Joint Study Committee on Medicaid Reform
November 18, 2013

Presented by:

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Memorial Health, Savannah, Georgia

Memorial Health in Savannah

- Founded in 1955 as a living memorial to nation's war dead
- Non-profit healthcare system serving 35 counties in southeast Georgia and southern South Carolina
- 622 bed tertiary hospital
- Only major academic medical center in south Georgia
- Nationally recognized for Quality
- Major employer - 4,500 Team Members
- 650 physicians on medical staff

BEST HOSPITALS U.S.News & WORLD REPORT RANKINGS

Commission on Cancer

Joint Commission National Quality Approval

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Comprehensive Services

- Anderson Cancer Institute
- Level I trauma center
- The Children's Hospital
- Level III neonatal intensive care nursery
- Heart and Vascular Institute
- Women's services / high-risk obstetrics
- The Rehabilitation Institute
- Neurology / Neurosurgery
- Orthopedics
- Center for Behavioral Medicine

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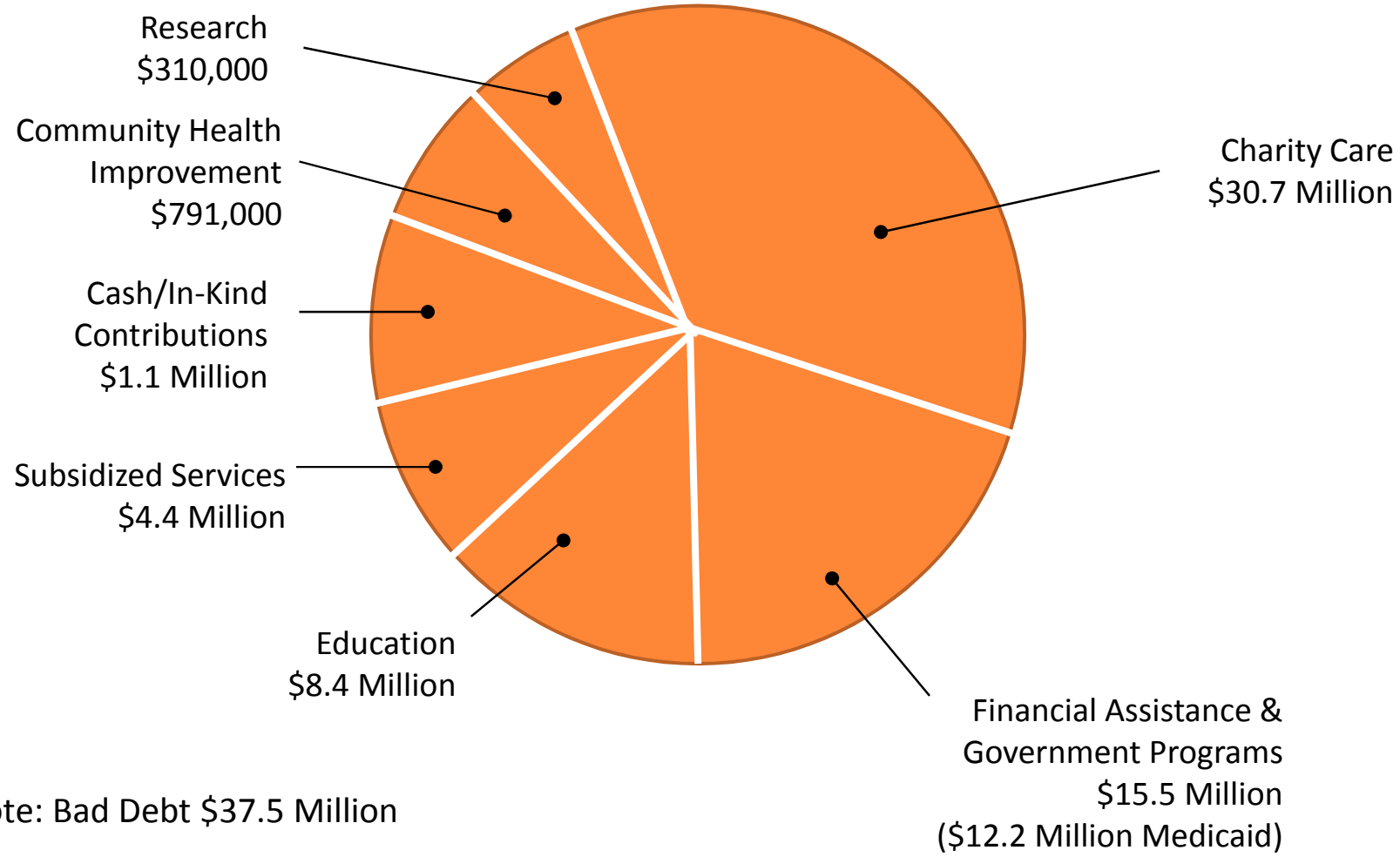
Significant Community Benefit
$61,240,421



