COLQUITT REGIONAL
MEDICAL CENTER

PRESIDENT:
James L. Matney

October 29th, 2024

Via Email at dpp.ideas@dch.ga.gov

Russel Carlson, Commissioner
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower
Atlanta, GA 30334

Dear Commissioner Carlson,

Thank you for the opportunity to provide input regarding the SFY26 Directed Payment Programs (DPPs). Colquitt Regional recognizes the care and detailed analysis the Department of Community Health (DCH) has put in over the years to develop a collection of DPPs designed to effectively address the state's overall health care priorities, and as state partners that have engaged in all these programs, it is a privilege for Colquitt Regional to participate.

The current Georgia DPPs are effectively supplementing innovations for the hospitals and qualifying physician groups; however, there is an additional opportunity for quality driven improvements for Emergency Medical Services (EMS). While the current upper payment limit funding within the fee-for-service system has helped bolster the EMS network's ability to fill coverage gaps for patients across the state, funding remains an impediment to growth and access. Limited Medicaid rate increases do not adequately compensate providers for lifesaving services, and this makes hiring, training, and retaining personnel difficult. Given these needs, we are proposing a Public EMS DPP where the same public EMS providers that are paying an IGT in the UPL would participate in the DPP, allowing them to receive more Medicaid supplemental payments in managed care that advance the state's Quality Strategy through documented and data-driven benchmarks. Implementing a DPP for the state's public providers would moderate funding gaps and workforce shortages while ensuring widespread healthcare access for Georgia's most vulnerable populations, particularly those residing in rural areas with limited access to care.

Thank you for your consideration of a new Public EMS DPP and for the Department's continued support of the Medicaid State Directed Payment Programs.

Sincerely

Julie Bhavnani (Oct 29, 2024 12:19 EDT)

Julie Bhavnani
Chief Financial Officer

ACADIA
HEALTHCARE

September 19, 2024
Via email at dpp.ideas@dch.ga.gov

Russel Carlson, Commissioner
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower
Atlanta, GA 30334

Dear Commissioner Carlson:

Acadia Healthcare appreciates the opportunity to provide input on potential changes to the state's Medicaid Directed Payment Programs (DPP) for the state fiscal year 2026. Acadia is the largest standalone provider of behavioral healthcare services in the United States with 250 locations and 11,000 beds across thirty-nine states and Puerto Rico. Our mission is to set the standard of excellence in the treatment of specialty behavioral health and addiction disorders. We currently operate three freestanding Psychiatric hospitals in the state of Georgia.

We request your consideration for the development of a DPP for psychiatric hospitals to support and enhance the delivery of essential behavioral health services across the state. A DPP for psychiatric hospitals will help to improve Medicaid patients' access to inpatient psychiatric services, which are vital in the behavioral health continuum of care. By taking this step, Georgia would align with most of the other states where we operate which have already implemented similar initiatives to support access to behavioral health services.

The state uses revenue collected under the Hospital Medicaid Financing Program to help finance the state share of payments made through the existing DPPs. A statutory change would be necessary to use this same financing method for a psychiatric hospital DPP. To that end, we suggest the following amendment to O.C.G.A. 31-8-179.1 (3):

"Hospital" means an institution licensed pursuant to Chapter 7 of this title which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, **psychiatric**, and other specialty hospitals but shall not include ~~psychiatric hospitals which shall have the same meaning as facilities as defined in paragraph (7) of Code Section 37-3-1~~, critical access hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

In advance of October 31, we expect to collaborate with the Georgia Hospital Association to submit additional comments outlining a proposed DPP design for psychiatric hospitals and will demonstrate how

ACADIA
HEALTHCARE

this payment arrangement is expected to advance the goals and objectives of the state's quality strategy as well as the DPP's goals.

Again, we appreciate the opportunity to provide input on potential changes to the state Directed Payment Programs and we may offer additional comments related to potential changes prior to the October deadline. Please do not hesitate to contact me with questions or to schedule a related discussion.

Respectfully submitted,

Brent Wilson

Brent Wilson,
Vice President of Reimbursement

Cc: Tim Sides, Senior VP Operations Finance
Andrew Lynch, Chief Strategy Officer

Children's Healthcare of Atlanta

New Ideas and Input for Georgia's DPPs

Notice of Intent to Accept Public Input:
"The Georgia Department of Community Health is accepting public input for consideration of new ideas for, and possible revisions to, the state Directed Payment Programs (DPPs) that align with the agency's mission and goals."

According to the Centers for Medicare & Medicaid Services (CMS), the goal of DPPs is to support states in achieving their overall objectives for delivery systems, payment reform, and performance improvement. Federal regulations[1] stipulate that DPPs must advance at least one of the goals and objectives outlined in a state's quality strategy. The Georgia Department of Community Health's (Department) 2024-2026 Quality Strategy[2] (Quality Strategy) has seven main goals that include improving access to care, wellness and preventative care, and behavioral health care outcomes. The Quality Strategy has 29 objectives, several[3] of which focus on preventative care and behavioral and mental health care **for children.**

Children's Healthcare of Atlanta (Children's) serves as Georgia's pediatric safety net provider. With the highest Medicaid payor mix[4] in the state at 59.3%, Children's supports the Department's access to care goals and objectives. **Children's is the only health system in Georgia dedicated solely to providing care to kids** and serves the sickest children. This includes patients from all of Georgia's 159 counties, many of whom require extensive resources. This in turn results in a cost structure that is higher than adult hospitals.[5] Each year, Children's receives 12,000 transfers from other hospitals in Georgia – hospitals which receive $1.2B[6] in federal DPP funds annually. This demonstrates the tremendous need for the specialized pediatric services offered at Egleston and Scottish Rite and contributes to the higher cost structure. In 2023, Children's provided care to more than 420,060 individual patients across 1,098,367 visits at 2 hospitals, 8 urgent care centers, and 105 community locations. Despite its unique, specialized, and vital role in providing care for Georgia's pediatric population, with the majority of those served on Medicaid, **Children's is currently excluded from all of Georgia's DPPs.**

A central theme to the Department's Quality Strategy is the need for more health care providers, as supported by the Strengthening The Reinvestment of a Necessary-workforce in Georgia (GA-STRONG) DPP[7] which explicitly "*recognizes the growing need to address the health care workforce shortage in Georgia to improve health outcomes and quality statewide.*" Children's is committed to addressing the health care workforce shortage in Georgia and improving pediatric health outcomes and quality statewide. As the primary pediatric teaching site for Emory University School of Medicine and Morehouse School of Medicine and the largest pediatric training site in the state, Children's is training the next generation of healthcare providers for Georgia's children. During the 2023-2024 academic year, 546 residents and 221 fellows completed training at Children's with 63% remaining in Georgia post-graduation. Plans are underway to further grow the teaching program. To ensure the required training standards of pediatric residents are met, Children's also partners with and subsidizes participating community pediatricians. In addition, Children's collaborates with the Mercer University School of Medicine (MUSM) and the Georgia Rural Health Innovation Center (GRHIC) to enhance the availability of pediatric services in rural communities. As part of this affiliation, Children's funds scholarships for MUSM medical students specializing in pediatrics and family therapy professionals who commit to serving in rural Georgia for at least four years after residency. The partnership with Mercer also supports the Kids Alliance for Better Care which provides rural hospitals the training and support needed to better respond to pediatric patients in their emergency departments. With the support of DPP funds, Children's could do even more to address Georgia's health care workforce shortage, such as expanding these initiatives and partnering with the forthcoming University of Georgia School of Medicine.

Other Department Quality Strategy goals, including improving wellness and preventative care and behavioral health care outcomes, align with Children's priorities[8] and mission: to make kids better today and healthier tomorrow. Examples of this alignment include:

- Children's Behavioral and Mental Health programs work to provide a full continuum of care for children to support their mind, brain, and behavioral development. In 2023, Children's saw 4,411 kids in crisis and cared for 16,901 unique patients with a primary behavioral and mental health diagnosis through 68,704 visits across all Children's settings. The Marcus Autism Center, which was brought into our System in 2008, diagnoses and treats thousands of children with autism and related disorders. Over 13,000 patient visits have occurred at Children's Healthcare of Atlanta Zalik Behavioral and Mental Health Center, which opened in October 2023 and works to balance prevention and outpatient treatment services. Additionally, Children's has created a dedicated Behavioral and Mental Health endowment which is one of the largest investments in child mental health by a U.S. healthcare system.
- The Children's Care Network (TCCN), Georgia's only comprehensive pediatric clinically integrated network, serves over 950,000 children. TCCN was created through a partnership of community physicians (477 pediatricians and 172 pediatric specialists) and Children's to strengthen pediatrics in Georgia and ensure better health outcomes for children.
- Strong4Life, Children's childhood obesity awareness and wellness movement, reaches families through public awareness, community partners, and school and healthcare provider programs. In 2023, Strong4Life reached more than 814,000 children, 856 clinicians, and 906 schools.

If eligible for DPP funds, Children's could further advance efforts to improve access to care, wellness and preventative care, and behavioral health care outcomes.

Considering the Medicaid population is disproportionately pediatric,[9] **it is striking that Georgia is the only state[10] with Medicaid Managed Care plans and freestanding acute care Children's Hospitals[11] that completely excludes these facilities and their affiliated providers from their DPPs**. Additionally, because in Georgia "Pediatric Wings in general hospitals received $202 million in SFY 2023 DPP payments for patients aged 21 and under, a 180% increase over their CMO base payments"[12] and freestanding Children's Hospitals do not participate in Georgia's DPPs, the Department needs to perform a holistic evaluation of Medicaid reimbursement, including any prospective changes to Medicaid Graduate Medical Education payments and parity across provider classes**.**

Children's should be included in GA-STRONG for State Fiscal Year 2026. Information we have gathered shows that other states with Medicaid Managed Care plans include freestanding acute care Children's Hospitals in their DPPs, and we believe that Georgia should emulate. This inclusion would allow for further advancement of efforts to improve wellness, preventative care, and behavioral health care outcomes. To achieve this, Children's recommends adding Egleston and Scottish Rite via a separate provider class, allowing for modeling of various reimbursement scenarios. Children's is prepared to engage industry experts to support the Department's efforts in evaluating this proposal.

To achieve the Department's access to care and behavioral health care goals and objectives, Children's also recommends evaluating other excluded provider classes whose missions align with the Quality Strategy for inclusion in Georgia's DPPs. Psychiatric and Critical Access hospitals do not participate in the provider fee, as such, legislative action will be required if Georgia plans to finance the state's share of DPP funding via a provider tax for these providers.

Children's has invested in Georgia's kids for over 100 years – including a new hospital opening on September 29th which will serve kids in our state for another 100 years. We ask the state to join us in investing in the health and wellbeing of Georgia's kids for the next century too by investing in the largest free-standing pediatric provider.

References:

[1] Code of Federal Regulations, Department of Human and Health Services, Centers for Medicare and Medicaid Services, Medical Assistance Programs, Managed Care, General Provisions, 42 CFR § 438.6 (c)(2)(ii): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6#p-438.6(c)

[2] Georgia Department of Community Health 2024-2026 Quality Strategy: https://dch.georgia.gov/medicaid-quality-reporting

[3] Relevant Quality Strategy objectives include 1.1, 1.3, 2.1, 2.2, 2.3, 2.4, 5.1, 5.2, 5.3, 5.4, 5.5, 5.6, 5.7.

[4] Medicaid payor mix = Total In-State Medicaid Charges (Disproportionate Share Hospital [DSH] Examination Pt II, Section H) / Total Patient Revenues (DSH Examination Pt II, Section F-3) for SFY 2023, by provider (minimum 10K days). Children's wholly owned hospital subsidiaries include Egleston Children's Hospital at Emory University, Inc. (Egleston) and Scottish Rite Children's Medical Center, Inc. (Scottish Rite).

[5]

Cost data from worksheet D-1 of the 2021 and 2022 Medicare Cost Reports; Case Mix Index (CMI) data from 2021 and 2022 GHA Surveys							
Provider Group	[1] General Inpatient Routine Per Diem	[2] ICU Per Diem	[3] Total Pop MSDRG CMI	[4] Pediatric (<19) MSDRG CMI	[5] = [1] / [3] CMI Adjusted Routine Per Diem	[6] = [2] / [3] CMI Adjusted ICU Per Diem	
Pediatric (Egleston and Scottish Rite)	$ 1,610	$ 3,074	1.78	1.78	$ 905	$ 1,728	
All Other GA Acute Hospitals	$ 1,113	$ 2,240	1.67	1.21	$ 665	$ 1,337	
Pediatric, CMI adjusted daily cost vs. All Other GA acute hospital CMI adjusted daily cost ----------> 136% 129%							

[6] Per the Georgia Department of Community Health's SFY 2024 projections.

[7] Georgia Department of Community Health SFY 2024 GA-STRONG preprint, see the Department's response to question 43: https://dch.georgia.gov/document/document/ga-strong-fy24-preprint/download

[8] Priorities denoted in Children's 2022 Community Health Needs Assessment: https://www.choa.org/about-us/community/community-health-needs-assessment

[9] Per the Kaiser Family foundation, in 2021 children (< 19 years of age) accounted for 38% of total Medicaid enrollees in the United States, but only 23% of the total population. In 2021, children (< 19 years of age) accounted for 55% of total Medicaid enrollees in Georgia, but only 25% of the total population: https://www.kff.org/state-category/medicaid-chip/medicaid-beneficiaries/, https://www.kff.org/state-category/demographics-and-the-economy/population/

[10] Based on Children's research of publicly available documentation.

[11] Children's Hospitals with a CMS Certification Number between xx3300 and xx3399, who offer acute care services.

[12] Per the Georgia Department of Community Health's Children's Hospitals Reimbursement Parity Report dated July 1, 2024.

