Final Report of the Joint Study Committee on Medicaid Reform

The Honorable Butch Parrish
Co-Chairman
State Representative, District 158

The Honorable Tim Golden
Co-Chairman
State Senator, District 8

The Honorable Craig Gordon
State Representative, District 163

The Honorable Gloria Butler
State Senator, District 55

The Honorable Barbara Sims
State Representative, District 123

The Honorable Dean Burke
State Senator, District 11

The Honorable Richard Smith
State Representative, District 134

The Honorable Jack Hill
State Senator, District 4

The Honorable Darlene Taylor
State Representative, District 173

The Honorable Fran Millar
State Senator, District 40

The Honorable Bruce Williamson
State Representative, District 115

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INTRODUCTION

House Resolution 107 created the Joint Study Committee on Medicaid Reform for the purposes of:

- evaluating the state's Medicaid program;
- examining best practices; and
- planning for future actions necessary to sustain appropriate levels of services and funding.

Representative Butch Parrish, Chairman of the House Health Appropriations sub-committee and Senator Tim Golden, Chairman of Senate Health Appropriations sub-committee, served as the Committee's Co-Chairmen. Other members of the Committee were: Representative Craig Gordon; Representative Barbara Sims; Representative Richard Smith; Representative Darlene Taylor; Representative Bruce Williamson; Senator Dean Burke; Senator Gloria Butler; Senator Jack Hill; Senator Fran Millar; Senator Renee Unterman; Commissioner Clyde Reese, III; Dr. Catherine Bonk; Mr. Tony Herdener; Mr. Patrick Healy; Ms. Sheila Shann Cook; and Mr. Ed Painter.

The Committee held public hearings on four dates: August 28, 2013, at the Coverdell Legislative Office Building in Atlanta; September 23, 2013, at Wiregrass Technical College in Valdosta; October 28, 2013, at Georgia Southern University in Statesboro; and November 18, 2013, at the Coverdell Legislative Office Building. During these hearings, the Committee heard testimony from the following individuals:

- Dr. Jerry Dubberly, Medicaid Division Chief, Department of Community Health;
- Dr. Jim Hotz, Clinical Services Director, Albany Area Primary Health Care;
- Charles Owens, Director, State Office of Rural Health;
- Blake Fulenwider, Healthcare Reform Administrator, Governor's Office of Planning and Budget;
- James Pettis, President, Assisted Living Association of Georgia;
- Randy Sauls, CEO, South Georgia Medical Center;
- Martin Miller, Coastal Home Care, Inc.;
- Pepi Nelson, ResCare Home Care;
- Paula Guy, CEO, Georgia Partnership for TeleHealth, Inc.;
- Denise Kornegay, Executive Program Director, Statewide AHEC at Georgia Regents University;
- Dr. Robert Phillips, Jr., Vice President of Research and Policy, American Board of Family Medicine;
- Dr. Jean Bartels, Provost, Georgia Southern University;
- Dr. Greg Evans, Dean of the College of Public Health, Georgia Southern University;
- Jon Howell, President, Georgia Health Care Association;
- Dr. Jacqueline Fincher, Chapter Governor, American College of Physicians Georgia Chapter;
- John Sparks, Chairman, Georgia Charitable Care Network, Inc.;
- Dr. Adrienne Zertuche, Emory University;
- Bridget Spelke, M.D. candidate, Emory University School of Medicine;
- Ajay Gehlot, CEO, Southwest Georgia Health Care, Inc.;
- Maggie Gill, CEO, Memorial University Medical Center;
- Matt Crouch, CEO, Peachford Hospital;
- HD Cannington, former CEO, Charlton Regional Hospital;
- Dr. Kathryn Cheek, Pediatrician;
- Eddie Grogan, Caremaster Medical; and
- Jesse Petrea, CHC/Altrus.

The testimony from the above-mentioned individuals, coupled with submitted written comments, led to the identification of the

following issues and the formulation of the accompanying recommendations to address the state Medicaid program.

BACKGROUND

The Georgia Department of Community Health (DCH) is designated as the single state agency for the Medicaid program. Medicaid and the State Children's Health Insurance Program (SCHIP or Peachcare for Kids) are jointly funded and administered by the states and the federal Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (USHHS). Currently, Georgia Medicaid and PeachCare for Kids cover 1.8 million people accounting for 19 percent of the state's population. In 2013, Medicaid and PeachCare health benefits cost the state $2.8 billion in state funds, representing 16 percent of the state budget. Combined state and federal health expenditures totaled $8.8 billion.

