APPLICANT PREFERENCE:

The Georgia Department of Health – Division of Medical Assistance (Medicaid) is requesting a preference based on the inclusion of rural and urban underserved areas where Medicaid recipients do not have regular access to primary care services.

There are 159 counties in Georgia; 110 counties are classified as rural counties and 49 are classified as urban counties. There are 179 hospitals in Georgia. Sixty-seven (67) of Georgia hospitals are located in rural areas, and 112 are located in urban/suburban counties. There are thirty-five (35) hospitals designated as Critical Access Hospitals, in Georgia.

According to the U.S. Census Bureau State and County QuickFacts, 2006 population estimates, there are 9,363,941 people living in Georgia, an increase of 14.4% since the 2000 Census. (U.S. population increase – 6.4%)

There are 143 of Georgia's 159 counties designated as a Federally Designated Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP) and 97 of the 159 are designated as Health Professional Shortage Areas (HPSA). (See Appendix A for a complete listing of counties designated as MUA/MUP and/or with a HPSA designation.)

Sixty-four (64) Georgia counties, approximately 40%, have a Federally Qualified Health Center. Federally Qualified Health Centers provide services in underserved areas and to underserved populations/communities. In Georgia, 26 organizations operate over 114 Federally Qualified Health Center (FQHC) delivery sites. In 2005, federally funded health centers were the family doctor and medical home to 248,000 individuals in Georgia. Approximately 69% of Georgia FQHC users are below 100% of the Federal Poverty Level; 46% are uninsured; 30% are enrolled in Medicaid/SCHIP; and 11% are enrolled in Medicare.

According to *America's Health: State Rankings – 2006 Edition*, Georgia is the 42th healthiest state in the nation. Clearly, Georgia has major unmet health needs, barriers to care and health disparities. In an effort to address the health needs of Georgians, the State and its many partners have embarked on several efforts that dovetail with the Centers for Medicare and Medicaid Studies *Alternative Non-Emergency Services Provider Demonstration*. Of prime concerns is educating Georgians about the importance of a medical home and shifting cost from the use of Emergency Departments for non-urgent care to less expensive more appropriate primary care settings.

The Georgia Department of Community Health – Division of Medical Assistance (Medicaid), will administer the proposed project and plans to use a Request for Grant Application (RFGA) process to select a minimum of four demonstration sites. The Georgia Division of Medical Assistance is requesting $2.5 million dollars to fund the proposed demonstration project. The Georgia Division of Medical Assistance is not requesting any funding to administer or evaluate the program. Project support and oversight will be provided as an in-kind function. The entire requested $2.5 million dollars will be spent on the delivery of non-emergent health care services outside the confines of participating hospital emergency rooms.

The Georgia Department of Community Health, particularly the Division of Medical Assistance and partners throughout the state (including but not limited to the State Office of Rural Health,

Georgia Hospital Association and the Georgia Association for Primary Health Care) will work to identify existing successful models of hospital/primary care partnerships/relations where alternative non-emergency services have successfully created an environment for the appropriate delivery of non-emergent care and cost containment.

ABSTRACT

Georgia Alternative Non-Emergency Services Provider Project

The number of America's under/uninsured is growing; this trend is mirrored throughout Georgia. The primary purpose of the Georgia Alternative Non-Emergency Services Provider Project (GNESPP) is to reduce non-emergent emergency room (ER) visits and increase the number of Georgians with medical homes. The anticipated results of the project will be a reduction in cost to the Georgia Medicaid Program; a decrease in uncompensated care realized by Georgia hospitals and improved health status for all Georgians.

Between 1994 and 2004, the number of ER visits (nationally) increased from 93.4 million visits to 110.2 million visits annually. This rapid growth represents an increase of more than 1.5 million ER visits per year. During the same time period, conversely, the number of hospital ER (in the US) decreased by 12.4% (National Hospital Ambulatory Medical Care Survey, 2004).

According to the National Association of Community Health Centers (NACHC), about one-third of all visits to hospital emergency rooms, each year, are non-emergent or treatable in primary care settings. Each year, according to NACHC, $18 billion dollars (nationally) is spent on avoidable visits to hospital ERs. Georgia, like most of the nation, has seen extraordinary growth in the number of non-urgent ER visits (over the last decade). The problem, of accessing ERs for non-urgent care, is epidemic in Georgia and includes insured and uninsured patients. Georgia, the largest State East of the Mississippi, has a population of 9,363,941 which encompasses 1,713,656 Medicaid recipients, 346,598 Peachcare (Georgia's SCHIP) recipients and 1,281,716 uninsured individuals; this accounts for over 36% of Georgia's population. The top five non-emergent Medicaid diagnoses in Georgia are otitis media, acute pharyngitis, bronchitis, acute URI and vomiting. These conditions are more appropriately treated in a primary car setting and not in hospital ER's. This grant will provide Georgia with the opportunity to address these issues and to develop cost effective solutions that will benefit all Georgians, as well as our state and federal governments.