Children's Healthcare of Atlanta

New Ideas and Input for Georgia's DPPs

Notice of Intent to Accept Public Input:
"The Georgia Department of Community Health (Department) is accepting public input for consideration of new ideas for, and possible revisions to, the state Directed Payment Programs (DPPs) that align with the agency's mission and goals."

Children's Healthcare of Atlanta (Children's), comprised of Georgia's only two free-standing pediatric hospitals, Scottish Rite and Arthur M. Blank, previously submitted a comment to the Department advocating for inclusion in Georgia's DPPs, in recognition of Children's critical role in Georgia as a safety net provider for pediatrics and its ongoing efforts to strengthen the state's healthcare workforce and meet the Department's quality goals. In this response, Children's offers additional input on how the Department can and should (1) modify the existing hospital assessment that finances the DPPs for private hospitals and (2) modify the existing DPPs as a critical step towards addressing reimbursement parity for pediatric care in Georgia.

Background

Children's has the highest Medicaid payor mix in Georgia at 59.3%,[1] and is the only healthcare system in the state with freestanding hospitals dedicated solely to providing care to children. Children's meets Georgia's need for specialty pediatric care and provides the largest training program in the state for pediatric physicians. Additionally, Children's receives 12,000 transfers from other hospitals in Georgia to care for the state's sickest children who need specialized pediatric services only available at Children's. Yet, Children's is excluded from Georgia's DPPs while all other acute care hospitals are allowed to participate. This results in a significant disparity in how much Georgia's Medicaid Care Management Organizations (CMOs) pay to Children's versus other acute care teaching hospitals for healthcare services provided to children covered by a CMO. When comparing Children's CMO payments (including the inpatient pediatric add-on) to other acute care teaching hospitals'[2] CMO payments (including their net DPP payments), acute care teaching hospitals[2] **are paid *twice* the amount as Children's for the same pediatric care**. This disparity is caused by Children's exclusion from these material Medicaid reimbursement programs.

On July 1, 2024, the Department issued its "Children's Hospitals Reimbursement Parity Report" (Parity Report). In the Parity Report, the Department acknowledged the significant disparity caused by excluding Children's from the DPPs and identified several hurdles to including Children's in these programs. The Parity Report did not include any recommendations for resolving the identified hurdles, nor any conclusions about how the Department intends to achieve parity for pediatric care in Georgia.

Children's Request

There is an opportunity for the Department to rectify the disparity in pediatric care reimbursement in State Fiscal Year (SFY 2026). Identified below are steps necessary to include Children's in the SFY 2026 DPP(s):

1) Identify a method to incorporate Children's into the DPP hospital assessment in a manner that enables Georgia to continue meeting the statistical test necessary to obtain a waiver of the statutory "broad-based" requirement.

2) Amend any relevant Georgia regulations governing the hospital assessment as needed to enable Children's participation in the DPP portion of the assessment.

3) Submit a DPP "preprint" to Center for Medicare & Medicaid Services (CMS) that incorporates Children's into the SFY 2026 DPP program(s).

The Department has or could obtain the data needed to model a method that includes Children's in the SFY 2026 DPP programs. Children's has completed initial modeling that has identified multiple ways to achieve a P1/P2 ratio over 1.0 with Children's included in the DPP assessment by employing different methodologies including updating data year for analysis, using different apportionment of Medicaid revenue, changing the DPP tax base, increasing the size of the DPPs, and creating classes within DPPs. These approaches are further discussed in the following sections.

Children's requests that the Department perform these steps to achieve parity for SFY 2026. Children's understands that there are hurdles to achieving Children's participation in the DPP(s). Therefore, in support of Children's request for inclusion in the DPPs, Children's offers the following information to address the concerns outlined in the Parity Report.

Lack of Available Data

In the Parity Report, the Department stated that expanding the DPPs to include Children's would be "challenging given the lack of data for analysis." The Parity Report goes on to state "[a] projection to estimate the fiscal impact of including [Children's] is not possible based on the information currently available . . . [b]ecause those facilities are not currently included in the DPPs, the data needed to calculate such impact has not previously been collected and is not available for analysis." The Department has the data it would need to assess the impact of incorporating Children's into the DPP hospital assessment and could collect any additional data it needs to assess the impact of incorporating Children's into the DPP distributions.

- ***Hospital assessment***: The data needed to analyze the impact of incorporating Children's is generally derived from participating hospitals' publicly available Medicare cost reports and the Medicaid data already maintained by the Department regarding hospitals' Medicaid days, charges, and payments. These data allow for analyzing multiple scenarios for how to satisfy the federal statistical test necessary to obtain a CMS waiver.
- ***DPP distributions***: In order to calculate the additional DPP room created by including Children's in the DPPs, the Department would need to collect data from Children's about its top five commercial payers for inpatient and outpatient services. Children's is ready and willing to quickly provide such data. Separately, the Medicaid data maintained by the Department is sufficient to model how various levels of Children's participation in a DPP (*i.e.*, different percentage increases) would impact Children's and acute care hospitals.

Obtaining a New Waiver from CMS

In the Parity Report, the Department noted that incorporating Children's in the DPP assessment (in order to finance Children's DPP payments) "would require a new waiver approval by CMS." Federal law generally requires hospital assessments to be "broad-based," meaning that all non-public hospitals within the state that provide the assessed service (*i.e.*, inpatient, outpatient) are included in the assessment.[3] However, CMS can waive the broad-based requirement if a

state can show that the assessment is "generally redistributive" under what is called the "P1/P2 test," which measures whether the tax is "proportionally derived from Medicaid and non-Medicaid revenues within a class.[4]" More specifically, P1 represents the proportion of assessment revenue attributable to Medicaid if the assessment is applied to all providers of the assessed service (*i.e.*, inpatient services). P2 represents the proportion of the assessment revenue attributable to Medicaid if the assessment is structured as proposed by the state.[4] CMS will approve an assessment that has a P1/P2 ratio over 1.0. If the ratio is between .95 and 1.0, CMS will review the proposed tax and assess whether the excluded groups satisfy CMS approved exclusions. CMS will not approve waivers if P1/P2 ratio is less than .95.

Because Georgia excludes some hospitals that provide inpatient services from its DPP assessment on hospital inpatient services (including Children's), Georgia had to obtain a waiver from CMS. If Georgia were to change the DPP assessment to include Children's (and possibly other hospitals that wish to participate in DPPs, such as psychiatric hospitals), the Department would need to submit a new waiver request to CMS and demonstrate a sufficient P1/P2 ratio.

A stated concern of the Department has been that including Children's in the DPP assessment could result in a lower P1/P2 ratio that would preclude CMS approval of Georgia's broad-based waiver and threaten the viability of the DPP programs. However, based on Children's initial modeling, there are a number of ways the Department could achieve a P1/P2 ratio over 1.0 after incorporating Children's into the DPP assessment (with or without adding psychiatric hospitals). For example:

1) ***Different data year***: If Georgia seeks a new waiver, Georgia will need to submit a new P1/P2 test using more recent data. The effect of using a different data year without making any methodological changes will yield a different result. Although Children's is unsure of the Department's exact process, Children's calculated the P1/P2 using what it believes was likely the Department's process for determining inpatient net revenue and the share of net revenue allocable to Medicaid, incorporating data from hospitals' as-filed 2023 Medicare cost reports and adding Children's to the tax. The result was a P1/P2 ratio over 1.0. Moreover, if psychiatric hospitals were also added to the DPP, the ratio would be even higher. Thus, both scenarios could exceed the necessary threshold to obtain a waiver from CMS.

2) ***Different Apportionment of Medicaid Revenue***: Part of performing the P1/P2 test requires determining what proportion of hospitals' assessed revenue is attributable to Medicaid. The Department appears to have estimated the proportion of assessed hospitals' inpatient revenue attributable to Medicaid by applying hospitals' proportion of Medicaid days to total census days to hospitals' inpatient revenue. While this is one way to calculate hospitals' Medicaid revenue, it is not the only way. For example, the Department could instead look to hospitals' actual inpatient Medicaid payments during the cost report year compared to their reported total inpatient revenue. Children's is aware that other states approach this differently and their broad-based waivers have been approved. The Department has some discretion in how it calculates this percentage and Children's is happy to assist the Department to test different potential approaches.

3) ***Different Tax Base***: Presently, Georgia assesses hospitals' inpatient net revenue to support the DPPs. In an effort to ensure that the assessment is sufficiently redistributive, however, Georgia could also evaluate the impact of assessing hospitals on a different basis, such as total net revenue (*i.e.*, inpatient and outpatient), total hospital days, or even total hospital non-Medicare days (which Children's understands are used in a few other states). Children's initial analysis of various scenarios indicates that there a number of possible methods for ensuring Georgia's P1/P2 ratio exceeds 1.0 (depending on whether only Children's or Children's and psychiatric hospitals participate. If Georgia also added psychiatric hospitals to the DPP, Children's identified multiple potential methods for ensuring a P1/P2 ratio over 1.0 through various combinations of modified tax bases and/or methods for determining the Medicaid share of assessed revenue.

As stated in Children's prior comment to the Department, Children's is committed to supporting the Department's efforts to achieve parity for all providers who provide care to pediatric patients covered by a CMO by engaging industry experts to assist in these analyses. To the extent the Department will share its available Medicaid data, Children's can provide more precise and accurate models for the Department's consideration for the DPP hospital assessment.

Adverse Impact to Other DPP Hospitals

In the Parity Report, the Department stated that "a significant increase in the assessment percentage could result in adverse impacts to other participants, so the new waiver would likely require a significant restructuring from the current approved version." Children's understands that the Department must consider the impact on all hospitals, including those already participating in the DPPs.

To that end, the Department has flexibility under federal law to take steps that would either mitigate or entirely eliminate potential adverse impacts to existing DPP participants. Two examples include:

1) ***Increase the Size of the DPPs***: Federal law allows States to pay hospitals through DPPs up to the statewide Average Commercial Rate (ACR). Presently, Georgia does not pay all hospitals up to that ceiling. Adding Children's will naturally grow the size of the DPPs, but the Department could also use more of the existing DPP hospitals' ACR room to mitigate the increased hospital assessment burden. There is sufficient room under the federal six percent "safe harbor"[5] on hospital assessments to finance larger DPPs, especially if the state were to tax both inpatient and outpatient net revenue.

2) ***Create Classes within the DPPs***: For State Fiscal Year 2025, there are two classes of teaching hospitals in GA-STRONG (Hospital DPP 3.0) and there are two classes of private hospitals in the HDPP (Hospital DPP 1.0), each of which receive a different uniform percentage increase on their CMO payments. This enables the Department to direct Medicaid funding in a manner that furthers the Department's goals. In line with the Department's current practice, the Department could develop one or more new classes within the DPPs to ensure it is able to direct Medicaid funds in a manner that furthers the Department's goals. For example, Children's is aware that free-standing children's hospitals are treated as a distinct class in a number of states' DPPs in recognition that their

patients, finances, and operations often differ from general acute care hospitals. The same is true for psychiatric hospitals.

Children's is committed to supporting the Department in any way necessary to design optimal programs that include all Medicaid providers and that meet the Department's Medicaid goals with the least amount of disruption possible. CMS requires a new DPP preprint for each of the DPPs annually, and Children's is confident that the Department can submit an approvable preprint that includes Children's in SFY 2026, as well as obtain a new P1/P2 waiver.

Conclusion

Children's requests the Department consider options for including Children's in the DPP assessment and distributions. Children's will support the Department in these efforts and its attempt to craft a solution that is equitable and workable. Upon identifying the best option, Children's requests that the Department seek a new broad-based waiver from CMS, amend any relevant regulations, and submit an SFY 2026 preprint(s) that includes Children's. Georgia must protect and invest in the important work Children's performs as the only freestanding healthcare system in Georgia solely dedicated to treating children. Children's is a critical component of the Medicaid safety net, and only asks to be reimbursed on par with other acute care hospitals for healthcare services provided to CMO covered pediatric patients.

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[1] Medicaid payor mix = Total In-State Medicaid Charges (Disproportionate Share Hospital [DSH] Examination Pt II, Section H) / Total Patient Revenues (DSH Examination Pt II, Section F-3) for SFY 2023, by provider (minimum 10K days). Children's wholly owned hospital subsidiaries include Arthur M. Blank Hospital, Inc. (Arthur M. Blank) and Scottish Rite Children's Medical Center, Inc. (Scottish Rite).
[2] Teaching hospitals with five or more Full-Time Equivalent employees (FTEs).
[3] 42 U.S.C.A. § 1396b(w)(3)(B); 42 C.F.R. §433.68(c).
[4] 42 C.F.R. §433.68(e).
[5] 42 U.S.C.A. § 1396b(w)(4)(c)(ii).

EMORY
HEALTHCARE

Joon S. Lee
1440 Clifton Road NE
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Phone 404.778.4432

October 28, 2024

Mr. Russel Carlson
Commissioner, Georgia Department of Community Health
1 Martin Luther King, Jr. Drive, SE
16th Floor, East Tower
Atlanta, Georgia 30334

Dear Commissioner Carlson,

Thank you for the opportunity to provide feedback to the Department of Community Health regarding the state's directed payment programs. As the most comprehensive healthcare system in Georgia, Emory has been an active partner with the state in the financial and quality design of each of these programs, and as one of the state's largest providers of care, our system continues to be fully committed to advancing the state's strategy to ensure greater stability and access to quality care within our entire state. We are grateful for your leadership and the Department's commitment to collaborating with health systems across Georgia to ensure our hospitals are fiscally sound, our citizens are healthy, and our healthcare workforce thrives.

To that end, Emory requests that the Department consider the variability of net benefit as a pillar of program design to bring stability to the level of funding, leading to meaningful investments in Medicaid outcome improvements. We are concerned about our health system's ability to build upon the lasting and comprehensive workforce investments it made using directed payment funding if our net benefit continues to negatively fluctuate year to year.