FY 2013 Average Monthly Members

Program	Enrollees	Percent
Aged, Blind, Disabled	463,569	26%
Low Income	1,117,640	62%
Peachcare for Kids	218,265	12%
TOTAL	1,799,474	100%

Source: Tim Connell, CFO, Presentation to DCH Board 8/22/13

Georgia Medicaid, like nearly all states, operates by both directly administering and contracting for the provision of member health services. DCH manages the Aged, Blind, and Disabled (ABD) population, and pays for care at fee-for-service (FFS) rates. ABD utilizes an "any willing provider" model of access, meaning any qualified provider can enroll. Care for the Low Income Medicaid (LIM) population is provisioned by one of three Care Management Organizations (CMO). The CMO is paid on a fixed per member per month (PMPM) basis and held financially at-risk. The CMOs are responsible for managing the benefits, provider network, and payment system for these members.

By 2020, one in four Americans, or about 26 percent of the population, is projected to be enrolled in Medicaid. DCH projects that by 2019, Georgia Medicaid enrollment will decline slightly as a proportion of the state population, to 14.9 percent, but will experience significant cost growth while experiencing flat enrollment. Medicaid enrollment trends are counter-cyclical; as revenues decline and unemployment rises, enrollment tends to increase. During the most recent economic downturn, Georgia experienced significant increases in enrollment, tracking well ahead of unemployment. Aside from an enrollment reduction in FY 2007 due to a change in citizenship verification requirements, Georgia has largely mirrored national trends since 2006 in both enrollment and cost growth.

Georgia is spending relatively less than its border states. The following table outlines Georgia's enrollment and expenditures compared to the southern states' averages for the same figures.

Expenditure	Georgia	Southern Average
Recipients, per 100,000 population	19,034	19,807
Per capita	$831	$1,114
Average Medicaid payment per recipient	$3,717	$4,859

States can utilize three policy "levers" to control Medicaid spending. These are reimbursement (amount paid for a service), eligibility (who receives service), and utilization (which services will be paid and under what conditions). Many states reduced provider reimbursement to meet budget constraints during the Great Recession, although this can reduce access to care. The Patient Protection and Affordable Care Act (P.L. 111-148 or PPACA) prohibits states from reducing Medicaid eligibility for adults through 2013 and children through 2019, effectively removing that policy option. Therefore

Georgia avoided reductions in provider reimbursement by relying on utilization controls. Despite this, among the states Georgia reimburses providers at a relatively low rate. Notwithstanding the temporary increase in some Primary Care Physicians' reimbursement rates through 2015, Georgia's low payment schedule begs the question of whether the bottom of the list is a desirable location. Low rates can have a negative impact on access to care for Medicaid members as well contributing to a shortage of medical professionals available to serve the general public.

COST DRIVERS

In Georgia, the ABD population is responsible for 58 percent of Georgia's Medicaid expenses, yet comprises only 29 percent of the membership. Higher cost members within this population often suffer from chronic conditions and are more frequent users of emergency room and inpatient services, which are the most expensive forms of care.

Distribution of Medicaid Payments by Enrollment Category, FY2010[1]

Location	Aged	Disabled	Adult	Children	Total
United States	22%	42%	15%	21%	100%
Alabama	23%	37%	8%	32%	100%
Florida	24%	42%	13%	20%	100%
Georgia	**21%**	**39%**	**15%**	**26%**	**100%**
Kentucky	17%	46%	12%	25%	100%
Mississippi	23%	43%	11%	24%	100%
N. Carolina	17%	45%	13%	24%	100%
S. Carolina	20%	43%	15%	22%	100%
Tennessee	15%	38%	21%	26%	100%