Commissioner Rhonda Medows, M.D. of the Georgia Department of Community Health adopted established the guiding principle that Georgian's should have *"the Right Care at the Right Time in the Right Setting."* This principle establishes the most cost efficient means of delivery and results in the highest level of quality service to the patient. In 2006, the State of Georgia introduced and began a phased approach to transition the Medicaid population to Care Management. The Medicaid Care Management Program has *three inter-connected goals, to improve the health care status of Georgians, to lower cost through appropriate utilization and to establish accountability for access and quality.*

The Georgia Department of Community Health, Division of Medical Assistance (Medicaid), will administer the proposed project and plans to use a Request for Grant Application (RFGA) process to select a minimum of four demonstration sites. The Georgia Division of Medical Assistance is requesting $2.5 million dollars to administer the proposed demonstration project. The Georgia Division of Medical Assistance is not requesting any funding to administer or evaluate the program. Project support and oversight will be provided in-kind. The entire requested $2.5 million dollars will be spent on the delivery of non-emergent health care services outside the confines of participating hospital emergency rooms.

PROJECT NARRATIVE

Statement of Project/Need

In 2006, the State of Georgia introduced and transitioned the Medicaid population to Care Management. The guiding principle of the Georgia Care Management program is *"the Right Care at the Right Time in the Right Setting."* The Medicaid Care Management Program has *three inter-connected goals, to improve the health care status of Georgians, to lower cost through appropriate utilization and to establish accountability for access and quality.* Currently (2007), there are three Care Management Organizations (CMO's) operating in Georgia; Amerigroup, Peach State, and Wellcare.

Amerigroup reports in the last quarter of 2006 and the first two quarters of 2007 serving 2,220,000 Medicaid recipients. Amerigroup reports that, for their Medicaid population, emergency room visits decreased by 12% over the included time period and primary care visits increased by 39%. **Peach State** reports, as of July 1, 2007 that they have provided coverage for 281,000 Medicaid recipients; 32% of all Peach State emergency room claims were classified and paid as non-emergent visits while 68% of claims were classified and paid as "true" emergencies. Peach State plan administrators determined a decline in ER utilization since the plan's inception; however, contrary to expectations the decease occurred "ironically" in urban centers where access to primary care providers is greatest. **Wellcare** reports (January 1, 2007 – June 30, 2007) that 58% of submitted emergency room claims were classified and paid as non-emergent and 42% of emergency room claims were classified and paid the full emergency room rate. As the three Care Management Organizations (CMO's) provided information in different formats it is difficult to quantify the scope of the need other than to state significant numbers of Georgians are

seeking services for non-emergent care/conditions throughout the Georgia hospital emergency room network.

In an effort, to provide Georgian's with *"the Right Care at the Right Time in the Right Setting,"* the Georgia Department of Community Health, Division of Medical Assistance (Medicaid Office) plans to build on recent progress in shifting non-emergent care from hospital emergency rooms to community-based primary care settings. It is a recognized fact that health care status improves and costs decrease when people have a primary medical care home. The use of emergency rooms for non-emergent health care needs is episodic, lacks coordination, and is expensive. Further, there is a growing trend in urban emergency rooms of longer waits for urgent services and a need on the part of hospitals to divert patients to other hospitals for emergency services resulting from a lack of emergency room capacity to treat incoming patients and a lack of hospital beds for critically ill patients.

The Georgia Department of Community Health, Division of Medical Assistance (Medicaid Office) is planning an Alternative Non-Emergency Services Project and will select a minimum of four Georgia hospitals for participation through a Request for Grant Application (RFGA) process. The Georgia Department of Community Health, RFGA process provides an opportunity for Georgia hospitals serving a Medically Underserved Area or Medically Underserved population and their primary care providers to experiment with primary care access options for Medicaid and underserved residents. The Georgia Division of Medical Assistance will work closely with the Georgia Hospital Association, the Georgia Association for Primary Health Care, the Georgia Department of Community, State Office Rural Health and the Georgia Care Management Organizations to provide support and guidance to the selected demonstration sites.

