

GEORGIA RESPONDS: A MEDICAID TRANSFORMATION PLAN

Summary article based on presentation by Abel C. Ortiz; Health Policy Advisor; Office of Gov. Sonny Perdue of Georgia at the Fifth Annual Primary Care and Prevention Conference and Health Policy Summit, September 22, 2005; Atlanta, Georgia.

The state of Georgia is initiating a transformation of its Medicaid system for low-income individuals and families. The new plan is designed to change the behavior of patients, as well as providers, in improving health care services and the health of the 1.5 million Georgians covered by Medicaid. The new plan would allow consumers to better manage their health care and establish personal "savings accounts" to pay for services not covered by Medicaid. As leader of the Medicaid transformation effort, Abel C. Ortiz addressed participants of the Health Policy Summit and provided details on the proposed plan, barriers, and system potential for improving health outcomes. (*Ethn Dis.* 2006;16[suppl 3]:S3-54-S3-55)

Key Words: Medicaid, Healthcare Insurance

THE MODEL FOR TRANSFORMING MEDICAID IN GEORGIA

To affect change in the delivery of Medicaid services in Georgia and to establish a plan that would offer cost-savings measures while preventing Georgians from high rates of diabetes, obesity, hypertension, kidney disease, heart disease and other chronic conditions, Ortiz suggested three strategies important to the success of the plan: 1) engaging consumers in managing prevention and health care; 2) changing the behavior of consumers; and 3) changing the behavior of providers.

Engaging Consumers in Managing Prevention and Health Care

Individuals must be educated and informed about how to become involved in handling health matters. They should become partners with healthcare providers in preventing and treating illnesses. Physicians should have conversations with their patients. Patients need to be educated about health conditions that exist or may develop in the future. They also need to know why followup care is necessary and why certain medicines have been prescribed. The decisions are in the hands of the patients and we need to educate and inform them about the decision-making process.

Under the proposed plan, Medicaid patients would select a "medical home," an alternative to a hospital emergency room, that is open around the clock, seven days a week, for easy access to primary care or health records. The medical home would provide an initial health screening, physician care, dental care for children, a pharmacy, and mental health services. If it's Saturday anywhere in Georgia, a person should have an alternative to an emergency room. The availability of a medical home is particularly important in rural areas of the state.

Changing the Behavior of Consumers

Each person covered under the proposed plan would have a "health account" to provide for funds for over-the-counter prescriptions and adult dental care that Medicaid does not provide. The account would be funded by state and federal dollars. If a patient makes a responsible healthcare decision, money would be added to the account. By the same token, funds would be deducted if the recipient uses an emergency room for non-emergency care, visits a provider not affiliated with his or her medical home, or chooses a brand name prescription drug rather than a generic version. With this type of accounting system, developers are exploring creative funding possibilities such as the possibility of allowing charitable

contributions into a patient's account. The idea of the health account is to provide funds to cover costs that are not ordinarily covered by Medicaid. If a person becomes employed and no longer qualifies for Medicaid, the funds in the personal account could be contributed to the employer to help with the employee's health coverage.

The consumer and the provider would develop an individualized health plan to include the following elements, which would be coordinated with the Division of Public Health's community-based education, wellness, and prevention services.

- Well-child care from birth to age five.
- A wellness plan of prevention or educational services for consumers who are at risk for chronic or persistent conditions. For example, doctors could refer Medicaid recipients to well-trained individuals for nutritional information.
- Disease management (including prevention, education, and services) for persons with chronic or persistent conditions. Case management and care management need to look different, depending on the patient's condition. It is conceivable that a well-trained layperson could serve as a case manager to help a new mother care for a baby with chronic ear infections.
- Acute care for short-term or episodic illnesses or health problems.
- Catastrophic care for conditions requiring immediate hospitalization, followed by wellness or disease management plans at discharge.

Changing the Behavior of Providers

Medicaid is notorious for treating providers poorly. Under Georgia's proposed plan, healthcare providers would be compensated for establishing "medical homes" where patients can receive care seven days a week. In addition, providers would receive enhanced rates if they develop and/or participate in education, prevention, and disease management; participate in price transparency and quality outcomes measures; and participate in peer-to-peer evaluation of practice patterns. They would be educated about how to refer patients to community resources provided by Georgia agencies in the areas of public health, aging, and mental health and substance abuse.

The Georgia plan would require the use of technology in medical care. Providers would receive enhanced rates if they use electronic systems to maintain records of patients' eligibility status, immunizations, medications, allergies, and health account balances.

MEDICAID TRANSFORMATION TIME LINE

Ortiz outlined the schedule for enacting the Medicaid transformation plan: 1) begin statewide public hearings in November 2005; 2) complete the plan in December 2005; 3) submit the plan to the state legislature for consideration in January 2006; and 4) submit a waiver of federal Medicaid requirements in February 2006.