From: Julie [mailto:julieellen10@me.com]
Sent: Tuesday, February 28, 2012 9:18 PM
To: My Opinion
Subject: Medicaid Redesign

Georgia Hospital Safety Net Coalition

Archbold medical Center - Columbus Regional Healthcare System - Floyd Medical Center - Georgia Health Sciences University Medical Center - Grady Health System - Medical Center of Central Georgia - Northeast Georgia Health System - Phoebe Putney Healthcare System - University Hospital

February 29, 2012
Mr. David A. Cook
Commissioner
Georgia Department of Community Health
2 Peachtree Street NE
Atlanta, Georgia 30303
VIA: Electronic Transmission

Dear Commissioner Cook,

The Georgia Hospital Safety Net Coalition (Safety Net Coalition) is comprised of nine healthcare systems representing 22 of the state's 182 hospitals. Based on State Fiscal Year 2009 data, the 22 hospitals of the Safety Net Coalition represent 12 percent of the state's hospitals but are responsible for approximately 33 percent of care provided to the uninsured and approximately 27 percent of services provided to Medicaid members. In addition, the Safety Net Coalition provides much of the state's trauma care, neo-natal intensive care and medical training programs. As a coalition representing the state's disproportionate share hospitals, the Safety Net Coalition is very interested in the state's plan to redesign its Medicaid program and greatly appreciates the opportunity to provide input on the Medicaid and PeachCare for Kids Strategy Report (strategy report), prepared by Navigant Consulting, Inc.

As organizations that are constantly struggling to find ways to balance budgets while still providing necessary medical services, the members of the Safety Net Coalition certainly recognize the budget constraints and fiscal pressures facing the state. In addition, the state is facing the expansion of the Medicaid program to cover an additional half million plus people under the Patient Protection and Affordable Care Act (ACA). Further, the expiration of the state's contracts with the current care management organizations (CMOs) is fast approaching and some system must be in place to care for the state's low income (LIM) enrollees.

Despite these fiscal and time pressures, however, we cannot agree with Navigant's proposal to continue and expand the current medicaid managed care (MMC) program. Since its inception in 2006, hospitals, physicians, and dentists alike have experienced delays in payments, lack of uniformity among forms and processes used by CMOs, duplicative and cumbersome credentialing requirements, paper and time intensive pre-authorization hurdles, and a lack of coordination of standards of care among the three CMOs and between the MMC and fee-for-service (FFS) programs. With regards to specific problems faced by our members, hospitals have experienced significant delays when attempting to find specialists who will see Medicaid patients, particularly in rural areas, when just five years ago, under the FFS system, there were very few instances of access problems. Despite promises to the contrary, hospitals have seen very little to no coordination of care. In fact, many of our members have hired additional staff to triage patients in an attempt to reduce emergency department utilization all the while having claims paid at triage rather than emergent rates.

With regards to the LIM population, the Safety Net Coalition would like to encourage the Department of Community Health (DCH) to look at alternatives to the MMC program, such as patient centered medical homes

(PCMHs) and provider-driven networks, perhaps with shared savings arrangements. Should the state determine to continue the MMC program for the LIM population, significant changes should be made to the contract(s) between DCH and CMO(s). Specifically, the Department of Insurance should be given oversight of the CMOs in order for the state to have greater enforcement powers. CMOs should be required to implement true coordination of care for members, standardize their processes and forms, and established shared-savings arrangements with providers when quality benchmarks are met. Further, the state should ensure that CMOs are fully and correctly reporting quality and financial data to DCH and to providers in a timely manner and that Medicaid enrollees only be allowed to change carriers once every twelve months.

Based on the limited research and analysis cited in the strategy report, the aged, blind and disabled (ABD) population should not be moved under the MMC program. This one size fits all approach does not account for the divergent needs of the ABD population and the move of the ABD from the fee-for-service (FFS) program to the MMC program is unwarranted given the fact that the percentage of Georgia Medicaid expenses currently spent on the ABD population is well below the national average (53 percent versus 64 percent). Further, the time constraints due to the expiration of the current CMO contracts does not apply to the ABD FFS program so the state can and should proceed with all due diligence before making any major changes. Given the chronic nature of many of the health issues facing the ABD population, they would most likely benefit from true case management and coordination of care, perhaps through PCMHs or the SOURCE program. The state may also want to consider paying a per member, per month fee to primary care providers for care coordination services, in addition to payments for actual medical services.

Finally, when determining how to structure the Medicaid program, the state should make every effort to maximize federal funds for the program. During the original implementation of the MMC program, the state failed to protect over $100 million per year available to hospitals from the federal Upper Payment Limit (UPL) program. Should the state decide to expand the MMC program to the ABD population, a waiver should be sought to protect the UPL funds for that population. Further, the state should consider expanding the waiver in order to recover the UPL funds lost when the LIM population was moved to the MMC program. These funds are particularly important since the state has implemented a Hospital Provider Payment to help balance the Medicaid budget.

For the reasons stated above, the Safety Net Coalition would encourage the state and DCH to consider alternatives to the current MMC program or, at the very least, make significant improvements to the program. The ABD population should not be moved into the MMC program but should be treated with true coordinated care and case management. And finally, the state should consider the real financial impact on federal supplemental payments of the various design aspects being considered for the Medicaid program.

The members of the Safety Net Coalition are willing and ready to help the state and your department as you move forward with redesigning the Medicaid program. We would very much like to discuss with you or your staff our ideas about the program design as well as sharing our ideas on innovative ways to maximize the state's federal draw-down from the UPL program. We thank you for the opportunity to provide meaningful input on this all important program.

Sincerely yours,

Rhonda Perry

Chair - Georgia Hospital Safety Net Coalition