Project Justification:

The guiding principle of the Georgia Medicaid Care Management strategy is *"the Right Care at the Right Time in the Right Place."* To fulfill the guiding principle and support a healthier Georgia the Office of the Governor and the Georgia Legislature provides leadership and funding to assist in transforming Georgia's systems of care into a national model of healthcare reform with cost savings, increased access to appropriate levels of care and improved health outcomes/status. The proposed project will encourage the delivery of care through a medical home, when appropriate rather than the inappropriate use of hospital emergency rooms. The proposed project will build on state-wide efforts to encourage the appropriate use of emergency room services through education and training (of patients and providers).

In 2006, there were nearly 10 million non-emergent emergency room visits in the United States. The average emergency room visit nationally costs $383. In Georgia, the average primary care office visit cost is approximately $80 including Federally Qualified Health Centers as well as other Primary Care Providers. Through the proposed Georgia Alternative Non-Emergency Services Provider Project the Georgia Medicaid Program will save, the participating hospitals will save, individuals will save and participating communities will save, eventually, by applying lessons learned the entire Georgia health care system will save. People seeking to access non-emergent services at demonstration site hospitals will be redirected, after triage, to primary care settings (located in or near hospital emergency rooms). For many people, the option of a primary care setting may be their first opportunity for a medical home. If all Americans made use of primary care, the health care system would see $67 billion in annual savings. The anticipated savings reflect not only those that do not have access to primary care, but also those that rely on expensive specialists for most of their care, creating expensive inefficiencies. Specifically, the

expansion of medical homes can dramatically improve effective use of health care, improve health outcomes, reduce health disparities, and lower the overall costs of care. Medical homes are patient-centered, regular, and are a continuous source of care, coordinated by a team of health care professionals committed to quality improvement. (National Association of Community Health Centers, 2007)

Nearly 22% of emergency room users nationally are Medicaid/SCHIP recipients. The emergency room visit rate for individuals receiving Medicaid/SCHIP is an alarming 80.3 per 100 compared to 47.1 per 100 for individuals enrolled in Medicare; 46.6 per 100 for individuals with no insurance; and 20.3 per 100 for individuals with private insurance. (National Hospital Ambulatory Medical Care Survey, 2004) With Georgia's uninsured, Medicaid and Peachcare recipients total in excess of 3,341,970 and with an average of forty-two percent of emergency room visits being non-emergent the participation in the Alternative Non-Emergency Services Program will have a tremendous Return on Investment.

As we have discussed opportunities for Georgia's Health Care Delivery System to improve the health status of Georgians, to contain escalating health care expense and develop into environment where our health care system does not financial struggle, the management of non-emergent patients burdening the emergency rooms is a constant concern and is readily identified as a viable component of the solution. As we discussed this application with the Governor's Office, elected officials, providers and stakeholders we were flooded with thirty-four letters of support. Appendix C contains a listing and selection of the letters. This gross outpouring of interest and support magnifies the urgency in which we must address alternatives for our emergency room providers.

Project Goals and Outcomes:

The unifying goal of the Georgia Alternative Non-Emergency Services Project is to provide "the Right Care at the Right Time in the Right Place." To align the project with Georgia's Guiding Principle Goal the project objectives are as follows:

Objective I	To indentify and select the hospitals that have co-located or offsite primary care practices/sites that will serve as points of care for patients presenting to emergency departments for non-emergent services or that will establish a new primary care site (see Appendix B, draft RFGA)
Object II	To work with selected hospitals to determine the most appropriated "hours of services," and "staffing mix" for the primary care access points (a careful study of emergency room use patterns will serve as a starting point)
Objective III	To train staff and providers in participating emergency departments and primary care access points in appropriate "triage" to determine those patients that can be better and more efficiently served in primary care access points
Objective IV	To establish separate entities to avoid commingling conflicts of the project sites. Careful attention will be given to the rules and regulations governing options to refer patients to primary care access points; the Georgia Hospital Association, the Georgia Rural Health Association, and Georgia Critical Access Hospital Program, Georgia Association for Primary Health Care and the Georgia Care Management Organizations

will work with the Georgia Department of Community Health, Division of Medical Assistance to identify regulatory guidelines for the proposed program

Objective V — To establish an evaluation team that will track project successes and identify project challenges and assist project participants in addressing/overcoming challenges

Objective VI — To incorporate and support the three principal goals of the Georgia Care Management Organizations (improve health care status of member population, lower cost through appropriate utilization, and establish accountability for access and quality) into the proposed project

Objective VII — To provide a medical home for Georgians through a system of care that improves health outcomes, reduces health disparities, and improves the overall health status throughout Georgia