Predictability is fundamental to the consistency of our progress and benchmarking, and year to year significant program funding variation creates challenges. We are excited and motivated to share a few highlights of the activities we have invested in during the inaugural year of the Strengthening The Reinvestment of a Necessary-Workforce in Georgia (GA-STRONG) program.

In Program Year 1, Emory implemented 83 workforce initiatives across our hospitals utilizing our GA-STRONG funds. Some of these investments include funds to increase the number of primary care faculty by over 85%, as well as increase the number of psychiatric learners and OB/GYN learners by well over 100%. Emory is proud to advance the state's focus on clinical areas with the greatest need.

We are partnering with nine area colleges to recruit and train healthcare staff, with an emphasis on forming a strong nursing pipeline. That pipeline is further supported through investments in our nurse residency programming to build and maintain quality care through robust competencies and skills training. Ultimately, the pipeline is completed through the recruitment and retention of nurses through updated salaries and benefits.

Emory is committed to stabilizing the healthcare workforce throughout Georgia, and our system is proud to engage with the state on this multi-year effort to demonstrate annual growth and improvement. Thank you again for ensuring we have a solid and reliable foundation of funding to maintain and build on these training and workforce investments. If you have any questions or would like to discuss any of our points further, please contact Sydney Wilkins, Director, State Affairs at Sydney.Wilkins@emory.edu.

Sincerely,

Joon Lee, MD
Chief Executive Officer, Emory Healthcare

Emory is thankful for the Department of Community Health's support and our continued partnership, especially in our shared goal to enhance Medicaid resources and outcomes through directed payment program.

- Emory is the ***single largest private contributor*** to funding these programs through the provider fee.
    - The provider fee impacts Emory significantly more than any other Georgia health system and those provider fees have increased every year since the program's inception.
- Using Tax Year 2022 instead of 2021 as the basis for the provider fee used to calculate the SFY25 assessments reduces the provider fee/IGT increase over two years to under 50% (47.2%) and stabilizes the program benefit to Emory by **~$5.7 million.** The impact on other health systems is nominal.
    1. **Less Drastic Increase in Provider Fee:**
        - **Tax Year 2021 Basis:**
            - Increase in the fee over two years: 81.7%
        - **Tax Year 2022 Basis:**
            - Increase in the fee over two years: 65.4%
        - The increase in provider fees is lower when using Tax Year 2022, making it easier to manage.
    2. **Stabilized Program Benefits:**
        - **Tax Year 2021 Basis:**
            - SFY24 to SFY25 decrease: -18.8%
        - **Tax Year 2022 Basis:**
            - SFY24 to SFY25 decrease: -10.8%
        - While we anticipate a decrease in program benefits for the SFY25 assessments, using Tax Year 2022 would ensure that the reduction is less substantial.
    3. **Consistent Investment in Programs:**
        - We ask that DCH considers the favorable financial situation of using Tax Year 2022 during the SFY25 Assessments. This ensures an additional ~$5.7 million can be invested in essential programs like eICU, maternal health initiatives, the Emory Addiction Center, Graduate Medical Education spots (including the new Rural Preventative Medicine rotation), Emory telehealth programs, and more. This consistency is crucial for maintaining high-quality outcomes in these areas.

Projected SFY25 Assessments

Hospital Name	Net Gain (21)	Net Gain (22)
Emory University Hospital Midtown	~$60.4 million	~$62.9 million
Emory University Hospital	~$(3 million)	~$(1.2 million)
Emory Saint Joseph's Hospital of Atlanta	~$(6.5 million)	~$(5.3 million)
Emory Johns Creek Hospital	~$(2.1 million)	~$(1.9 million)
Total	**~$48.8 million**	**~54.5 million**

Atrium Health

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Atlanta, GA 30303
VIA E-Mail: dpp.ideas@dch.ga.gov

October 30, 2024

Dear Commissioner Carlson,

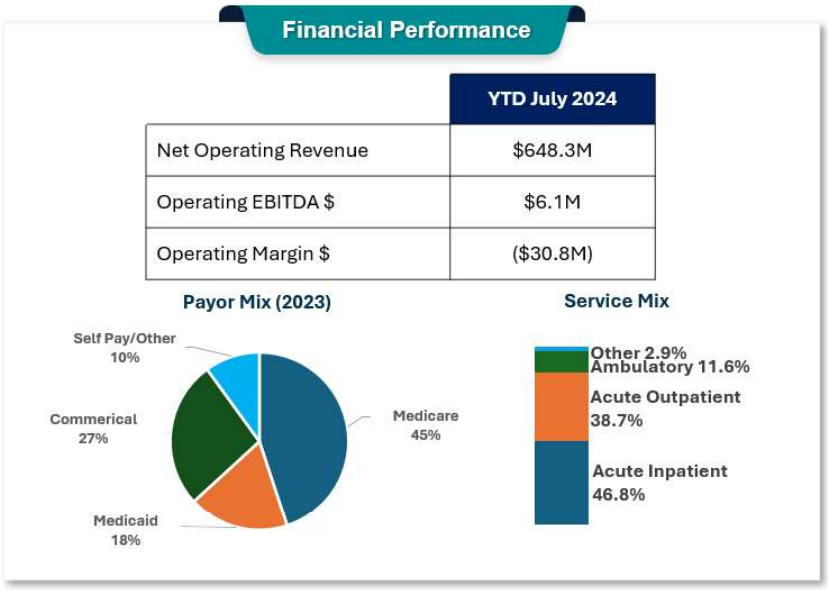
Thank you for the opportunity to provide comments regarding the Georgia Department of Community Health's (DCH) continued commitment to the healthcare provider community. The department's unwavering support for safety net providers through enhanced direct payment program (DPP) initiatives has been instrumental in sustaining access and ensuring quality care for Medicaid patients across Georgia.

AHN serves communities throughout central and South Georgia, predominantly rural areas along the I-75/I-16 interstate corridor. As one of six Regional Perinatal Centers, including a Level III NICU, in 2023 alone, 3,000 mothers gave birth at AHN with over 40% of those births covered by Medicaid. As we continue to support rural access to maternal care, we are committed to collaborating with DCH to further expand this essential service and ensure optimal and equitable outcomes for Georgia mothers and babies.

In addition to maternal care, AHN is dedicated to expanding our women's services including additional exam/procedure rooms, equipment and recruiting new providers/residents. Obstetrics/gynecology residents are expected to increase from 16-20 once state approval is received. The total plan will enable us to treat additional underserved patients with the best quality care available.

We believe that the patient demographics and financial challenges of AHN (*shown in the chart below*) aligns closely with other hospitals such as Grady Memorial and Phoebe Putney, both members of the Georgia's Advancing Innovation to Deliver Equity (GA-AIDE) program. While Grady serves patients statewide from its base in Atlanta and Phoebe Putney is based in South Georgia, AHN serves a critical role in central to South Georgia. AHN is the only Level 1 Trauma south of Atlanta and with the current expansion of trauma bay capacity the ability to better serve patients in this part of the state will increase. Navicent treats over 4,400 trauma patients annually and costs run in excess of $11 million.

Outside of freestanding Children's Hospitals, Navicent ranks second to Grady in the state in costs of Medicaid and Uninsured services with Medicaid Inpatient Utilization exceeding 45%. Despite limited resources, AHN continues to demonstrate our commitment to the community as a safety net hospital. In 2023 alone, we provided over $250M of "community benefit" costs to our community through the provision of charity, uncompensated care, and investments in training future physicians.



We respectfully request that AHN Medical Center be considered for inclusion into the GA-AIDE program effective with the SFY 2026 pre-print approval process. We understand there are necessary investments and improvements required to advance women's services and maternal health, and AHN is prepared to meet the program's outcomes. We believe our inclusion in the GA-AIDE program would greatly enhance our ability to improve women's services, maternal health, and rural access to care in the region.

In summary, we would like an opportunity to meet with you and representatives from DCH to discuss the details of AHN's participation in the GA-AIDE program and to review any necessary requirement for inclusion. The Macon-Bibb Hospital Authority is prepared to support the GA-AIDE program with an intergovernmental transfer (IGT), ensuring that any incremental funding would not require any state financial support.

Thank you once again for your leadership and the continued support of Georgia's healthcare providers. We look forward to partnering with you to further enhance healthcare access and outcomes for our Medicaid patients in Georgia.

Sincerely,

Delvecchio S. Finley

Delvecchio S. Finley, MPP, FACHE
President
Georgia Market
Atrium Health

GA AIDE. AHN FINAL letter 10.30.24 (003)

Final Audit Report 2024-10-30

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Mental Health Funders Collaborative

Enhancing the Wellbeing of Georgia's Youth

Strengthening Youth Mental Health:

Essential Strategies for Georgia's Future

October 2024

Public Works Alliance (PWA) is a collaborative of policy experts, system leaders, researchers, and advocates.

We help public systems that serve children and low income families increase revenue.

We design and implement career development programs for underserved and system-involved youth.

We work for system change that advances communities toward a place where every child has the opportunity to attain their potential, free from discrimination and restores agency and power to underserved communities and families.

Mental Health Funders Collaborative exists to improve the mental health of all young Georgians by strengthening providers, broadening access, and marshalling resources to create a comprehensive and whole-person centered system for youth mental health in Georgia.

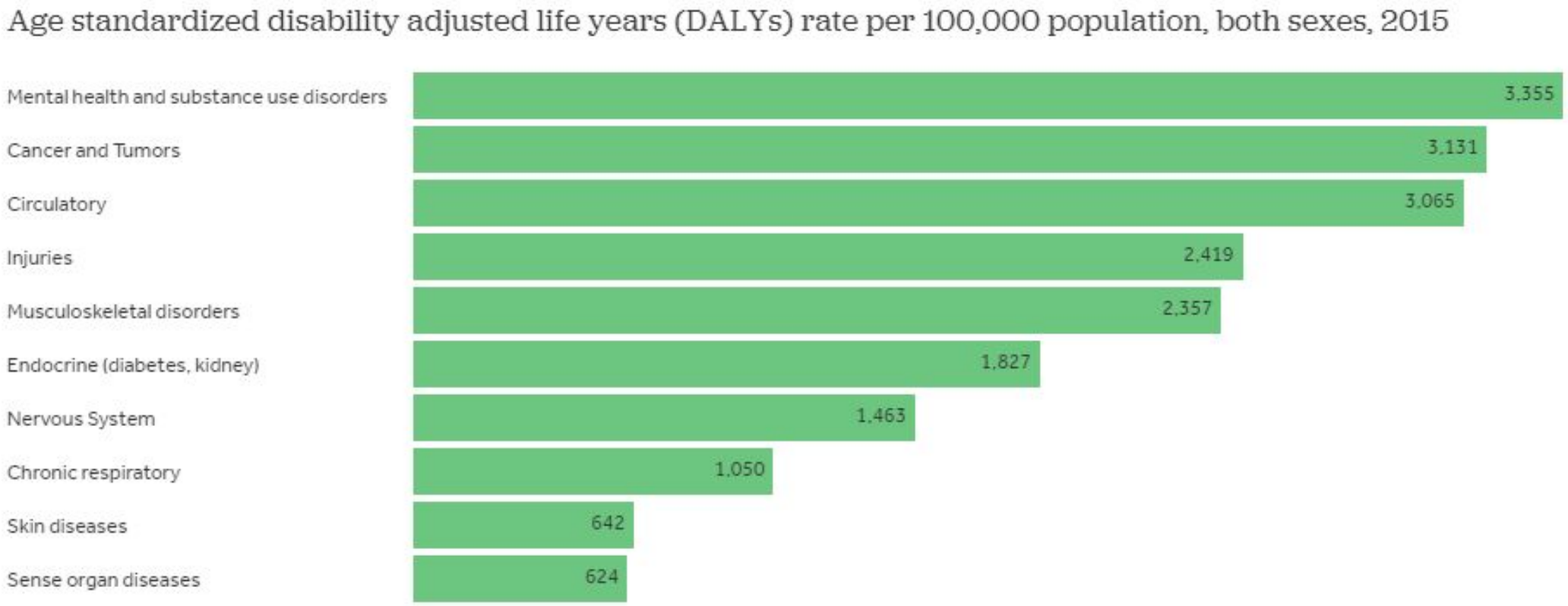
Over 40 donors convene regularly to collaborate, learn, and fund Georgia-focused systems-change efforts that prioritize workforce and access.