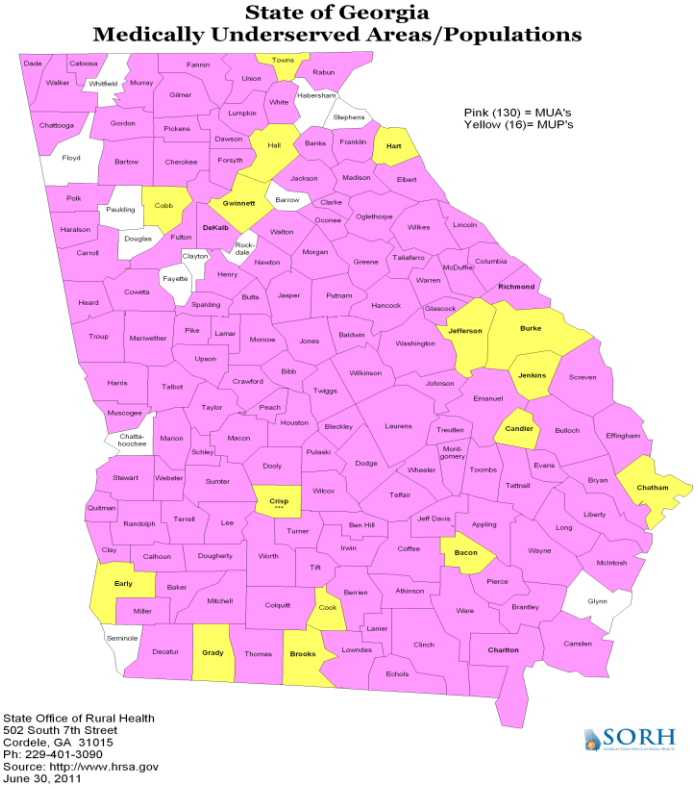
Source: Kaiser Family Foundation, kff.org

With the goal in mind of improving outcomes and reducing costs over time, the Department of Community Health recently outlined its vision of a care coordination program for the ABD population. Some features of the new program are that it will be voluntary for members (all members will have the ability to opt out) and will include care coordination, case management, and disease management services. Members will have access to a care coordination call center, a nurse line, and outreach and education relative to the member's disease state. High-risk, high-utilization members will access more intensive medical coordination services, which may involve interdisciplinary treatment teams, medical homes, and promotion of member engagement. The program will be managed by a single statewide vendor, but administrative functions, such as claims payment, rate setting and policy, and denial or authorization of services will remain with DCH.

ACCESS

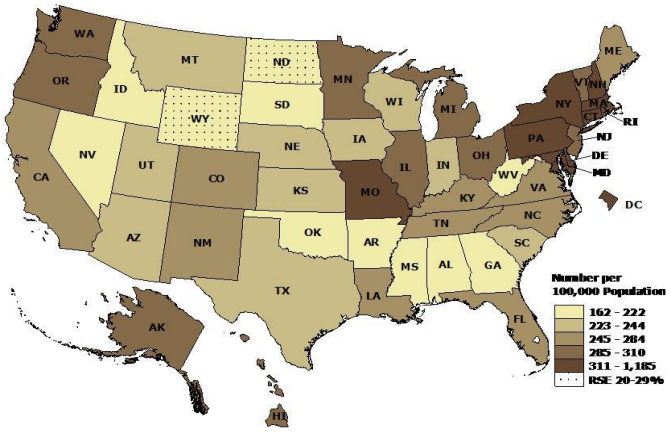
Not accounting for the impact of the PPACA, the national primary care physician shortage stands at 46,000, a figure projected to increase to more than 100,000 by 2025. Medicare, through the Department of Health and Human Services, funds the vast majority of residency training programs in the United States. This tax-based financing covers resident salaries and benefits through payments called Direct Medical Education (DME) payments. However, funding levels have remained frozen over the last ten years, creating a bottleneck in the training of new physicians in the U.S. States have steadily expanded their medical school programs, resulting in more residents needing training locations. In response, a large number of teaching hospitals have begun funding resident training to increase the supply of residency slots.

[1] NOTE: The figures included in the table total 60% of expenses as attributable to the Aged and Disabled. The 58% figure in the column represents the ABD program. This slight discrepancy results from different classification methodology.



The cap imposed on residency slots in the 1990s has prevented Georgia from developing and funding the expansion of residency slots the state needs. Nationally, Georgia ranks 39th in total medical residents per hundred thousand people. For the 2012-2013 academic year the state could claim 2,345 residency slots, of which 2,122 were filled.[2] Concurrently, the five medical schools reported enrollment of 2,377. Georgia has 20.8 doctors per hundred thousand citizens; nationally, there are 35.7 doctors per 100,000 citizens. To address the current physician shortage in Georgia would require an additional 1,450 physicians. The state of Florida, in a similar situation with only 3,000 residency slots for 4,000 trained medical students, is planning to invest $80 million over the next few years into expanding residency slots in the state.