Objective VIII — To provide successful models demonstrating the provision of a health care system that provides access to primary, emergency and acute care points access points that are appropriate and accessible to the consumer that can be replicated throughout Georgia and the nation

The focus of the proposed project is on models of care rather than on geographic distribution. Georgia has 159 counties. Several Georgia counties are large metropolitan areas with multiple private and not-for-profit hospitals partnered with highly acclaimed medical schools and allied health programs. Of Georgia's 110 rural counties 43 have no hospital; the remaining are served by the 32 small community hospitals and 35 served by Critical Access Hospitals. The existing

studies and literature make clear that the strongest, most likely to succeed models are either co-located or in close proximity to offsite primary care access points. In the co-located model a primary care practice/clinic is physically located in a hospital close to the emergency room. In an offsite model, patients can be immediately diverted to a primary care access point that is located in close proximity to a hospital emergency room with transportation provided to the offsite location, if needed. Each model offers patients appropriate access to a primary care services with qualified providers and education about the importance of a medical home.

The Georgia Department of Community Health, particularly the Division of Medical Assistance and partners throughout the state (including but not limited to the State Office of Rural Health, Georgia Hospital Association and the Georgia Association for Primary Health Care) will work to indentify existing successful models of hospital/primary care partnerships/relations where alternative non-emergency services would most likely flourish. The Division of Medical Assistance, participating hospitals and primary care access points and the Georgia Care Management Organizations and other partners will analyze the benefits to the Georgia Medicaid Program, primary care providers, hospitals, and those receiving care.

Estimate of Impact to Beneficiaries:

The Georgia Department of Community Health, Division of Medical Assistance envisions a project that builds on the current Medicaid program of Care Management. Whether the selected project site models include a co-located or offsite primary care option, the users/patients are given appropriate access to a primary care provider and, perhaps most importantly, educated about the importance of having a medical home. The beneficiaries of the proposed project are many and include the Division of Medical Assistance (Medicaid), the Care Management

Organizations (CMO's), the participating hospitals and ultimately and most importantly Georgia's Medicaid recipients and Georgia's large and growing uninsured population.

The introduction of Medicaid Care Management Organizations (CMO's), throughout Georgia in late 2006, has already effected non-urgent emergency room use and reduced costs to the Medicaid system. As indicated earlier the CMO organizations indicate a decrease in emergency room use and an increase in primary care access. The proposed project, in concert with ongoing efforts will establish models that can be modified and adopted throughout the state adding to a decrease in non-urgent emergency room use and the establishment of medical homes.

Description of Magnitude of the Impact to Medicaid:

The exact magnitude of the proposed project cannot be fully determined until a minimum of four project demonstration sites are selected. Georgia's 159 counties are very diverse in size, in number of eligible and actual Medicaid recipients and in the availability of alternative non-emergency primary care service providers. Appendix A includes an illustration of each of Georgia's counties Medicaid and Peachcare recipients, underserved and/or shortage designations, as well as the key health care delivery system members including hospitals, Federally Qualified Health Centers, Rural Health Clinics and other key participants. According to Wellcare one of Georgia's three CMO the four most common presenting symptoms for non-emergent care in an emergency room setting, under their plan were fever, ear pain, common cold, and headache; all symptoms that could be treated at considerable less cost in a primary care setting. Beyond cost children with ear pain could be treated in a primary care setting where risk factors for ear infections could be discussed and meaningful patient education provided with attention paid to immunization status and growth and development monitored and tracked;

patients with common colds and fever could be evaluated and treated in a primary care setting with follow-up provided through a medical home. The same is true for headaches and other non-emergent presenting symptoms.

People can be educated, successfully about the importance of a medical home for better health and wellness. According to Amerigroup average emergency room charges vary by Georgia regions; there data indicate that an average emergency room charge in the Atlanta area is $878.71, in the east region the average emergency room charge is $586.02, in the north region the average emergency room charge is $827.14 and in the southeast region the average emergency room charge is $620.73. The Care Management Organizations are aggressively working with providers and consumers to encourage the appropriate utilization of emergency room services.

Currently, the Georgia Care Management Organizations (CMO's) educate Medicaid recipients about the importance of a medical home. The CMO's plans, information and marketing efforts serve to provide primary care options and the plan requirements for assignment to medical homes. Again, the notion of "*the Right Care at the Right Time in the Right Place"* underlies the efforts of the State and the Division of Medical Assistance to "change" the way Medicaid and uninsured people access the health care system. As mentioned all three Georgia CMO's report a decrease in non-emergent emergency room access with a corresponding increase in primary care visits. The proposed project will serve to compliment and strengthen Georgia's ongoing efforts to educate and better serve our Medicaid recipients while simultaneously preserving the state and federal financial resources that support our program.