October 2024

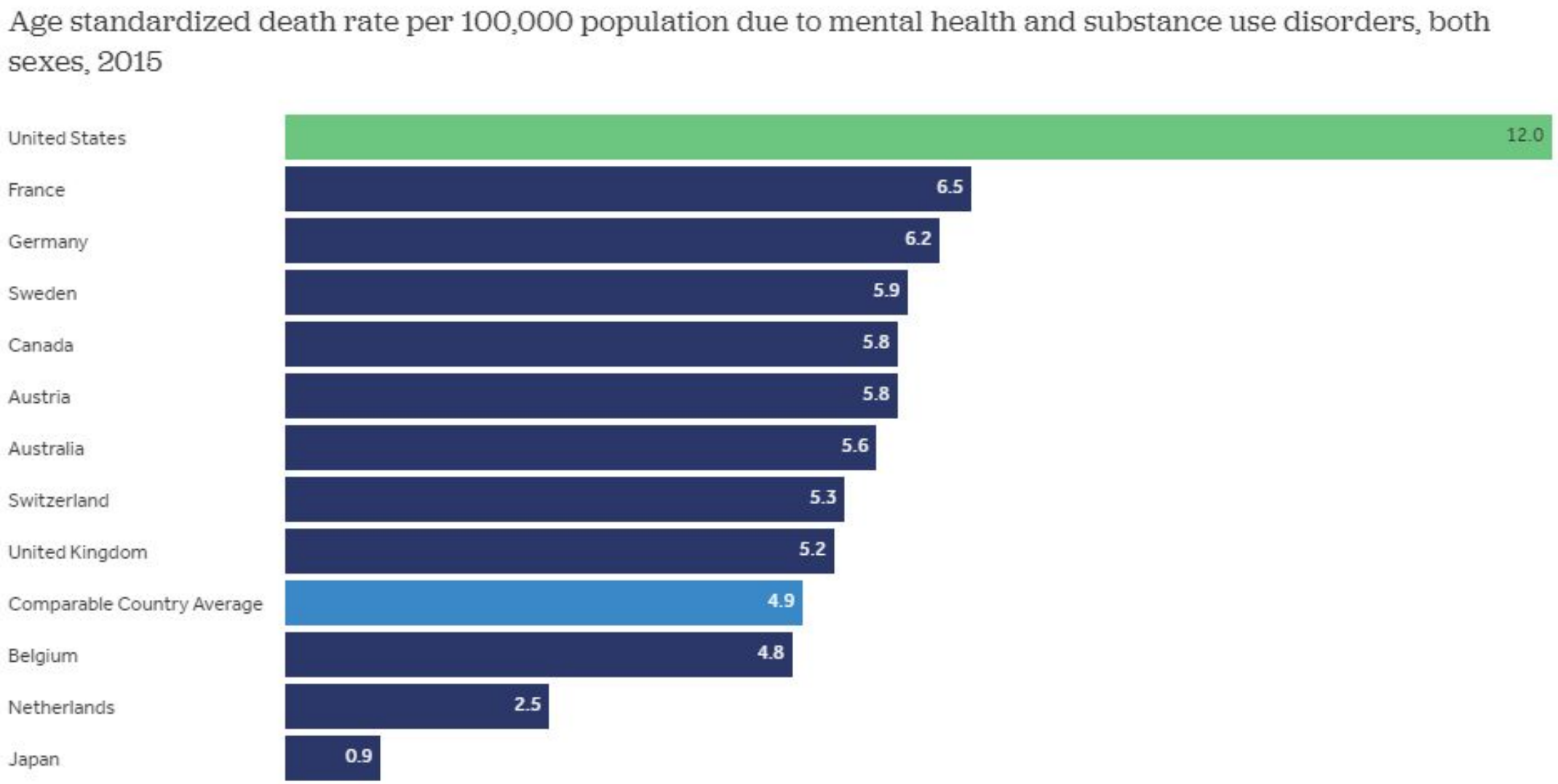
The youth mental health crisis is real.

Mental health & substance use disorders are the leading causes of disease burden in the US.

More than cancers and circulatory/heart diseases.



And this is a uniquely American phenomenon.



This crisis has been growing for youth.

Before the pandemic…

Increase in inpatient visits for suicide, suicidal ideation, and self injury for children ages 1-17 years old, and 151% increase for children ages 10-14 from 2006 to 2011.

Increase in mental health hospital days for children between 2006 and 2014.

…and as a result of the pandemic.

Children's Healthcare of Atlanta has seen the number of children visiting emergency departments for behavioral and emotional crises double from 2015 to 2024.

One in four young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic.

The "Price" is Higher for Rural Children.

Rural teens have a higher prevalence of behavioral health problems, anxiety, and depression than their urban counterparts.

75% of Georgia's counties are rural.

---

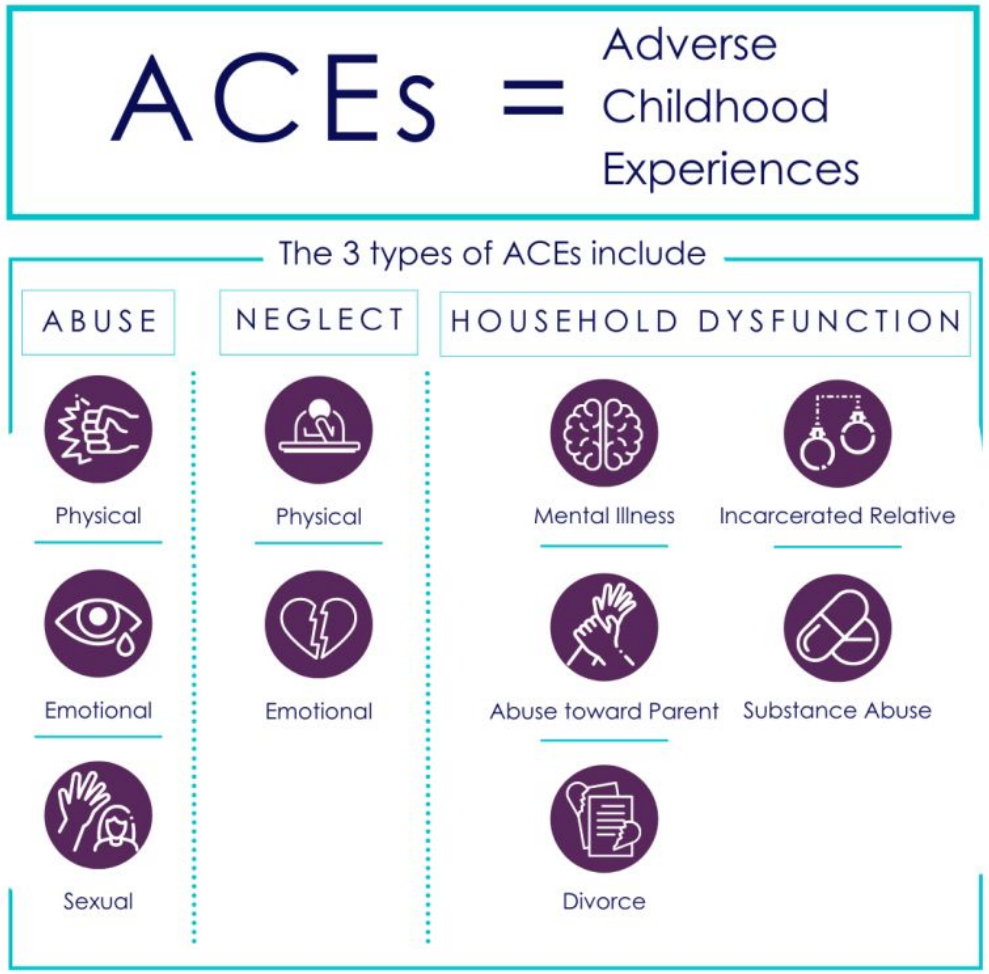
1 in 3 rural children grow up in poverty.

40% of Georgia's counties have no pediatricians.

7

We must address ADVERSITY, not just pathology.

Reimagine mental health as a support for healthy development.



Georgia is a leader in supporting youth mental health.

When we talk about Medicaid in Georgia, we are talking about children.

In Georgia, 53% of children are covered by Medicaid & the Children's Health Insurance Program (CHIP).

69% of participants in Medicaid are under the age of 18.

Children and adults in rural Georgia are enrolled in Medicaid at almost double the rates than those in cities.

Children have unique access to federal matching dollars.

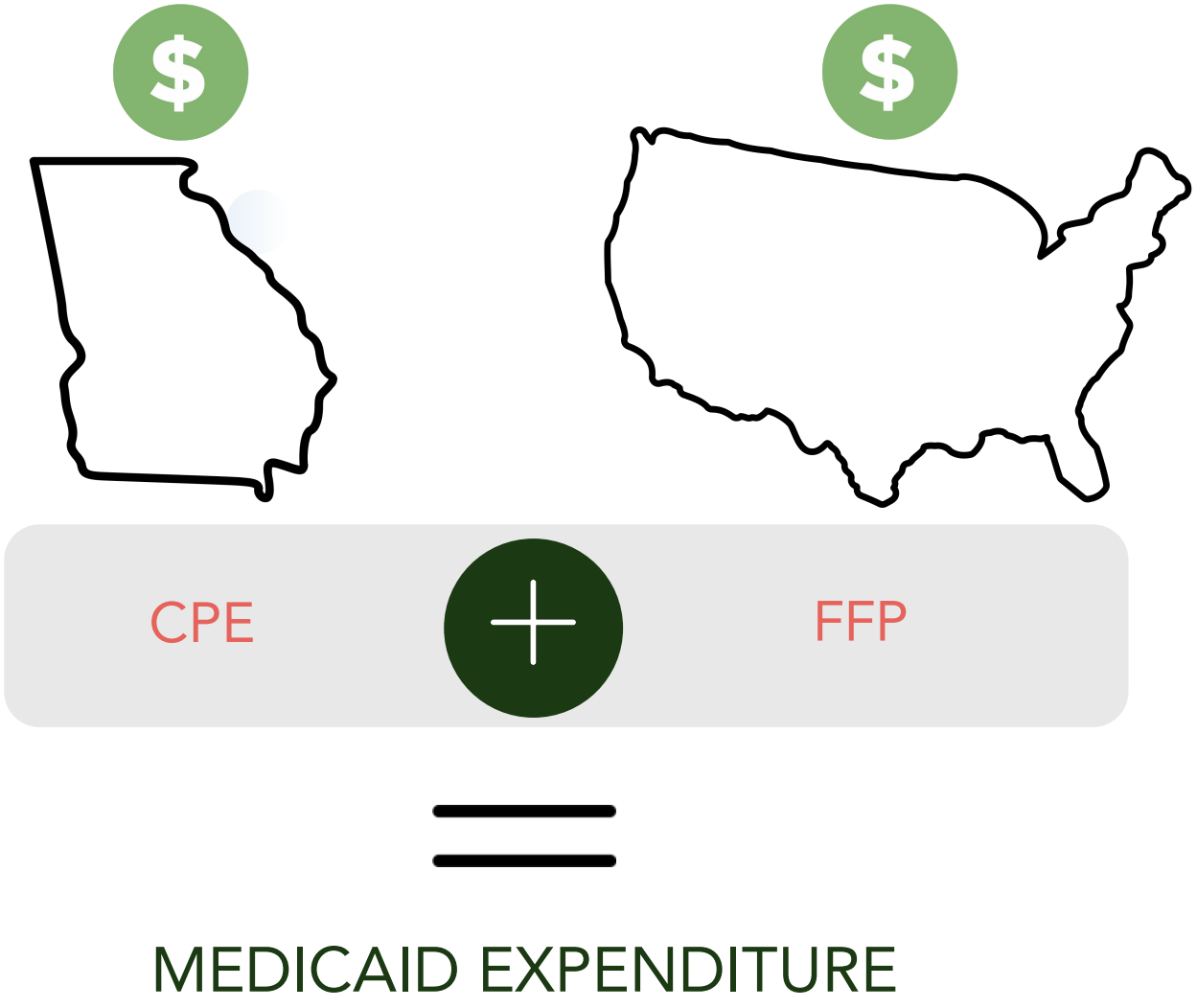
Medicaid guarantees access to care for children through EPSDT (Early and Periodic Screening, Diagnostic and Treatment) benefit.

Georgia's EPSDT screening and referrals have improved dramatically in recent years.

The federal match is GUARANTEED.

Certified Public Expenditure (CPE) A government agency, like a county hospital or local school, spends money that qualifies for federal Medicaid funding according to the state's Medicaid plan.

Federal Financial Participation (FFP) The federal share of Medicaid dollars when all state and federal requirements are met.



Three Managed Care Organizations (MCOs) provide Medicaid coverage for children.

These contracts are up for reprocurement.

Amerigroup

peach state health plan

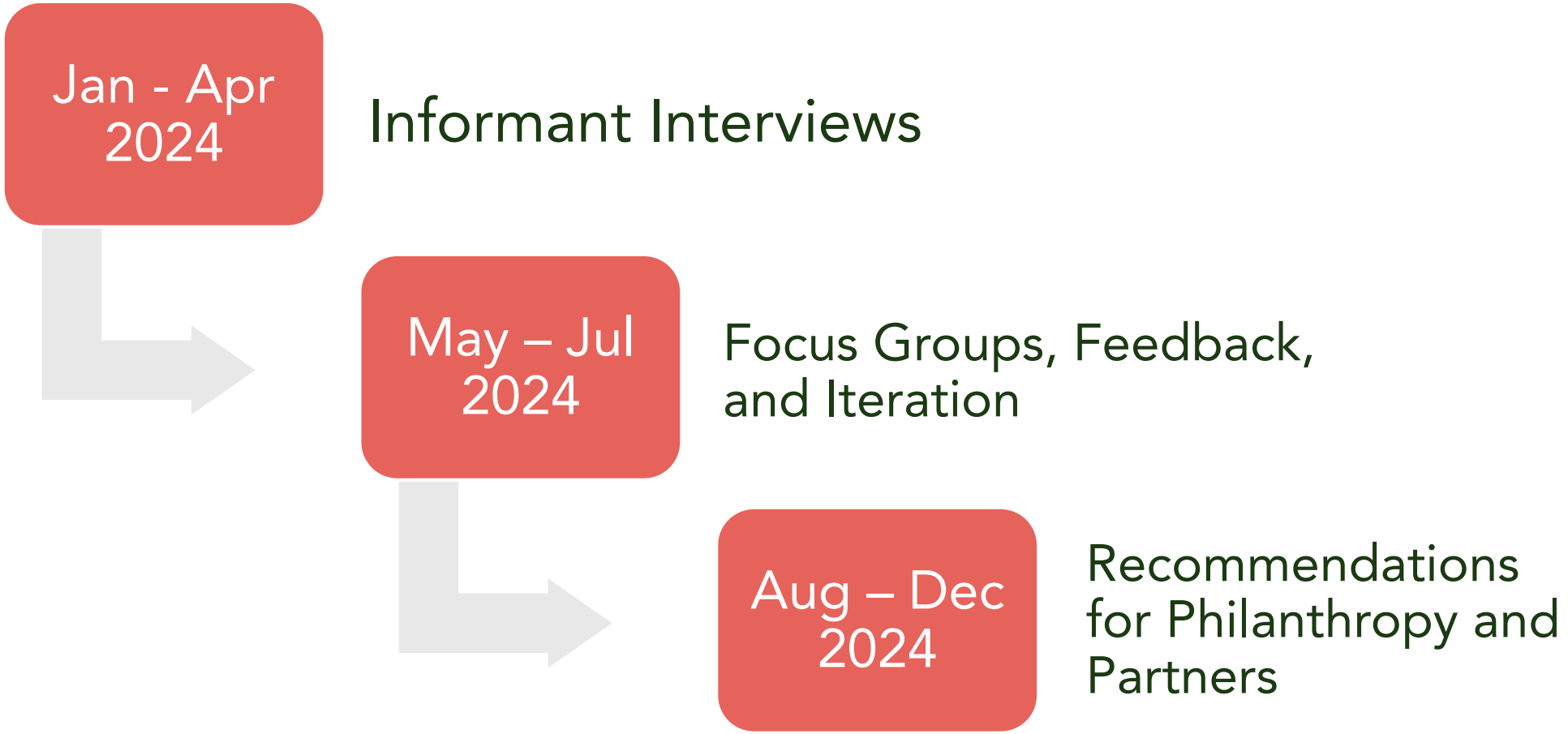
CareSource

Georgia Families®
Choices for a Healthy Life

*Amerigroup also provides coverage for Foster Youth via Georgia Families 360°

Right now is the time to
do more and do it better.