Physicians per 100,000 working age population, by State, 2008-2010



Source: HRSA; The US Health Workforce Chartbook; Part I: Clinicians

The Georgia GME (Graduate Medical Education) Exit Survey Report continues to show the best way to retain a doctor is to grow your own. With only 16 percent of medical school graduates staying in Georgia residency programs, the state is essentially investing in medical education only to see the students leave the state for their residency training. Access to quality care becomes an issue when Georgia residents train outside the state. Exacerbating the situation is the volume of chronic disease conditions and number of low-income citizens.

The federal requirements for access are generic and vague; however, with the advent of Care Management Organizations (CMOs), DCH worked to make this more specific for each provider type, including actual geographic areas. Geo-mapping software helps to determine an individual's distance from providers. CMO access requirements are contractually defined and based upon distance and the timeliness with which a member can get an appointment. Each standard varies by region and type of service. Other alternative means of increasing access to care in Georgia are greater utilization of telemedicine and non-emergency transportation (NET), as well as loan forgiveness programs for medical students in return for serving in medically underserved areas (MUAs) for a certain time period after they become licensed professionals.

[2] GBPW; GME Fact Sheet 2013

Telemedicine is currently available in 50 nursing homes in Georgia, and is a tool which helps avoid the trauma and expense of sending an elderly person to the emergency room. Telemedicine decreases transportation costs dramatically; sending a nursing home patient to a psychiatric consult once a day would cost $400 for each visit. Such visits are now conducted remotely via telemedicine. Children are being diagnosed early with the use of telemedicine, which helps keep those children in school. Many local school systems are using this technology: school-based clinics are increasing from 16 to 41 this year. Follow-up appointments may be completed via telemedicine, which greatly reduces the burden on rural patients with less access to care. Finally, telemedicine can greatly increase access to specialty or sub-specialty providers that may otherwise only be available in more developed areas.

ADMINISTRATIVE SIMPLIFICATION

DCH has made significant strides to reduce the administrative burdens placed on providers, but there is still opportunity for continued improvement. Many Georgia providers spend considerable time navigating confusing and varied rules related to obtaining pre-certification, authorizations, credentialing, and reimbursement for care. Testimony to the committee revealed that much of this complexity results from the division of the Medicaid program into the state administered Fee-for-Service (FFS) model which exists alongside the capitated CMO arrangement for Low Income Medicaid (LIM). Each CMO can have different procedures for many common business processes. This can effectively mean that Georgia providers have to navigate four separate sets of requirements and procedures to see Medicaid patients. The following steps would help in streamlining these processes:

- publish a list of all authorization requirements among all CMOs, detailed by current procedural terminology (CPT) code and/or a healthcare common procedure coding system (HCPCS) and place of service codes, published on each CMO's web site; and
- a common preferred drug list (PDL) among all CMOs and a consistent method for making changes and then filling prescriptions based on date of order; and
- a credentialing process among fee-for-service (FFS) Medicaid and the CMOs to reduce the cost and timeframe for providers to join a CMO provider panel. In Georgia, credentialing can take up to four months, while a neighboring state, Alabama, credentials in 14 days.

RATES AND REIMBURSEMENT

As mentioned, Georgia refrained from reducing provider rates, even in the midst of the recent economic downturn, but the state's provider rates still remain lower than the southeastern average. Low Medicaid rates and reduced private insurance reimbursement rates, combined with high numbers of uninsured patients, have affected many of Georgia's healthcare providers, but probably the most adversely affected have been Georgia's rural hospitals. According to the Office of Rural Health, rural hospitals in Georgia average 38 days of cash on hand, and the recent closure of three rural hospitals is indicative of this financial strain. Reimbursement and its wider impact on the economy and job growth is also evident—when a select group of Medicaid providers were surveyed, most of those surveyed expressed that they had no intentions of expanding their businesses.

