

December 3, 2019

***Via Overnight Mail and Online Webform at
<https://medicaid.georgia.gov/patientsfirst>***



Norman Boyd, Chair
Board of Community Health
c/o Lavinia Luca
Post Office Box 1966
Atlanta, Georgia 30301-1966

Re: Georgia Pathways to Coverage 1115 Demonstration Waiver

Dear Chairman Boyd:

On behalf of the Georgia Hospital Association (GHA) and its 170 hospital and health system members, we welcome the opportunity to submit comments on the Georgia Department of Community Health's (the "Department's") Medicaid 1115 Demonstration Waiver: Georgia Pathways to Coverage ("Georgia Pathways" or the "1115 Waiver"). **GHA appreciates the Department's hard work under the *Patients First Act* to develop a Georgia solution to ensure low-income citizens have access to affordable health care coverage. The 1115 Waiver is a positive first step toward the goal of making affordable, comprehensive health care coverage available across the state.**

As you know, Georgia currently has the fourth highest percentage of uninsured residents in the nation.¹ This is a significant contributor to the current health care crisis in our state, which has led to seven hospital closures since 2010 and resulted in a rank of 46 out of 50 for access to quality health care and preventative services.² The *Patients First Act* provides the state with a historic opportunity to not only increase access to health care coverage, but also improve the overall health of Georgia citizens. As outlined in the 1115 Waiver, a healthier Georgia leads to a more productive workforce and a reduction in the poverty rate.³ With these goals in mind, GHA respectfully offers the following comments and recommendations regarding the 1115 Waiver.

¹ Kaiser Family Foundation, 2017 Health Insurance Coverage of the Total Population, available at: <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Nov. 24, 2019).

² Georgia Department of Community Health Waiver Project, Georgia Environmental Scan Report (July 8, 2019).

³ See, Naomi Zewde and Christopher Wimer, Antipoverty Impact of Medicaid Growing With State Expansions Over Time, *Health Affairs* 38, No. 1 (2019) 132 – 138.

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GHA Strongly Supports the 1115 Waiver's Goals to Improve Access, Affordability and Quality

According to the Department's Georgia Environmental Scan Report dated July 8, 2019, "Georgia is facing challenges related to healthcare access and preventative care based on rural hospital closures..." While the challenges facing Georgia's hospitals are many, much of their struggles can be attributed to the large amount of uncompensated care hospitals provide each year. In 2018, the most recent year for which data is available, the provision of uncompensated care cost Georgia hospitals \$2.21 billion. (Note this amount represents the cost of providing care, not the charges for care.) Most of this uncompensated care is provided to uninsured patients in the form of indigent, charity or other free care.⁴

Georgia has over 1.2 million uninsured adult, non-elderly residents.⁵ Around 408,000 of these residents have incomes below 100% of the federal poverty line (FPL)⁶ and would be eligible to participate in the Georgia Pathways program. The fastest and most efficient way to help stabilize Georgia's hospitals is to increase access to health care coverage via the Medicaid program. **GHA strongly supports the 1115 Waiver's new Medicaid eligibility category for adults with incomes below 100% of the FPL, the maximum amount allowed under current law.** This new eligibility category will improve access, affordability and quality of health care by reducing the number of uninsured Georgians.

Increased Utilization of Employer-Sponsored Coverage is Good for Patients and Providers

The 1115 Waiver would increase access to employer-sponsored insurance (ESI) by implementing a mandatory Health Insurance Premium Payment (HIPP) program. For individuals with incomes below 100% of the FPL that have access to ESI, the Medicaid program would subsidize the premiums and cost-sharing for the individual so that the ESI matches the affordability of the Medicaid coverage provided under the 1115 Waiver. Utilizing ESI rather than Medicaid when available is good for patients because it may help eliminate a potential gap in coverage when the patient begins earning too much to qualify for Medicaid. Under the 1115 Waiver, patients have a smoother transition since they already enrolled in their ESI and understand how it works.

Hospitals and other health care providers also benefit from the mandatory HIPP program in the 1115 Waiver. ESI typically reimburses providers for the full cost of care, whereas Medicaid typically reimburses providers less than the cost of care. Even after considering all payment

⁴ In 2018, Georgia hospitals provided \$1.48 billion in indigent, charity and free care and had \$0.72 billion in bad debt. Department of Community Health, Hospital Financial Survey (2018).

⁵ Georgia Environmental Scan Report.

⁶ *Id.*

sources for Medicaid, hospitals were paid only 92 percent of cost for Medicaid patients⁷. ESI plans also impose less administrative burdens on providers than Medicaid plans, allowing providers to focus more on caring for patients and less on pursuing adequate reimbursement. While ESI and other commercial health plans do not typically cover non-emergency medical transportation (NEMT), the lack of an NEMT wrap-around benefit for this low-income population disproportionately impacts rural Georgia. See below for additional comments on the potential impact of waiving the requirement to provide NEMT services.