Steps for developing aligned recommendations.



Partners were engaged.

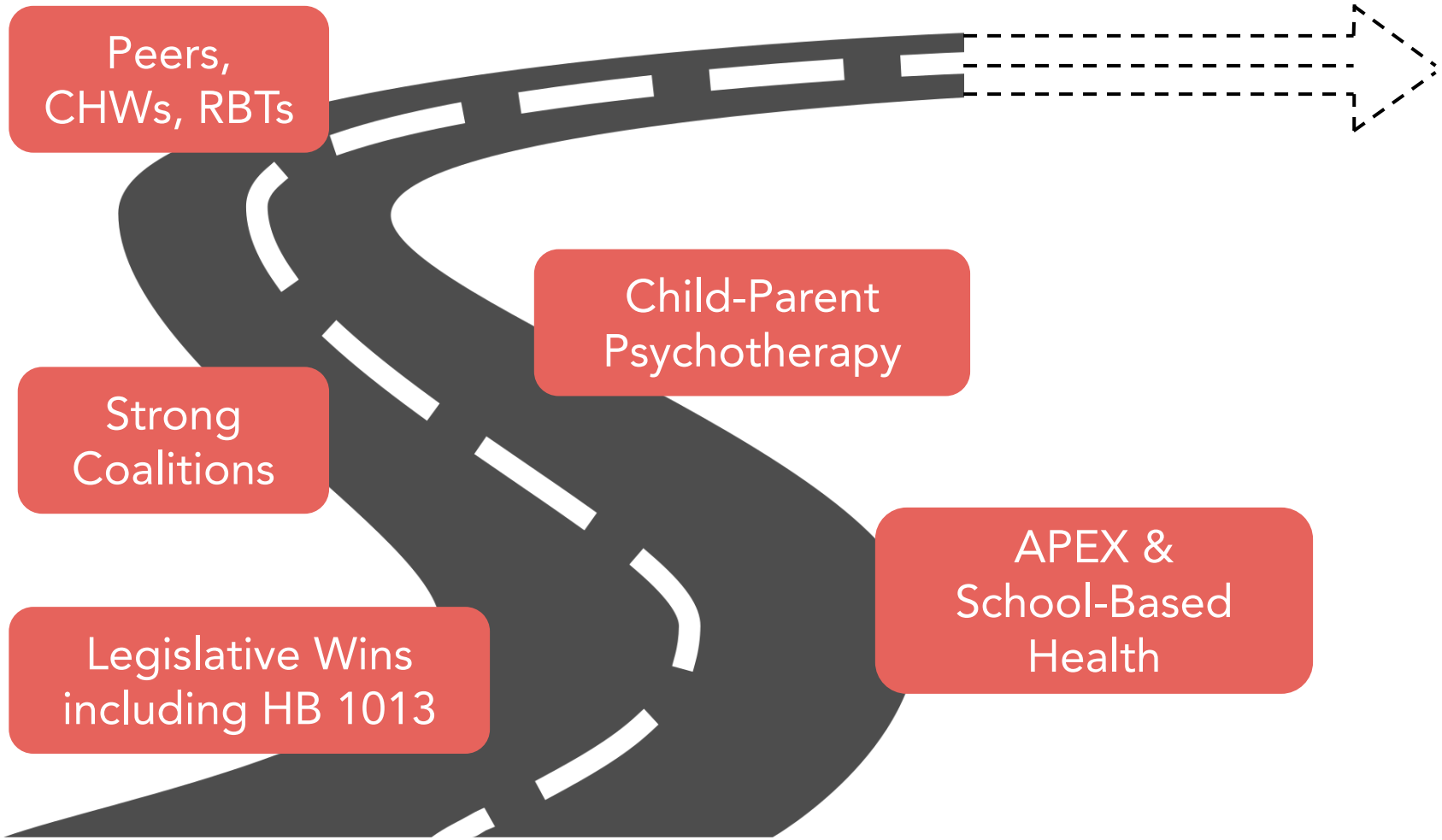
Advocates

Providers

Public Systems

Philanthropy

Georgia is doing incredible work… but has a “last mile” problem.



Efforts are not reflected in reimbursement policies and practice from the Managed Care Organizations.

Strategies to Build on Georgia's Youth Mental Health Work

Strategy

1 Make it Easier to Qualify for Care

Reimagine access criteria and link eligibility to the true drivers of the youth mental health crisis.

2 Meet Children and Families Where They Are

Provide mental health services at pediatric appointments, churches, and schools, and treat parents with their children.

3 Develop, Retain, and Expand the Workforce

Increase access by supporting existing MH staff, streamlining processes for paneling and credentialing, and expanding provider classes.

4 Hold Health Plans Accountable to Children

Acknowledge the centricity of the managed care plans and hold them accountable to the needs of children through benefit design and data dashboards.

5 Go Get the Federal Matching Dollars

Maximize federal matching funds and formally require MCO accountability and contribution.

Center the Experience and Wisdom of Young People

Select Opportunities

1

A. Tie eligibility to social determinants of health, "suspected" diagnosis, housing instability and ACEs.

B. Remove the discretion of a MCO to deny a claim based on the absence of a qualifying diagnosis.

2

A. Socialize and utilize child-parent psychotherapy CPT codes for parents of children ages 0-3.

B. Integrate technology (i.e. telehealth, referral, self-directed care & psychoeducation).

3

A. Support State Plan Amendments to add CHWs, ASWs, MFT Interns, RBTs, doulas, and more.

B. Make it easier for providers to enroll with, and be paneled and credentialed by health plans.

4

A. Include a "Directed Payment Strategy" (bundled payment) in MCO contracts for wraparound services.

B. Create a dashboard that measures which children are receiving what services.

5

A. Identify where the "non-federal share" exists to take advantage of a Directed Payment Strategy with MCOs.

B. Explore the creation of a Health Services Initiative (HSI) using opioid settlement dollars.

Strategies to Build on Georgia's Youth Mental Health Work

Strategy

Make it Easier to Qualify for Care

Reimagine access criteria and link eligibility to the true drivers of the youth mental health crisis.

Meet Children and Families Where They Are

Provide mental health services at pediatric appointments, churches, and schools, and treat parents with their children.

Develop, Retain, and Expand the Workforce

Increase access by supporting existing MH staff, streamlining processes for paneling and credentialing, and expanding provider classes.

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Go Get the Federal Matching Dollars

Maximize federal matching funds and formally require MCO accountability and contribution.

Center the Experience and Wisdom of Young People

APPENDIX: Additional Detail & Opportunities

Strategies to Build on Georgia's Youth Mental Health Work

1. Make it Easier to Qualify for Care
2. Meet Children and Families Where They Are
3. Develop, Retain, and Expand the Workforce
4. Hold Health Plans Accountable to Children
5. Go Get the Federal Matching Dollars

Center the Experience and Wisdom of Young People

STRATEGY 1: Make it Easier to Qualify for Care

Reimagine access criteria and link eligibility to the true drivers of the youth mental health crisis.

Bright Spots & Innovation in Georgia

- HB 1013 passage and defining "medically necessary".
- MATCH Committee forming and defining population of youth with complex treatment needs and their entitled services.

Opportunities to Build on the Momentum

- Redefine what qualifies as medical necessity to be consistent with EPSDT entitlements, which could include use of Adverse Childhood Experiences (ACES), social determinants of health, "suspected" diagnosis, housing instability.
- Remove the discretion of a MCO to deny a claim based on the absence of a qualifying diagnosis.

STRATEGY 2: Meet Children and Families Where They Are

Provide mental health services at pediatric appointments, churches, and schools, and treat parents with their children.

Bright Spots & Innovation in Georgia

- Child-Parent Psychotherapy codes, training, and integration.
- School-based health centers operational at 119 school sites.
- Apex – School-Based Mental Health Program at over 730 school sites.
- An established mechanism for school nurses to bill Medicaid.

Opportunities to Build on the Momentum

- Create a unified vision for how Apex and School-Based Health Centers (SBHCs) work together in an integrated Multi-Tiered System of Support (MTSS) strategy for all children in all schools.
- Integrate technology (i.e. telehealth, referral, self-directed care/psychoeducation), coordination of services, school culture, peer-to-peer, and social-emotional learning in a reimagined MTSS framework.
- Maximize existing DBHDD federal matching opportunities and formally require MCO participation in school-based services and supports.
- Socialize and utilize child-parent psychotherapy CPT codes for parents of children ages 0-3.
- Explore partnerships with Federally Qualified Health Centers (FQHCs) to expand integrated behavioral health for children ages 0-5.

STRATEGY 3: Develop, Retain, and Expand the Workforce

Increase access by supporting existing MH staff, streamlining processes for paneling and credentialing, and expanding provider classes.

Bright Spots & Innovation in Georgia

- First state to request and receive Medicaid reimbursement for Certified Peer Support Specialists – since 1999.
- Community Health Workers.
- Registered Behavioral Health Technicians.
- Georgia Crisis Access Line (GCAL) 988.

Opportunities to Build on the Momentum

- Support State Plan Amendments to expand who can provide reimbursable youth mental health services to include Community Health Workers (CHWs), Associates in Social Work (ASWs), Marriage and Family Therapist Interns (MFTIs), Registered Behavioral Technicians (RBTs), Doulas, and more.
- Collaborate with EMS and Hospital-Based Violence intervention programs to expand reimbursement opportunities for violence prevention and alternative response.
- Add AMFT and ASW by state plan amendment and activate FQHCs.
- Bring new provider classes into Medicaid state plan to increase access and promote delivery system reform.
- Strengthen security clearance process to align with and expand extender community-based workforce.
- Streamline the administrative process for provider enrollment, credentialing, paneling and contracting within Georgia Medicaid.
- Provider/community training for pre-psychosis signs / symptoms (aka “first break work”).

Georgia Professional Certifications

Certified Peer Specialist (CPS): A trained professional who uses their personal experience with mental health or substance use challenges to provide support and guidance to others in similar situations.

Community Health Worker (CHW): frontline health worker who is familiar with the community and often shares similar life experiences, language, and background, helping them better understand and address patients' needs.

Doula: A trained professional who offers emotional, physical, and informational support before, during, and after childbirth.

Registered Behavior Technician (RBT): A trained professional who provides direct support and implementation of behavior intervention plans under the supervision of a behavior analyst.

Intern or Associate Social Worker (ASW)/ Associate Marriage & Family Therapist (AMFT): An individual in the early stages of their career in the field of social work or marriage and family therapy.

Licensed Therapist: A highly trained mental health professional authorized to provide therapeutic interventions and support to individuals dealing with emotional, psychological, or behavioral challenges.

Provider Expansion Essential Considerations

Rates

What is the time, frequency, duration, and reimbursement level of all eligible services? Does it reflect a living wage?

Credentialing

Who is responsible for curriculum development, certifying the content and quality of the training, defining the core competencies, and certifying attainment?

Scope

What can the provider do, in what setting, under what supervision and articulation, and what codes will they bill? Are community defined and culturally concordant practices specifically named and included?