FEDERAL ENVIRONMENT

The federal climate relating to healthcare is incredibly fluid at the moment, with the long-term impacts of the PPACA still unknown. Uncertainty surrounds the implementation of the law, including concerns about the ability of the federal government to fund Medicaid expansion at 100%-90% of cost, continuing

legal challenges, and missteps related to the establishment the federal Health Insurance Marketplace.

Although the Section 1115 premium assistance waivers in Arkansas, Iowa, and Pennsylvania represent a potential alternative model for Medicaid expansion, there are a number of unknowns related to the waiver. For example, the Center for Medicare and Medicaid Services (CMS) approved Arkansas's waiver only through 2016. This short timeline equates to uncertainty in the future, including a question of the states' abilities to continue to absorb the higher costs of a waiver program.

An additional concern for states contemplating a premium support model is the need to maintain a "wrap-around" Medicaid program that provides mandated services that would not be included in a private plan purchased through premium support. Even if a state was to reach an agreement with the federal government allowing for a premium support model, the state would still need to maintain a significant footprint including a fiscal agent to pay fee-for-service claims, utilization review to ensure appropriate care, as well as all the associated administrative and program integrity activities that occur today.

Further, the looming cuts to Disproportionate Share Hospital (DSH) funding create additional uncertainty. A number of witnesses noted the projected impact of these cuts, including hospital closures. The ACA proposed reduction to national Medicaid DSH is $4 billion by 2020, lowering the national DSH allocation amount from $11.5 billion in FY 2013 to $7.5 billion in FY 2020. Compared to FY 2013, this represents a 34.8 percent reduction by 2020. For Georgia, the DSH reduction is estimated to be at least $77 million between FY 2014 and FY 2017. The uncertainty of reduced DSH payments to Georgia leaves policymakers with reduced flexibility to make significant changes in healthcare policy.

CONCLUSION

The study committee began its review of the Medicaid program in July uncertain of where the meetings, research, and hearings would lead. A few points are clear—Georgia consistently ranks lowest in terms of Medicaid per capita spending when compared to the southeastern states, and Georgia compares favorably to all southeastern states in terms of the level and quality of care patients receive. However, Georgia ranks low in numbers of physicians, especially in rural areas. In order to maintain its low-cost and high quality Medicaid program, but also continue to provide affordable quality care for a growing population, Georgia should first address the physician shortage by creating additional residency slots for Georgia medical school graduates. Research indicates that students are more likely to practice where they complete their residency training.

As far as changes to the Medicaid delivery model are concerned, while premium assistance models such as those in Arkansas and Indiana might one day be an option for the Georgia Medicaid program, the implications and long-term costs of such premium assistance programs are not yet fully understood. In the meantime, Georgia should continue to monitor the many effects of the Patient Protection and Affordable Care Act on its hospitals and providers, particularly DSH payment reductions, and should not resort to wholesale policy changes until the impacts of the ACA are clearer.