Note: Bad Debt $37.5 Million

Uninsured and Underinsured in Georgia

- Georgia ranks 45th in the nation in healthcare spending
- High number of Georgians uninsured or underinsured
  - *19.7% uninsured, approximately 2 million people, 5th highest in U.S.*
  - *Memorial patients, 34.6% uninsured or underinsured*
- Georgia is one of 21 states not expanding Medicaid
  - *"Coverage gap" 489,000 Georgians would have coverage under ACA, but remain uninsured since Medicaid not expanded*
- Disproportionate share reimbursement (DSH), supplemental funding for hospital with high number of uninsured, is cut 75% whether Medicaid is expanded or not
- **Georgia giving up current funding and forgoing new funding**

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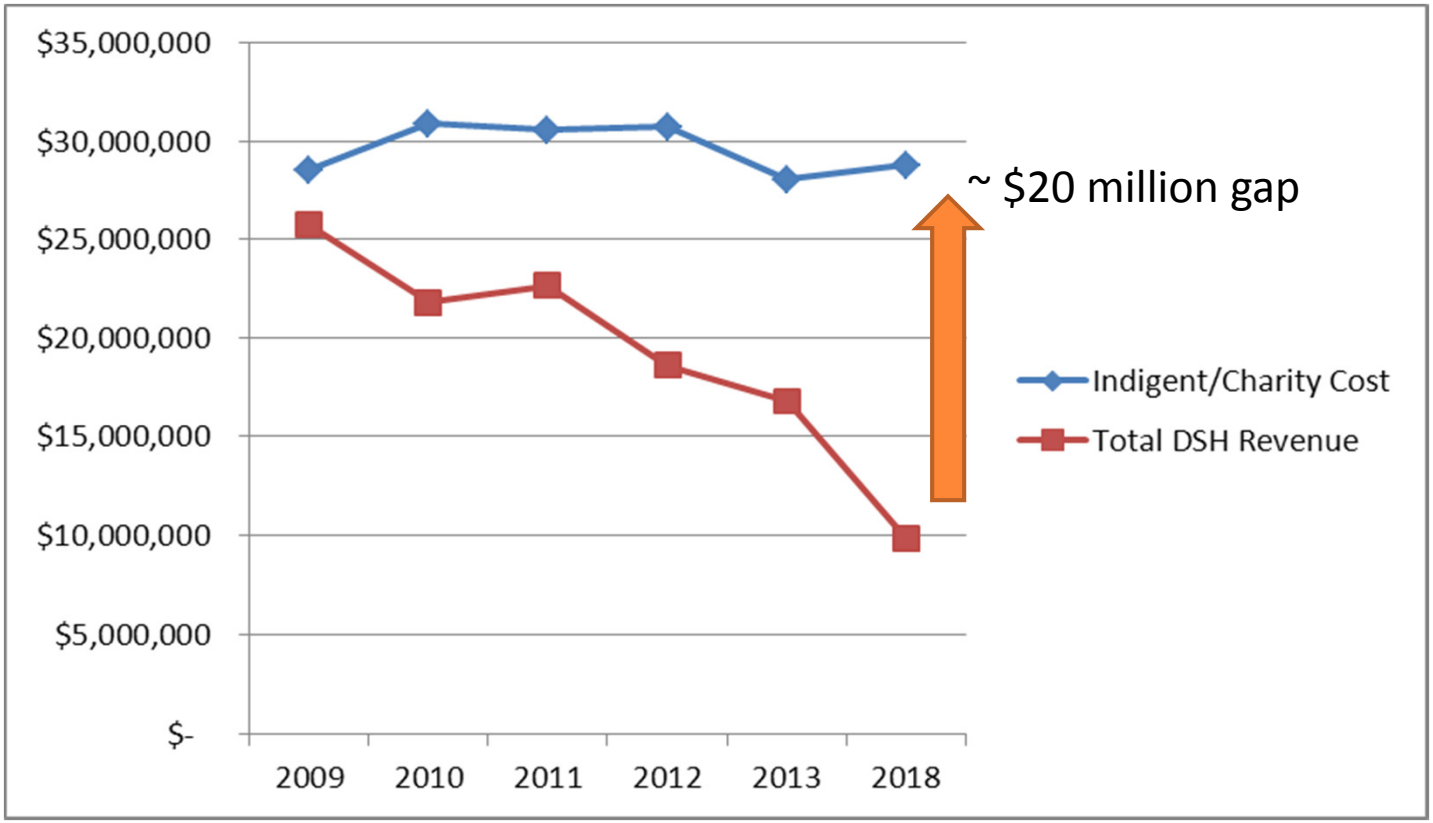
Unsustainable Cuts:
Memorial Charity Care Cost vs. DSH Funding