Payor

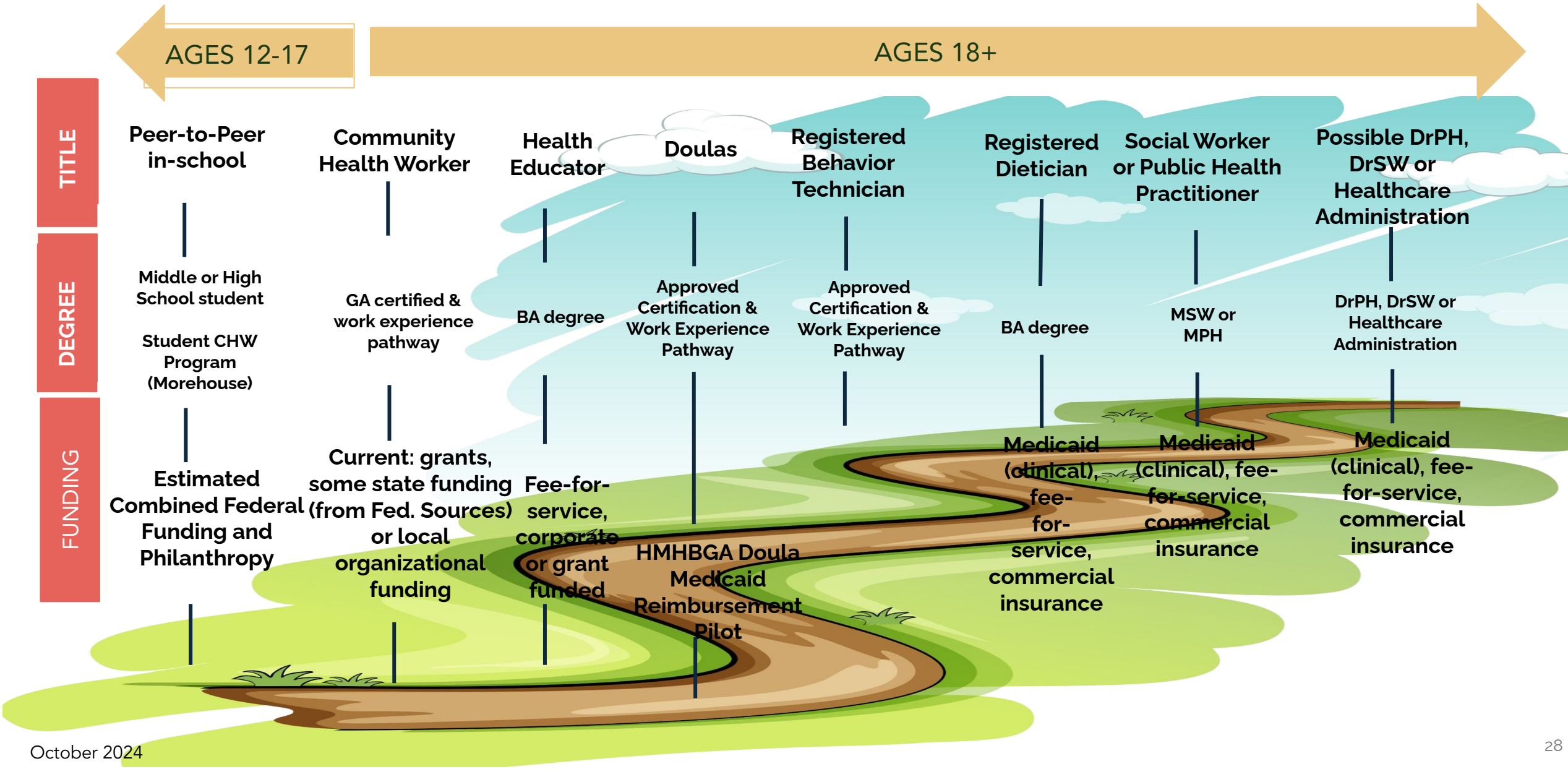
Who pays the claim - the MCO or Mental Health Plan? Under what authority and what process?

Paneling

How does the new class sign-up with the payor? What is the required process and documentation?

Possible Medicaid Reimbursable Career Pathways to Support CHWs

Leveraging and Integrating The Wisdom and Experience of Culturally Concordant Providers



Special Projects

12 YEARS OF EMS CORPS

24+ COHORTS
289 GRADUATES
88% PROGRAM PASS RATE SINCE 2017
350+ WORKING

- 30 PURSUED HIGHER ED
- 20+ FIRE FIGHTERS
- 4 POLICE OFFICERS
- 3 DOCTORS
- 2 IN MEDICAL SCHOOL
- 2 MILITARY NURSES
- 1 COAST GUARD

STRATEGY 4: Hold Health Plans Accountable to Children

Acknowledge the centricity of the managed care plans and hold them accountable to the needs of children through benefit design and data dashboards.

Bright Spots & Innovation in Georgia

- 20 new oversight positions in DCH for MCO contracts.
- Conversion to CCBHCs.

Opportunities to Build on the Momentum

- Have MCOs open Z-codes to allow billing for Adverse Childhood Experiences (ACES) and other social determinants of health and remove diagnosis as a prerequisite for care.
- Include a "Directed Payment Strategy" (bundled payment) in MCO contracts for developing an Assertive Community Treatment (ACT) team benefit for wraparound services for high-acuity youth (MATCH).
- Standardize discharge benefit for all children transitioning from residential care with a focus on MATCH youth.
- Support strategy for growth complex-care residential bed continuum for high-acuity youth (MATCH).
- Develop tiered care coordination benefit structure for MCOs and DBHDD.
- Explore housing and housing-enabling services as a Medicaid benefit by submitting an 1115 Waiver or establishing "in lieu of services" options for transitional rent or housing for high-acuity youth (MATCH).
- Ensure a faithful conversion from CSBs to CCBHCs that supports higher reimbursements of services.
- Professional development and capacity building for new CMO accountability staff at DCH.

STRATEGY 5: Go Get the Federal Matching Dollars

Maximize federal matching funds and formally require MCO accountability and contribution.

Bright Spots & Innovation in Georgia

- Rate study implementation by DBHDD, to yield additional Federal matching funds.

Opportunities to Build on the Momentum

- Analyze budgets of DCH, DBHDD, DFCS, Apex and select CBOs for Medicaid Administrative Activities (MAA) claiming potential.
- Explore S-CHIP Health Service Initiative (HSI) for early childhood.
- Pursue Directed Payment Program / rate range intergovernmental transfer (IGT) at DCH.
- Explore opioid settlement dollars opportunity for federal matching.

THROUGHLINE:
Center the Experience and Wisdom of Young People

Cultivate youth voice and communication strategy for movement building.

Bright Spots & Innovation in Georgia

- Strong and engaged coalitions and youth organizations including MAAC, The Deep Center, Youth Move, Youth Justice Coalition.

Opportunities to Build on the Momentum

- Cultivate a cadre of youth leaders and youth-serving organizations to hold systems and philanthropy accountable to what young people want and need.

- Support HB1013 parity law, implementation, and fidelity measures.

MHFC Leadership Council

Beth Brown, Arthur M. Blank Family Foundation, Co-Chair
Brittany Collins, Betty & Davis Fitzgerald Foundation, Engagement Co-Catalyst
Dick Hallock, The John and Polly Sparks Foundation, Treasurer
Bonnie Hardage, Jesse Parker Williams Foundation, Co-Chair
Ebony Johnson, United Way of Greater Atlanta, Grantmaking Co-Catalyst
Mary-Flynn Niemetz, Trinity Community Partners, Engagement Co-Catalyst
Mary Spanburgh, Kaiser Permanente, Grantmaking Co-Catalyst

Mental Health Funders Collaborative
Enhancing the Wellbeing of Georgia's Youth

The "Price" is Higher for Black and LGBTQ+ Children.

	Black Youth	LGBTQ+ Youth
Poverty	Half the children living in poverty in Georgia are Black	40% of homeless youth in Atlanta identify as LQBTQ
Access	Uninsured rates are highest for Black children	64% of LGBTQ youth in Georgia who wanted mental health care in the past year were not able to get it
Workforce	In the US, only 4% of therapists are Black	Finding culturally competent therapists is particularly challenging for LGBTQ youth of color
Outcomes	Suicide rates are rising among Black youth in Georgia faster than any other racial/ethnic group	46% of LGBTQ youth in Georgia seriously considered suicide in the last year


Black Girls Smile, Atlanta

Mental Health Funders Collaborative

Enhancing the Wellbeing of Georgia's Youth

Georgia Youth Mental Health Systems Change

October 2024

Wellstar

October 31, 2024

Russel Carlson
Commissioner
Georgia Department of Community Affairs
2 Martin Luther King Jr. Drive SE East Tower
Atlanta, GA 30334 US

Dear Commissioner Carlson,

Wellstar Health System is pleased to offer the following comments on the continuation of the Strengthening The Reinvestment of a Necessary-workforce in Georgia (GA-STRONG) program.

We would like to commend the Department for its vision and commitment in crafting GA-STRONG to address the healthcare workforce shortage in Georgia while improving health outcomes and quality statewide. The innovative payment structure of the program ensures that teaching hospitals in Georgia receive adequate payment to deliver effective, efficient, and affordable care. The additional funding provided through this program would allow Wellstar to grow our healthcare workforce and enhance the access and delivery of services to Georgians across the spectrum of care. Wellstar Spalding Regional Hospital is a particularly good example of the importance of GA-STRONG funding. Wellstar has made significant investments in this rural hospital, which already faces financial headwinds, and without the assurance of the GA-STRONG funding, its long-term viability will be further weakened.

While we understand it takes time to develop a program that meets these goals, we would respectfully request that DCH utilize the following FY 26 program amendments regarding eligibility:

- Continue the minimum 5 FTE resident threshold for hospital participation in GA-STRONG
- Utilize the latest available cost reports in the pre-print submission to CMS – the FY 2023 Medicare cost report.

GA-STRONG was established to address Georgia's shortage of healthcare workers by creating an incentive for providers, like Wellstar, to invest in GME programs. Implementing the amendments above would go a long way in helping the Department meet those goals.

Sincerely,

Joseph A. Reppert
Senior Vice President, Interim Chief Financial Officer
Wellstar Health System

October 31, 2024

Commissioner Russel Carlson
Georgia Department of Community Health
2 Martin Luther King Jr. Drive SE, East Tower
Atlanta, GA 30334

Dear Commissioner Carlson:

On behalf of our 150 member-hospitals, the Georgia Hospital Association (GHA) appreciates the opportunity to provide suggestions for the future of Georgia's Directed Payment Programs (DPPs). Our proposals are designed to support key policy areas that are critical to the health and well-being of all Georgians. Specifically, our recommendations aim to support the following:

1. **Behavioral Health:** Increase access to and funding for behavioral health services throughout the state, ensuring that more individuals can receive the mental health care they need.

2. **Rural Health:** Enhance the financial stability of rural hospitals and improve access to maternal care for rural communities.

3. **Quality Strategy Alignment:** Align with the Department of Community Health's (DCH) quality strategy, including supporting programs that maintain and expand access to obstetric care, which is vital for the health of mothers and newborns in rural areas.

As you consider program changes for SFY 2026, several recommendations, highlighted below, will ensure that we continue to address these critical areas so that Georgia can continue to provide innovative, quality care to improve health outcomes for Georgians.

1. **STRENGTHENING THE REINVESTMENT OF A NECESSARY-WORKFORCE IN GEORGIA (GA-STRONG) – Annually Update the Medicare Cost Report and Available Data**

GA-STRONG is designed to address Georgia's healthcare workforce shortage by providing increased funding to teaching hospitals, enabling them to expand innovative programs, stabilize and diversify the healthcare workforce, and ultimately improve patient outcomes. State fiscal year 2025 eligibility for GA-STRONG is based on hospitals' 2022 Medicare cost reports. To recognize hospitals that have invested in graduate medical education (GME) programs in more recent years, **GHA recommends annually updating the Medicare Cost Report year for GA-STRONG eligibility to utilize the most recent data available, specifically the 2023 cost reports for state fiscal year 2026.** This update bolsters the overall goal of GA-STRONG to grow the healthcare workforce by acknowledging the financial contribution of all hospitals with GME programs and incentivizing more hospitals to invest in workforce training.

2. **GEORGIA'S ADVANCING INNOVATION TO DELIVER EQUITY (GA-AIDE) – Include Hughes Spalding Hospital**

We support the inclusion of Hughes Spalding Hospital in the GA-AIDE program. Hughes Spalding Hospital provides comprehensive pediatric specialties and subspecialties, serving as a critical safety net for underserved and vulnerable populations in Atlanta and across Georgia. Due to its unique affiliations with Grady Health System, which is already a participant, and Children's Healthcare of Atlanta, the inclusion of Hughes Spalding Hospital offers an opportunity to improve Georgia's care for pediatric Medicaid patients by improving access to screening and prevention services and addressing health equity for the medically underserved. Hughes Spalding Hospital's participation will have no negative impact on existing GA-AIDE participants.

3. **DEVELOP THREE NEW DIRECTED PAYMENT PROGRAMS**

Hospitals Providing Obstetric Care in Rural Areas

GHA recommends a new DPP for hospitals providing obstetric care in rural areas (the "OBDPP"). Rural hospitals are often the primary, if not the only, source of obstetric care for their communities. However, these services are costly, and reimbursement often does not cover the total cost of care. Providing these hospitals with enhanced funding through OBDPP payments will help ensure that expectant mothers and newborns receive the care they need close to home, reducing the risks associated with long travel distances for medical services. The OBDPP would help improve the financial stability of rural hospitals, enabling them to invest in necessary infrastructure, staff, and services to maintain and potentially increase the number of rural hospitals offering obstetric care.

Based on GHA's modeling, the additional OBDPP payments for both public and private hospitals are projected to cause eligible hospitals to hit their hospital-specific limits in the Disproportionate Share Hospital (DSH) program. Those funds could be reallocated to other private hospitals.

Psychiatric Hospitals

GHA recommends a new DPP for free-standing psychiatric hospitals (the "PsychDPP"), equivalent to the payment increases under the existing Hospital DPP. Supporting behavioral health is vital for the well-being of our communities. The PsychDPP will help ensure that psychiatric hospitals have the necessary resources to offer comprehensive behavioral health services. This includes addressing the needs of individuals with severe mental health conditions, reducing the burden on emergency departments, and providing a continuum of care that supports long-term recovery and stability.

As noted in our letter dated Aug. 27, 2024, independent psychiatric hospitals have, until recently, been ineligible to receive Medicaid payments.[1] However, federal law now allows for Medicaid care management organizations to make payments to psychiatric hospitals. By creating a Psych DPP,

[1] Since its inception in 1965, the Medicaid program has prohibited payments to institutes for mental disease (IMDs) for services provided to adult, non-elderly beneficiaries. Most independent psychiatric hospitals are categorized as IMDs.

Georgia would align with several other states' Medicaid programs that have already implemented similar initiatives to support access to behavioral health services. To use the Hospital Medicaid Financing Program to help finance the PsychDPP, a statutory change to O.C.G.A. § 31-8-179.1 is necessary to allow psychiatric hospitals to participate in the program.