Respectfully Submitted,

The Honorable Tim Golden
Co-Chairman
State Senator, ~~District~~ 8

The Honorable Butch Parrish
Co-Chairman
State Representative, District 158

APPENDIX

1. Text of HR107

A RESOLUTION
1 Creating the Joint Study Committee on Medicaid Reform; and for other purposes.
2 WHEREAS, Medicaid serves a vital role in ensuring the health of the needy citizens of this
3 state who would otherwise be without access to necessary health care; and
4 WHEREAS, the cost of providing Medicaid continues to escalate and to require significant
5 amounts of state resources each year; and
6 WHEREAS, with Medicaid enrollment increasing at the same time that states are facing
7 unprecedented budget pressures, there is widespread recognition that expanded access to care
8 is unsustainable without changes in how states deliver and pay for care; and
9 WHEREAS, for the purposes of determining an appropriate plan for Medicaid reform, it
10 would be beneficial to study current policies and procedures of Medicaid and whether current
11 programs are being implemented in the most efficient and effective manner, the federal
12 expansion of Medicaid as authorized under the federal Patient Protection and Affordable
13 Care Act, and models in other states to enable the General Assembly to understand and
14 determine appropriate levels of service and expenses of Medicaid in order to ensure
15 sustainability of the Medicaid program.
16 NOW, THEREFORE, BE IT RESOLVED BY THE GENERAL ASSEMBLY that there is
17 created the Joint Study Committee on Medicaid Reform to be composed of 18 members as
18 follows:
19 (1) Six members of the Senate, appointed by the Lieutenant Governor, at least one of which
20 shall be a member of the minority caucus;
21 (2) Six members of the House of Representatives, appointed by the Speaker of the House
22 of Representatives, at least one of which shall be a member of the minority caucus; and
23 (3) Six members appointed by the Governor as follows:
24 (A) One representative from the Department of Community Health;
25 (B) One member representing hospitals;
26 (C) One member representing insurance providers;
27 (D) One member representing nursing homes;
28 (E) One physician; and
29 (F) One consumer member.
30 The Lieutenant Governor and the Speaker of the House of Representatives shall each
31 designate one of their appointees to serve as cochairpersons. The committee may elect other
32 officers as deemed necessary. The cochairpersons may designate and appoint subcommittees
33 from among the membership of the committee as well as appoint other persons to perform
34 such functions as they may determine to be necessary as relevant to and consistent with this
35 resolution. The cochairpersons shall only vote to break a tie. The committee shall meet at
36 the call of the cochairpersons. A quorum for transacting business shall be a majority of the
37 members of the committee.
38 BE IT FURTHER RESOLVED that the committee may conduct its meetings at such places
39 and at such times as it may deem necessary or convenient to enable it to exercise fully and
40 effectively its powers, perform its duties, and accomplish the objectives and purposes of this

resolution. Legislative members of the committee shall receive the allowances provided for in Code Section 28-1-8 of the Official Code of Georgia Annotated. Members of the committee who are state officials, other than legislative members, and state employees shall receive no compensation for their services on the committee, but they shall be reimbursed for expenses incurred by them in the performance of their duties as members of the committee in the same manner as they are reimbursed for expenses in their capacities as state officials or employees. The allowances authorized by this resolution shall not be received by any member of the committee for more than five days unless additional days are authorized. The funds necessary for the reimbursement of the expenses of state officials, other than legislative members, and state employees shall come from funds appropriated to or otherwise available to their respective departments. All other funds necessary to carry out the provisions of this resolution shall come from funds appropriated to the House of Representatives and the Senate.

BE IT FURTHER RESOLVED that the committee shall make a report of its findings and recommendations to the General Assembly and the Governor, with suggestions for proposed legislation, if any, on or before December 31, 2013. The committee shall stand abolished on December 31, 2013.

2. Section 1115 Premium Assistance Waivers

Table 1:
Key Similarities and Differences Between States' Medicaid Expansion Premium Assistance Proposals

	AR (approved)	IA (approved)	PA (proposed)
Overview:	Would use Medicaid funds to pay premiums for Marketplace QHPs for some or all newly eligible Medicaid beneficiaries under the ACA's expansion.		
Duration:	2014-2016		2015-2019
Coverage Groups:	All newly eligible beneficiaries ages 19 to 64: parents between 17-138% FPL, and childless adults between 0-138% FPL. (Would include currently eligible parents and children in future years.)	Newly eligible beneficiaries ages 19 to 64 above 100% to 138% FPL.	All newly eligible beneficiaries ages 21-64: parents between 33-138% FPL, and childless adults between 0-138% FPL.
Enrollment:	Would be mandatory for affected beneficiaries and exempt beneficiaries who are medically frail.		
Premiums for Enrollees:	None	Premiums not to exceed 2% of annual income. Can be waived by meeting specified healthy behavior activities.	Sliding scale based on income, maximum $25 individual/$35 household per month in year 1. Required for enrollees from 50-138% FPL. Can be reduced by participating in specified healthy behavior and work search activities.
Cost Sharing:	Required for enrollees between 100-138% FPL. (Would require for those between 50-100% FPL in subsequent years.)	Required for non-emergency use of the emergency room.	
Benefits:	QHPs would provide services in the state's Medicaid Alternative Benefit Plan. Prescription drug coverage would be limited to the QHP formulary.		
Wraparound Benefits:	Provided on a fee-for-service basis.	EPSDT provided FFS. One year waiver of non-emergency medical transportation.	Would not be provided.
QHP Oversight:	Written agreement between state Medicaid agency and QHP (and state insurance departments in AR and IA) covering data reporting and auditing.		

Source: *KFF.org;* *Medicaid Expansion Through Premium Assistance*