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When People Don't Have Insurance for Basic Health Care: more suffering and higher costs for all

- A waitress with throat cancer waits two years to see a doctor, assuming she has a sore throat
- A construction worker goes on a respirator when, after weeks of untreated asthma attacks, he cannot breathe on his own
- An unemployed diabetic patient goes the emergency dept. and is admitted for a wound that became worse over time because of no treatment


The New York Times

SATURDAY, NOVEMBER 9, 2013

Cuts in Hospital Subsidies Threaten Safety-Net Care

Poor Are Vulnerable in States That Didn't Expand Medicaid Under Health Law

Hundreds of Thousands Flee Storm in Philippines

Bloomberg News Is Said to Curb Articles That Might Anger China

Right Wing's Surge in Europe Has the Establishment Rattled

People do not receive the right care in the right place at the right time when they don't have access to healthcare.

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Other Mounting Financial Pressures

- Sequestration
- Value-based purchasing
- Readmission penalties
- Meaningful Use
- RACs
- MACs
- HACs
- SGR

The breaking point is near…

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Hospitals Want to Help

- **Alternative financial models for Medicaid**
  - Shared risk based on quality outcomes
  - Required co-pays and responsibility to engage patients
  - Bundled payments to incent better care coordination
  - Waiver for alternative Medicaid expansion
- **Care delivery models that better control utilization and reduce cost**
  - Patient Centered Medical Home (PCMH) to manage patient healthcare needs: prevention, wellness, acute care, chronic care
    - Memorial's *Family Medicine Center* was first PCMH in Savannah and first "Level 3" facility in Georgia (National Committee for Quality Assurance)
  - Use of telemedicine to fill service gaps in rural areas
  - Population health to manage chronic conditions

Medicaid expansion does not have to mirror traditional fee-for-service Medicaid.

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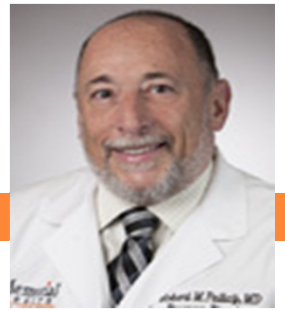
Specific Memorial Example,
Sickle Cell Population Health at Family Medicine Center



- Improved care for a specific underserved population
- Fundamentally changes the way adult sickle-cell disease patients are cared for; they often use emergency department or inpatient hospital as primary routes of care
- NIH-funded program creates a fast-track pathway in a PCMH setting for patients in two outreach cities (Savannah, Albany)
- Patients cared for in a lower cost observation setting where family medicine residents take over care for painful crises

Patients have access to physicians who know how to care for them, residents gain skills and cost of care is lower.

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Training Physicians for Georgia

- Memorial's physician residency programs launched in late 1950s
- Today, we train six specialties – family medicine, internal medicine, OB/GYN, pediatrics, general surgery, and diagnostic radiology
  - 135 residents; > 30 slots *over* funded cap
  - 41% of Memorial's residency program graduates practice in Georgia
  - 21% of Georgia medical school students completed residency training at Memorial

Established residency programs have the infrastructure to fast track expansion efforts.

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Expand Existing Residency Programs

- Memorial has 18 ACGME-approved residency slots available for expansion; 13 of these slots are in primary care

Residency Program	Number of Available Slots
Internal Medicine	5
Pediatrics	8
General Surgery	3
Radiology	2

- These unfilled slots are at risk for federal redistribution
- Average cost to fund a new resident slot is $140,000/year
- Existing programs, physicians, infrastructure already in place

Memorial could begin training 18 new doctors if funding were available for these slots.

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Support Undergraduate Medical Education

- Mercer University School of Medicine four year medical school on Memorial campus
- First class of 38 students graduated in 2012
- Mercer graduated 235 physicians 2004 – 2011
  - 40% stayed in Georgia to practice
  - 25% practice in Memorial's primary, secondary, and tertiary referral areas
  - New physicians look for locations where they can get help with school loans; debt load is high

Consider state-sponsored loan forgiveness, scholarships and stipends for working in underserved areas to help retain Georgia-educated physicians.

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Key Takeaways

- Consider the benefits of Medicaid expansion and alternative methods to expansion
- Pursue alternative care delivery models for Medicaid
- Support funding for safety net hospitals
  - Support bills to delay DSH cuts
  - Support appropriate methods for redistribution of Medicare DSH (to prevent losing to other states)
  - Upper Payment Limit - Ensure decisions at the state level do not negatively impact the draw down of federal funds
- Grow established graduate medical education programs

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Thank you