Outpatient Services at Free-Standing Children's Hospitals

We recommend a new DPP for outpatient services provided at private free-standing children's hospitals to increase reimbursement to the Medicare equivalent (the "PFCDPP"). These facilities manage complex and high-acuity cases, making them critical to the healthcare infrastructure for Georgia's pediatric population. Additionally, the PFCDPP would significantly support the specialized behavioral health services for children provided by these facilities. The new PFCDPP will help ensure free-standing children's hospitals have the necessary resources to expand and enhance their outpatient behavioral health services. This will help more children receive timely and effective behavioral health care, reducing the long-term impact of untreated behavioral health issues, including the need for hospitalization, residential treatment, or other more-intensive services.

In conjunction, the PsychDPP and PFCDPP will work in tandem to ensure that both the inpatient and outpatient needs of behavioral health patients are supported and that we continue to prioritize improvements in the behavioral health continuum of care across the state.

4. Seek CMS Approval to Add New Provider Class-Specific Rates to the Hospital Provider Fee

We recognize the significant value of the existing provider fees collected under the Hospital Medicaid Financing Program, which have enabled private hospitals to participate in the DPP. The state's provider fee structure requires a waiver from the Centers for Medicare and Medicaid Services (CMS) to certain portions of the federal regulations governing provider taxes used to finance the state share of Medicaid payments. Unfortunately, the current waiver limits the state's ability for private hospitals to participate in the three new DPPs recommended above without negative consequences to the existing DPPs. **GHA recommends the Department seek CMS approval of a revised waiver that would allow for sustainable expansion of the DPP.**

According to GHA's modeling, private hospitals in existing programs could continue to be assessed using the current methodology, while private hospitals participating in a new DPP would be assessed at a provider class-specific rate.

5. Transparency and Communication Throughout all Directed Payment Programs

We appreciate the Department's extensive work in the development and maintenance of the existing DPPs. We understand the complexities involved with annual CMS approvals and the need to reconcile payments across various stakeholders. However, **we respectfully request greater transparency regarding both payment schedules and amounts.** Currently, the timing of payments is unclear, and hospitals are often required to provide IGTs and assessment payments on very short notice, sometimes

less than a week. This unpredictability can strain financial planning and budgeting, creating cash flow challenges, particularly for smaller hospitals.

Information regarding the payments for other Medicaid supplemental payment programs (e.g., DSH and UPL) is posted online. **We respectfully request similar payment information be provided for the various DPP payments.** Hospitals frequently struggle to understand how their payments are calculated or even which period the payments cover—whether interim or prior year reconciliation.

To alleviate any added burden on the Department, GHA would be glad to assist with communications. **We suggest implementing regular webinars or update meetings,** perhaps on a quarterly basis, to keep all stakeholders informed. GHA is available to help coordinate and prepare materials for these sessions. Such measures would enhance transparency, improve financial planning, and ensure that hospitals can continue to provide high-quality care to Medicaid beneficiaries.

6. MANAGED CARE FINAL RULE

Under its recent Managed Care Final Rule,[2] CMS will prohibit the use of separate payment terms and require all state directed payments to be included in actuarially sound capitation rates effective for rate years beginning after July 9, 2027. Because of complexities associated with this change, we strongly recommend the Department collaborate with its actuaries in the immediate future to prepare for implementation.

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We are grateful to the Department for its diligent work on the complex financing and implementation of the state's DPPs and for consideration of our comments. Your efforts have been instrumental in advancing healthcare quality and access across Georgia.

GHA has prepared detailed financial modeling for our new program recommendations. We look forward to sharing these insights with the Department and are eager to collaborate to move these initiatives forward. Our team is available and ready to assist in any capacity to ensure the successful implementation of these recommendations, ultimately benefiting all Georgians.

Sincerely,

Carie Summers

Carie Summers
Chief Financial Officer

[2] Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Fed. Reg. 41002 (May 10, 2024).

October 31, 2024

Commissioner Russel Carlson
Georgia Department of Community Health
2 Martin Luther King Jr. Ave
Atlanta, GA 30303

Dear Commissioner Carlson:

On behalf of Grady Health System, a proud participant in the Georgia Advancing Innovation to Deliver Equity (GA-AIDE) program, we are grateful for the opportunity to provide input on the future direction of Georgia's Directed Payment Programs (DPPs). We believe that Georgia's leadership in Directed Payment Innovation has set a national standard: making great strides in Medicaid quality improvement, improving access to care, advancing health equity, and ensuring workforce stability. Grady remains committed to supporting the state's goals of improving the provision of healthcare services for Medicaid beneficiaries through innovative approaches.

As a hospital deeply engaged in the GA-AIDE program, we would like to offer the following recommendations to further strengthen and optimize the state's DPP's:

1. Consistency and Clear Communication for Payment Timing
One of the hallmarks of a successful directed payment program is its reliability and clear measures of success. The existing GA-AIDE program has made significant progress in fostering accountability and aligning payments with service delivery improvements. However, there is a critical need for more consistent and transparent communication regarding payment timelines. Hospitals, including Grady, rely on predictable payment schedules to continue program investments required to meet quality targets, which includes effectively managing cash flows, ensuring operational continuity, and meeting our workforce obligations.

While Grady appreciates that DCH moved quickly to take advantage of COVID flexibilities to reduce Intergovernmental Transfer requirements, we urge the Department to now establish a more consistent and transparent process for communicating payment schedules to participating providers.

Currently, the timing of payments is unclear, causing uncertainty that can strain hospital resources. A clear schedule, regularly updated with any anticipated delays, would alleviate the

financial planning challenges that hospitals face, ultimately ensuring that we can continue to provide the high-quality care that Medicaid beneficiaries deserve.

2. Exploring the Opportunity for Multi-Year Approvals
To streamline the administrative processes and create longer-term financial stability for providers, Grady encourages the Department to explore the opportunity for multi-year approvals within the DPP structure. By providing multi-year approval cycles, the Department could reduce the administrative burden on both the state and providers, allowing hospitals to focus more on service delivery improvements and long-term planning.

Multi-year approvals would also provide greater predictability in funding and would better align payment structures with the multi-year nature of hospital capital investments and workforce development initiatives. Given the complex nature of DPP's and aligning with future requirements within the Medicaid managed care rule, we recommend the Department seek technical assistance from CMS should it decide to explore multi-year approvals.

However, if multi-year approvals are not feasible within the current structure, we recommend revisiting the existing interim payment approach.

3. Two Interim Payments Instead of One
Grady recommends a revision to the proposed interim payment structure of the Hospital DPPs. As proposed, providers receive a single interim payment, which can create difficulties in managing operational costs throughout the fiscal year. We propose splitting the interim payment into two distributions. This change would provide hospitals with a more stable cash flow throughout the year, better aligning financial resources with service provision and operational needs.

Two interim payments would also reduce the financial strain placed on providers during the wait for the final settlement. By ensuring that providers are more financially balanced throughout the year, the Department would support improved resource allocation toward patient care, workforce development, and service delivery innovation. This proposed adjustment aligns with the state's mission to bolster healthcare services through smarter spending by making the flow of funds more consistent and predictable.

4. Development of an EMS Directed Payment Program (DPP)
The current Georgia DPPs are supplementing innovations for the hospitals and qualifying physician groups; however, there is an additional opportunity for quality driven improvements for Emergency Medical Services (EMS). While the current upper payment limit funding within the fee-for-service system has helped bolster the EMS network's ability to fill coverage gaps for patients across the state, funding remains an impediment to growth and

access. Grady is a public provider with the highest volume of Medicaid EMS transports. We are proposing a Public EMS DPP through which the same public EMS providers that are paying an inter-governmental transfer in the existing EMS UPL program would participate. The DPP could allow for Medicaid supplemental payments in managed care that advance the state's Quality Strategy through a documented, data-driven evaluation plan based on NEMSQU benchmarks. The implementation of a DPP for the state's public providers would also moderate funding gaps to address workforce shortages. Limited Medicaid rate increases have not adequately compensated providers for lifesaving services, and this makes hiring, training, and retaining personnel difficult.

Given these needs, the implementation of a DPP for the state's public providers would moderate funding gaps and workforce shortages while ensuring widespread healthcare access for Georgia's most vulnerable populations.

5. Including Hughes Spalding in GA-AIDE

To further align with the objectives of the GA-AIDE program, Grady strongly recommends including Hughes Spalding Children's Hospital, managed by Children's Healthcare of Atlanta (CHOA), in the GA-AIDE program. Hughes Spalding serves a critical role in providing pediatric care to underserved and vulnerable populations in Atlanta and across Georgia.

By incorporating Hughes Spalding into the GA-AIDE framework, the program could expand its impact on addressing healthcare disparities among the state's pediatric Medicaid population, while also supporting health equity and workforce development in pediatric care. Including a children's hospital of this scale would also ensure that GA-AIDE's objectives are met across the full spectrum of care, from neonatal and pediatric services to adult care, creating a more cohesive and inclusive approach to Medicaid-funded healthcare improvements.

6. Addressing the Recently Finalized Managed Care Rule

Considering the recently finalized managed care rule, Grady recognizes the importance of adapting to the changes in regulatory guidelines that impact Directed Payment Programs. Specifically, the rule prohibits separate payment terms between Care Management Organizations (CMOs) and providers, which directly affects the operational mechanics of DPPs. This presents new challenges that require clear and proactive guidance from the state to ensure all stakeholders are adequately prepared for the rule's implications.

We strongly recommend that the Department take immediate steps to provide clear, actionable guidance to CMOs and providers on how the state intends to align with this prohibition on separate payment terms. Without proper preparation, both CMOs and healthcare providers may struggle to navigate the financial and contractual complexities that arise from the new

rule. A comprehensive educational initiative led by the Department would ensure all parties understand the changes and how they impact payment structures within DPPs.

To ensure a smooth transition to compliance with the new managed care rule, we urge the Department to engage in active outreach and provide dedicated resources for CMOs and providers. This should include clear communication about how the prohibition of separate payment terms will be operationalized within existing DPP agreements and what modifications will be required at both the CMO and provider levels.

We recommend hosting a series of state-led workshops or webinars where CMOs, providers, and other key stakeholders can discuss the forthcoming changes and work collaboratively to find solutions. These sessions would foster a shared understanding of the changes, while also providing an opportunity to raise concerns, clarify expectations, and work through potential operational challenges. The Department's leadership in this transition will be crucial to minimizing disruptions to the care delivery process while maintaining the integrity of the DPP structure.

Grady Health System appreciates the opportunity to offer our recommendations for the continued improvement of Georgia's Directed Payment Programs. We believe that Georgia is setting the standard for innovation in Medicaid payment structures, and by refining the consistency of payment timing, exploring multi-year approvals, implementing a two-interim-payment structure, expanding the DPP model to include EMS and Hughes Spalding Children's Hospital, and addressing the new managed care rule, the Department will continue to lead the nation in ensuring that Medicaid beneficiaries receive high-quality, equitable, and accessible care.

We look forward to continuing our partnership with the Georgia Department of Community Health and remain available to provide further insights or clarification on our recommendations. Thank you for your leadership and commitment to advancing healthcare in Georgia.

Sincerely,

Ryan Loke
Chief Health Policy Officer
Grady Health System

August 27, 2024

Via Email at dpp.ideas@dch.ga.gov

Russel Carlson, Commissioner
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower
Atlanta, GA 30334

Dear Commissioner Carlson,

We appreciate the opportunity to provide input on potential changes to the state's Medicaid Directed Payment Programs (DPP) for state fiscal year 2026. On behalf of our psychiatric hospital members, we request your consideration for the development of a DPP for psychiatric hospitals to support and enhance the delivery of essential behavioral health services across the state. Until recently, independent psychiatric hospitals have been ineligible to receive Medicaid payments.[1] However, federal law now allows for Medicaid care management organizations to make payments to psychiatric hospitals.[2] A DPP for psychiatric hospitals will help to improve Medicaid patients' access to inpatient psychiatric services, which are vital in the behavioral health continuum of care. By taking this step, Georgia would align with several other states' Medicaid programs that have already implemented similar initiatives to support access to behavioral health services.

The state uses revenue collected under the Hospital Medicaid Financing Program to help finance the state share of payments made through the existing DPPs. A statutory change would be necessary to use this same financing method for a psychiatric hospital DPP. To that end, we suggest the following amendment to O.C.G.A. 31-8-179.1 (3):

> "Hospital" means an institution licensed pursuant to Chapter 7 of this title which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, **psychiatric**, and other specialty hospitals but shall not include ~~psychiatric hospitals which shall have the same meaning as facilities as defined in paragraph (7) of Code Section 37-3-1,~~ critical access hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

[1] Since its inception in 1965, the Medicaid program has prohibited payments to institutes for mental disease (IMDs) for services provided to adult, non-elderly beneficiaries. Most independent psychiatric hospitals are categorized as IMDs.

[2] *See*, The SUPPORT for Patients and Communities Act of 2018 (P.L. 115-271).

In advance of October 31, we will submit additional comments outlining a proposed DPP design for psychiatric hospitals and will demonstrate how this payment arrangement is expected to advance the goals and objectives of the state's quality strategy as well as the DPP's goals. Our aim is to develop a proposal that does not have a negative fiscal impact to other hospitals already participating in DPP.

Again, we appreciate the opportunity to provide input on potential changes to the state Directed Payment Programs and we may offer additional comments related to potential changes prior to the October deadline. Please do not hesitate to contact me with questions or to schedule a related discussion.

Respectfully submitted,

Carie Summers

Carie Summers
Chief Financial Officer

cc: Joseph Hood, Chief Operating Officer
Cody Whitlock, Chief Financial Officer

October 30, 2024

Via Email at dpp.ideas@dch.ga.gov

Russel Carlson, Commissioner
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower
Atlanta, GA 30334

Dear Commissioner Carlson,

Thank you for the opportunity to provide input regarding the SFY26 Directed Payment Programs (DPPs) and for your leadership regarding these programs. Piedmont Healthcare recognizes the care and detailed analysis the Department of Community Health (DCH) has put forward to develop a collection of DPPs designed to address the state's overall health care priorities. It has been a privilege for Piedmont's hospitals and physician groups to participate in Georgia's Strengthening The Reinvestment of a Necessary-Workforce (GA-STRONG), Hospital DPP, and Physician DPP.

