility of services to areas with high levels of need.

The public sector joined in the consensus to recommend Option 4.

APPENDIX A

1996 GEORGIA COALITION FOR HEALTH BOARD MEMBERS

APPENDIX A
1996 GEORGIA COALITION FOR HEALTH, INC.

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APPENDIX B

GEORGIA HEALTH POLICY CENTER MEDICAID REFORM PROJECT TEAM

APPENDIX B
THE GEORGIA HEALTH POLICY CENTER'S MEDICAID REFORM PROJECT TEAM

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APPENDIX C

LONG TERM CARE PROJECT ADVISORY COMMITTEE

APPENDIX C
LONG TERM CARE PROJECT ADVISORY COMMITTEE

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STATE OF GEORGIA

OFFICE OF THE GOVERNOR

ATLANTA 30334-0900

Zell Miller
GOVERNOR

November 13, 1995

Honorable Marjorie P. Smith, Commissioner
Department of Medical Assistance
2 Peachtree Street, N.W., Suite 27-100
Atlanta, Georgia 30303

Dear Marge:

Thank you for your letter of October 26th. I am aware of the significant changes in the Medicaid program being considered by Congress. As you know, I have strongly supported the legislation calling for block grants with no strings attached. It is now time to think about the issues facing the state, should federal legislation pass this year. Issues such as who will receive insurance subsidies under the new program and how providers will be paid need to be carefully analyzed. While this work goes on, privatization efforts need to continue as well.

As I have thought about the most appropriate place in state government for this planning to occur, it seems obvious that the work should be conducted by the Health Policy Center under the direction of the Georgia Coalition for Health. This will allow for all stakeholders to have input, and continue to have a strong sense of business leadership at the helm of some of the tough decisions that will have to be made. Using the Center also allows for the involvement of key legislative leadership.

I am directing you to establish a formal working relationship with the Center that will result in the development of a range of options for me to consider at the appropriate time. I will meet with you and Jim Ledbetter in the near future to discuss this important work. Thank you for your cooperation.

With kindest regards, I remain

Sincerely,

Zell Miller

ZM/lld
cc: Allen Franklin, Georgia Power

State of Georgia
Department of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

Marjorie P. Smith
Acting Commissioner

October 26, 1995

Honorable Zell Miller
Governor
State of Georgia
State Capitol
Atlanta, Georgia 30334

Dear Governor:

As you are aware, there are several proposals before Congress which radically reform the Medicaid program. As we briefly discussed yesterday, the reform proposals pass significant decision-making responsibilities to states. In response to these proposals, many states are forming Commissions or other entities to make recommendations regarding the decisions that must be made.

I would like to outline for you most of the key decisions that will need to be made, and recommend a strategic way to deal with the details. The changes before us are broad, far reaching and affect the citizens of Georgia, those covered by the current Medicaid program, all providers, and the business community.

The Medicaid program will no longer be an individual entitlement program. However, certain groups of individuals will be protected, such as pregnant women and children, the elderly over age 65 and disabled individuals under age 65. Therefore, each state must determine which populations will be covered under the new low-income insurance subsidy program. Depending on the amount of Federal dollars available, decisions will have to be made regarding whether coverage will be offered to the minimal number of individuals defined by law or additional groups of people.

Benefits will no longer be prescribed. Therefore, states must define benefit packages for each group of covered individuals.

While the legislation allows states to provide a broader range of services, it mandates very little. The list of benefits allowed will certainly raise expectations and no one will want existing benefits to be reduced.

States will have the flexibility to design health care delivery systems which control costs and provide quality health care. This will be an opportunity to carefully examine and implement systems that may be desirable over the fee-for-service system and allow for the state to purchase

health care from entities other than just licensed HMO's. There are many groups in favor of integrated health care systems which may not be licensed entities covered by current insurance regulations. These debates will be contentious, but necessary. Since no waivers will be required, states are totally free to pursue systematic changes on their own. This work will be complex and will require a very public process. The business community will have a great interest in this effort since it will likely affect how they may choose to purchase care because of possible cost savings. These savings would be possible if the system allows groups to increase their purchasing power by pooling their resources.

States will no longer have federal mandates regarding standards of care that govern health care providers such as nursing homes. Decisions will have to be made about the degree to which providers will be regulated. Advocates will be vocal about more regulation and providers for minimal or no regulation.

As you can see, there is an enormous amount of work ahead for states if Congress passes legislation. It may be useful to officially request that the Health Policy Center, under the umbrella of the Georgia Coalition on Health, study these issues and provide you with a range of options and recommendations. In doing so, you will have all stakeholders at the table and have a place to refer the various contentious groups for their input. The business community is well represented in the group and on the Board. Allen Franklin is Chairman of the Board. I have enclosed a brief summary of the purpose of the Coalition and a list of Board members for your reference. Please note that Senator Charles Walker and Representative Ronnie Culbreth were chosen to serve by the Lieutenant Governor and the Speaker.

Thank you for your continued support. Please let me know if I can provide any additional information.

Sincerely,

Marjorie P. Smith
Commissioner

MPS:gw
Enclosures