The Department has not yet released the details of how the ESI premium and cost-sharing subsidies would flow under the 1115 Waiver. **GHA respectfully requests the Department consider implementing cost-sharing subsidies in a manner that will ensure hospitals and other providers are held harmless for providing covered services to HIPP participants.** Cost-sharing subsidies should go directly to the provider rather than to the beneficiary, who would then have to pass the payment on to the provider. This is more efficient for both the provider and the patient and prevents scenarios where beneficiaries sometimes fail to reimburse the provider after receiving the funds from their health plan and the provider is left with uncompensated care in the form of bad debt. This is particularly important as ESI plans often have high deductibles and significant cost-sharing in order to help keep premiums lower.

The Legality of Medicaid Work Requirements is Uncertain

To date, the Centers for Medicare and Medicaid Services (CMS) has approved work or community engagement requirements under 1115 demonstration waivers in nine states. However, seven of these have either been set aside by the courts or voluntarily suspended by the states themselves. The other two states, Utah and Michigan, have been approved by CMS to implement work requirements beginning in 2020.⁸ **Given the current legal landscape, the inclusion of a work requirement as part of the 1115 Waiver may serve to delay implementation, possibly for years.** Georgia cannot wait any longer to increase access to affordable health care coverage of individuals earning less than 100% of the FPL.

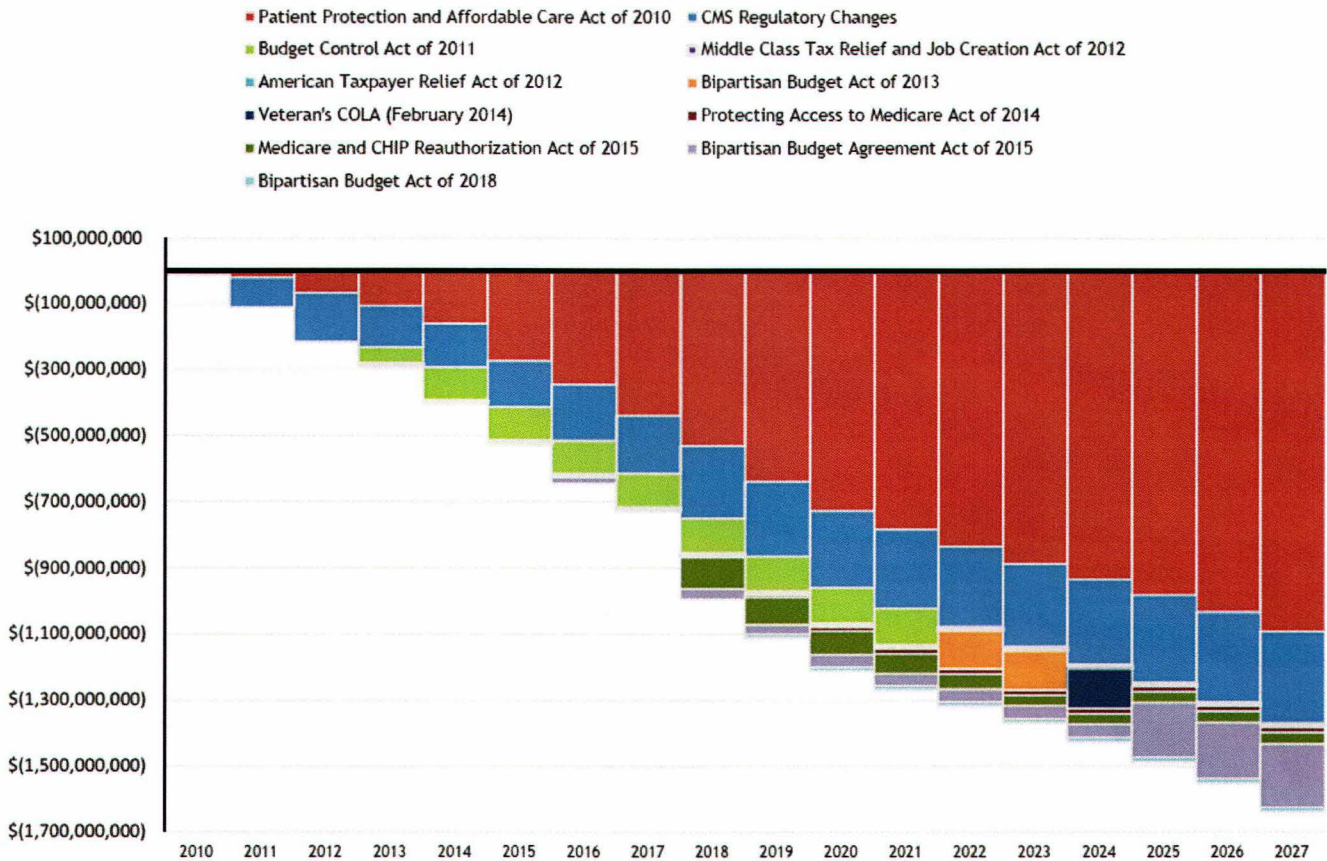
As detailed in the figure below, federal legislation codified over the last ten years is expected to reduce future Medicare reimbursement to Georgia's hospitals by up to 16.3%, accounting for \$17.3 billion in revenue reductions between 2010 and 2027.⁹

⁷ Derived from 2017 hospital payment and cost data compiled for FY 2019 Medicaid Disproportionate Share Hospital Payments.