The financial needs of operating a hospital are complex and while DPP funding is appreciated, there is a need for consistent and frequent payments that support robust and enduring initiatives at the system level. With that in mind, we appreciate the department's consideration of the following proposals:

- The SFY25 preprints suggest one interim payment per year, which has the unintended effect of destabilizing ongoing funding and encouraging short-lived, low-return expenditures. Continuing the practice of paying at least two interim and one reconciliation payment a year enables Piedmont to predict the timing of payments and plan the optimal ways to utilize those funds for maximum benefit; stabilizing the investment of funds that support quality benchmarks and innovative programs is critical for the lasting impact of these programs. In addition, a predictable cadence of payments also allows time to prepare and budget for the intergovernmental transfer (IGT), which increases significantly with a longer duration between payments.

- Providing the underlying calculations with each IGT notice would decrease administrative back and forth, increase transparency, and be an appropriate tool for confirming utilization data across sources.
- Given the impact new Private entrants have on the GA-STRONG assessment, Piedmont requests that the Department consider the variability of net benefit when making program eligibility decisions. Stable year to year program funding allows Piedmont to make meaningful investments in initiatives that serve to improve Medicaid patient outcomes.
- As the graduate medical education environment in Georgia continues to evolve, the participants in the GA-STRONG program should not be negatively impacted by a year where FTE counts dip below the required five. Given the emphasis the GA-STRONG program has on quality improvements, it is important that hospitals are given flexibility within their FTE counts to ensure progress is tracked through variations in residents. Continuously tracking quality measures over the long term is essential to seeing the value of GA-STRONG and if hospitals are allowed to fluctuate in and out of the program the impact on Quality will suffer.
- To understand and improve Quality metrics in the Hospital and Physician DPPs, the establishment of a quality feedback loop between providers and CMOs would allow providers to gain insight into the reported performances of participating hospitals and physician groups. The quality feedback loop would promote best practices and ensure the provision of high-quality care to managed care patients.

Additionally, Piedmont would like to propose the following quality measure suggestions:

- ***GA-STRONG***:
    - Current measures (self- reported):
        1. NTSV Cesarean Birth (NQF 0471)
        2. NQF 30-Day All-Cause Readmission
        3. Hospital Emergency Room Diversion (In Hours)
    - **Ideal future state / comments**:
        - Despite small volumes, we're performing relatively well on measures 1 and 2.
        - Suggestion would be to consider performance differences between an all-payer version of these metrics (vs the current metric that is restricted to only Managed Medicaid). All payer metrics are generally where CMS is going anyway.
        - Measure 3 (ER Diversion) appears to biased against larger facilities like PAH. Would suggest a measure that is adjusted based on facility demographics (e.g. Case-Mix.
        - Suggest that the state considers patient safety metrics that we tend to perform well on (i.e. HACs, HAIs, PSIs, etc).

- ***HDPP***
    - Current measures (measured by payers):
        1. NQF 30-Day All-Cause Readmission
        2. Total Average Inpatient Length of Stay
    - **Ideal future state / comments**:
        - Would prefer for this measure set to mirror / be the same as GA-STRONG and move towards self-reporting (vs current claims / payer reporting).
        - If measures must remain, both measures should be adjusted for each facilities case mix index (I don't believe they are today)
- ***PDPP***
    - Current measures (measured by payer)
        1. Diabetes A1C Control
        2. Depression Screening
        3. Controlling Hypertension
    - **Ideal future state / comments**:
        - We like all 3 of these measures for Primary Care, but they do not make sense for hospital- based physician groups / specialties
        - Given this program varies based on the specialties / TINs involved, we would suggest that the state allows each physician group to select ~3 metrics from a menu of quality metrics that are more relevant to their specialty (i.e. this is how the CMS MIPS program works).

As a reminder, Piedmont has utilized DPP funding to support multiple long-term programs including:

Anesthesia Service Line- To bring Anesthesia Services in-house in order to reduce expenditures, improve quality and performance, and to provide stability to improve patient care with this service line.

Community Connect- Piedmont is investing in additional implementation resources to reduce the backlog of physician providers wanting to utilize the Piedmont Healthcare's instance of EPIC Community Connect. EPIC Community Connect is a collaborative System by EPIC that allows healthcare organizations and independent providers without an interoperable EHR to access relevant patient records across systems when they partner with a healthcare organization that uses EPIC"s EHR system. The ability of different healthcare technologies to exchange and use information effectively is at the heart of EPIC Community Connect. This system allows healthcare providers to: Access patient data efficiently; Streamline operational functions; Ensure continuity and improve health outcomes, especially for the vulnerable Medicaid population.

Workforce Rebuild- The current Workforce Rebuild initiatives seeks to increase hiring of qualified clinical resources coupled with an emphasis on retaining our current talent. Piedmont's Workforce Rebuild is committed to quarterly recruitment goals for both Nursing and Technical resources.

Internal Staffing Agency- Piedmont has created First Call Staffing Solutions (FCSS) an internally owned & operated staffing agency with the goal to provide a flexible & timely competitive Contract Agency model at a lower cost by removing the external profit margin. FCC growth this year and future years has the desired potential to eliminate the need for outside Agency resources for our core clinical areas (Routine, ICU, ED and Respiratory Services).

These programs have increased the quality of care received at Piedmont hospitals while allowing for increased support for our workforce, and we look forward to continuing the programs we have in place while exploring new opportunities to care for our patients.

Thank you for your consideration of these changes to the administration of Georgia's DPPs and for the Department's continued support of the Medicaid State Directed Payment Programs.

Sincerely,

Robert C. Cross

Robert C. Cross | Vice President | Government Reimbursement
2727 Paces Ferry Road, Suite 2-920| Atlanta, GA 30339
O: 470-271-3401| M: 404-520-5501 | E: robert.cross@piedmont.org

cc: Thomas Arnold, Executive CFO, Piedmont Healthcare
Johnette Wasko, Executive Director, Government Reimbursement, Piedmont Healthcare
Scott Connor, CFO Corporate Services/ Analytics, Piedmont Healthcare
Marie Gaffney, VP Finance, Piedmont Healthcare
Katie Morris, VP, Government Quality Programs, Piedmont Healthcare
Francis Larossa, Director, Government Quality Programs, Piedmont Healthcare

Georgia Department of Community Health,

CareSource appreciates the opportunity to provide input and ideas for the SFY26 Directed Payment Programs in Georgia. CareSource has several suggestions for the current Directed Payment Programs and also has additional recommendations that we believe will help DCH prepare for the new CMS Directed Payment Requirements that will be effective in a few years. On May 10th, 2024 CMS released a new Rule, *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*[1], that includes updated requirements for State Directed Payments that will be effective for rating periods starting July 9th, 2027 or after.

A few of the requirements under the new CMS Rule that will be of most impact to Georgia's Directed Payment Program are:

- All State Directed Payments (SDPs) must be incorporated into the capitation rates.
- State Directed Payments and associated revenue are required to be included as separate lines in annual MLR reporting.
- The use of post-payment reconciliation processes for State Directed Payments that are based on fee schedules is prohibited.

Since these new requirements go into effect in calendar year 2027, CareSource believes it would be beneficial to use the next several years to start preparing for the changes in order to make the transition to the new requirements smoother. Once the Directed Payments are required to be contained within the capitation rates, the tracking and calculation of Directed Payment amounts will be important in order to allow the state to break out the Directed Payment amounts in the MLR Reporting as is required by the new CMS Rule. It will also be important that the correct capitation rates be paid timely to the CMOs for each corresponding state fiscal year to ensure the CMOs have the funds to be able to pay the providers the Directed Payment amounts they are due. The items below are CareSource's recommended updates to the Directed Payment Programs to improve the current programs and help DCH prepare for the changes that will be required under the new CMS Rule.

Directed Payment Fee Schedule

Firstly, CareSource recommends for the State Directed Payments (SDPs) to be based on the utilization for each specific provider and calculated as a percentage of the Medicaid fee schedule. Having the payments tied to the Medicaid fee schedule will allow for easier tracking and calculation of the magnitude of payments that providers receive for a given time period. Since one of the requirements of the new CMS Rule is that the SDPs and associated revenue are required to be included as separate lines in MLR reporting, being able to easily track and monitor the magnitudes of payments will be very

important, especially as the SDPs transition to being included in the capitation rates in the future.

To help track the Directed Payment amounts being paid to each provider, CareSource requests that separate fee schedules be created for services that are paid at the Directed Payment Program rate and those that are not. The services that are not eligible to be paid the Directed Payments will have the typical fee schedule similar to prior years, and the services that are eligible to be paid the higher Directed Payment rate will have a separate fee schedule which equals a percentage of the typical fee schedule. Having these separate fee schedule values will allow the state to easily calculate how many dollars are attributed to Directed Payments and track how the directed payment rates are changing over time. This method of tracking Directed Payments will be especially beneficial as the SDPs move to be covered within the capitation rates and are required to be included on a separate line item within the annual MLR summary report shared with CMS.

Quality Metrics

In order to help the state continue to hit their quality metrics, CareSource recommends for the Directed Payments paid to providers to be tied to the quality of services and care that the providers are giving the members. We suggest for DCH to include quality metric thresholds for the providers to meet in order for them to receive the Directed Payments for a given time period. Adding these quality metrics will ensure the Directed Payments are tied to the actual quality of services provided by the provider and will motivate the providers to continue improving the quality of services that they provide to their patients. It will also help drive innovations in the provider space as providers look to find new ways to improve the quality for their patients. Some examples of quality metrics that could be tied to the Directed Payments include readmission rates, healthy birth outcomes, appropriate emergency department utilization, and substance use disorder treatment. Having these metrics in place improves quality of care for the members and also allows for DCH to attain the goals within their quality strategy. These quality metrics can help DCH accomplish goals within each of the four pillars of their Quality Strategy Key Goals[2] such as increasing the percentage of members getting needed care, decreasing the number of low birthweight babies, and decreasing the 30-day readmission rate for behavioral health and among members 18 years of age and older.

Directed Payment Type

CareSource believes it would be best to continue to have the Directed Payments be paid outside of capitation rates as these additional items are being adjusted within the payment methodology. This will help with a smooth transition to incorporate the new changes and will ensure that the tracking and distribution of the payments are efficient

prior to transitioning the whole process to be incorporated within the capitation rates. When the Directed Payments are moved to be contained within the capitation rates, the magnitude of the Directed Payments will still be required to be tracked and explicitly identified for each Directed Payment Program for each time period. Therefore, CareSource recommends that DCH utilize the next several years to better understand the impact of any Direct Payment process changes and to determine any tracking improvements needed prior to including the payments within the capitation rates.

Thank you for the opportunity to provide input and ideas about the SFY26 Directed Payment Programs. Please let us know if you have any questions about the suggestions we outlined above.

Sincerely,

Sam Lundstrom, ASA, MAAA
Managing Actuary
CareSource
Samantha.Lundstrom@caresource.com

References

[1] https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

[2] https://dch.georgia.gov/medicaid-quality-reporting

From: Reg James
To: Dpp.Ideas
Subject: UPL - Private Ground Ambulance Provider Inclusion
Date: Friday, August 30, 2024 12:00:06 PM
Attachments: Outlook-1lv4rndw.png

Greetings,

We are writing to request inclusion in the UPL – Private Ground Ambulance Provider subclass based on the following:

Background

- "House Bill 271 of the 2021-2022 regular session of the Georgia Assembly authorized the Department of Community Health (DCH) to develop an assessment program for the purpose of funding the state share of Medicaid supplemental payments for ambulance providers." *(Reference #1 below)*
- "Effective with dates of service beginning on January 1, 2020 and thereafter, the Fee-for-Service (FFS) Ground Ambulance Upper Payment Limit (UPL) Program will compensate eligible ambulance providers for ambulance services provided to Medicaid FFS members." *(Reference #1 below)*
- "The Department of Community Health (DCH) recently received approval from the Centers for Medicare & Medicaid Services (CMS) to provide a supplemental payment adjustment to **government-owned (hospital affiliated or free-standing) ground ambulance providers** in Georgia. Effective with dates of service beginning on January 1, 2020." *(Reference #1 below)*
- The legislation authorizes DCH to implement the assessment program on a subset of ambulance services, and DCH intends to implement the assessment program **for privately owned (private) ground ambulance providers**. *(Reference #1 below)*
- During implementation for "privately owned (private) ground ambulance providers, the subclass was further defined to only include **"private 911 ground ambulance providers",** which effectively excluded a group of privately owned ground ambulance providers that provide non-911 emergency Medicaid ambulance transports. These emergency Medicaid transports are typically medically necessary for members to be transported from one hospital to another for a higher level of care not available at the originating hospital.

Proposal/Request

- Further define a subclass of privately owned ground ambulance providers to be included in one or both of the following new subclasses:
    - Make eligible any privately owned ground ambulance provider that operates in all Georgia Health Districts.

      And/Or
    - Make eligible any privately owned ground ambulance providers that provide greater than three hundred (300) emergency Medicaid ambulance transports per month (on average). As you may know, Sellers Dorsey ran the models and concluded our company (Amerimed Emergency Medical Services) should be eligible based on this subclass.

1. https://dch.georgia.gov/providers/provider-types/ground-ambulance-upl

I can be reached by reply email and/or direct cell: 404-557-4097 should you have any question or would like to discuss this request in further detail.

Thank you!

Kind Regards,

Reg P James III
President
rjames@amerimed.net

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4908 Golden Parkway, Suite 800
Buford, GA 30518