Description of Sustainability of the Project

As in all current and planned efforts supported by and through the Georgia Department of Community Health and the various divisions efforts are ongoing to reduce current costs and shift cost savings to providing access to efforts at improving health care status for all Georgians, particularly Medicaid recipients and the un/underinsured, lower the cost of care through appropriate utilization of services and establishing accountability for patient access and quality of care.

An example of ongoing efforts to strengthen and sustain health care throughout Georgia is the Georgia Rural Health Safety-Net Program (complemented by the proposed projected). The purpose of the Rural Health Safety-Net Program is to create non-traditional, regional systems of care that are financially viable and designed to meet the health needs and service demands of Georgia's rural and underserved communities. The Rural Health Safety-Net Program goals include:

- Increase access to integrated health services (physical health, prevention services, behavioral health, etc.);
- Transition to consumer-driven health care;
- Encourage regionalization of services so that providers are more financially stable;
- Use medical technology to improve health outcomes and improve efficiency;
- Ensure the long-term viability of the state's health care safety-net; and
- Ensure continued job opportunities for employees in new roles that support the innovative health care delivery model, as well as creating a strong workforce of healthy citizens.

Further, the Georgia Hospital Association supports the Partnership for Health and Accountability (working together to improve health and safety). The Partnership for Health and Accountability brings together the healthcare field with agencies and individuals to ensure quality and safety in healthy communities. The Partnership for Health and Accountability assists in strengthening collaboration between providers, community members and other stakeholders by providing education and data-driven tools to facilitate improvement.

The two previous examples, Georgia Rural Health Safety-Net Program and the Partnership for Health and Accountability stand as examples for a myriad of efforts throughout Georgia that are directed toward improved systems of care and a willingness to try new and different approaches to providing medical homes, reducing costs, ensuring patient safety and building healthy communities. The current environment in Georgia supports and rewards traditional and non-traditional partnerships designed to address the growing need for appropriate health care access for more and more underserved Georgia residents. The proposed project will build on the strong and growing relationships between the Georgia Department of Community Health, Division of Medical Assistance, State Office of Rural Health, Offices of Men's, Women's and Minority Health, State Health Benefit Plan, and the Volunteer Clinic Program; the Georgia Hospital Association; Georgia Association for Primary Health Care; and other interested and committed partners. The proposed project will have multiple avenues for sustainability not the least being a potential growth in Federally Qualified Health Center sites, physician practices, and other primary care provider options. The state Medicaid agency will realize cost-savings by reducing the use of emergency rooms for non-emergent visits. And, in the long and short term increased access to medical homes will make for a healthier population with less demand for chronic and episodic health care services.

Evaluation Plan:

The key evaluative measures of the Evaluation Plan include:

1. Number of non-emergent emergency room visits and associated costs compared to baseline data prior to implementation of the Alternative Non-Emergency Services Provider pilot site
2. Number of visits and costs to the Alternative Non-Emergency Services pilot sites
3. Change in patient behavior by which they access non-emergency services based on patient satisfaction surveys
4. Return on investment measured as a ratio of cost savings to grant funds
5. Financial solvency of the Alternative Non-Emergency Services Provider pilot site

Description of Project Implementation Readiness:

Upon receipt of the federal Notice of Grant Award (NGA), the Georgia Department of Community Health (DCH), Division of Medical Assistance will convene an Alternative Non-Emergency Services Provider Committee to serve as the work group to advise on the implementation and further action of the expansion of non-emergency services alternative providers. The core of the group developed the concept paper upon which this proposal and the Request for Grant Application (Appendix B) were crafted. The core group consisted of Medicaid, Georgia Primary Care Association, State Office of Rural Health, Offices of Minority, Men's and Women's Health, the Georgia Hospital Association, Hometown Health and a volunteer physician. Within thirty (30) days of receipt of the NGA, the Department of Community Health will post the solicitation for the RFGA. Applications will be accepted for a

minimum of sixty (60) days. The $2.5M will be awarded to the Alternative Non-Emergency Services Provider pilot sites no later than March 1, 2008. DCH has extensive experience in implementing programs through this mechanism. The RFGA selection process and programmatic implementation structure described above was highly effective with Georgia's $1.5M Rural Health Safety Net Program, which was recently launched.