⁸ A lawsuit was filed in November to stop implementation of the Michigan work requirement. Utah has submitted a second waiver request that also includes a work requirement. It is unclear whether Utah plans to move forward with the current work requirement in 2020 while it is awaiting approval of its new waiver.

⁹ Data Gen, *2018 Enacted Medicare Cuts Analysis* (March 2018).

Medicare Cuts By Legislative and Regulatory Action Cumulative Impact on Georgia Hospitals



In addition, the Patient Protection and Affordable Care Act (ACA) included significant cuts to the Medicaid disproportionate share hospital (DSH) program beginning in 2014 through 2020. These cuts have since been delayed, however, the longer they are delayed the more they are projected to grow in out-years. The DSH cuts were designed on the premise that more patients would be insured due to the other provisions of the ACA (*e.g.*, participation in the Health Insurance Marketplace and Medicaid expansion), and therefore, hospitals would not incur as much uncompensated care. The opposite has happened in Georgia where hospitals' uncompensated care has increased over the last three years. Georgia's DSH cuts, if not further delayed, will amount to \$73 million in federal fiscal year 2020 and increase to \$145 million by federal fiscal year 2021. These cuts will occur regardless of the state's decision to expand

Medicaid.¹⁰ Georgia hospitals cannot continue to sustain reimbursement cuts from government payers without a corresponding increase in the number of Georgians with access to health care coverage.

Therefore, GHA respectfully requests the Department consider removing the work requirement from the 1115 Waiver as a condition of Medicaid eligibility in order to ensure that implementation of the Georgia Pathways is not delayed by the courts. Work or community engagement could instead be used as an incentive to gain more favorable treatment for beneficiaries that report meeting the requirements. For example, such incentives could include access to additional services, decreased cost-sharing or additional funds placed in the Member Rewards Account. Assuming the courts eventually confirm the legality of Medicaid work requirements, Georgia could amend its eligibility requirements at that time.

Other Options to Make Targeted Improvements to Health Care Access

In addition to the activities described in the 1115 Waiver as acceptable for meeting the work requirement, there may be other activities that help advance the state's policy goals for specific categories of individuals. For example, for individuals with incomes below 100% of the FPL that are diagnosed with substance use disorder and serious mental illness, activities could include participation in evidenced-based activities shown to help patients remain stable, productive members of the community. These activities, which support the state's efforts to curb the opioid crisis, could include medication assisted treatment (MAT), peer-to-peer counseling or residential or outpatient treatment, and members could move on to the other more traditional work-related activities when appropriate.

The Department could also consider targeting eligibility toward high cost populations, where early intervention could provide overall cost savings to the state. For example, individuals with certain medical diagnoses, like HIV, substance use disorder, serious mental illness, diabetes, or other chronic conditions. Other options could include targeting eligibility to women of childbearing age to help with Georgia's various initiatives to decrease maternal mortality rates¹¹ or simply increasing the current income eligibility limits for parents.¹²

¹⁰ Subsequent federal legislation delayed these cuts until 2020 but extended them through 2025. Federal fiscal year 2020 began October 1, 2019. However, the latest continuing budget resolution extended the DSH cut delay to December 20, 2019. There is no guarantee that the cuts will continue to be delayed beyond this date.

¹¹ Increasing the availability of health coverage for women of childbearing age helps increase access to preventative care, reduce adverse health outcomes before, during and after pregnancies and reduces maternal mortality rates. Adam Searing and Dana Cohen Ross, Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies, Georgetown University Health Policy Institute Center for Children and Families Report (May 2019) available at: <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf> (last visited Nov. 24, 2019).

¹² More than half of the other non-expansion states have higher income eligibility limits than Georgia does for parents to enroll in Medicaid. Kaiser Family Foundation, *Where are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults* (Mar. 2019), available at: <https://www.kff.org/medicaid/fact->

GHA respectfully requests the Department consider these or other options beyond work requirements that allow the state to maintain affordability while also helping to ensure that low-income individuals have the access to care needed for them to be healthy, productive citizens.

State Administration of Work Requirements is Complex

The administration of work requirement programs by the state can determine whether or not the programs accomplish their stated goals of empowering Georgia Pathways participants to become active participants and consumers of their health care, increasing the number of persons who become employed or engaged in employment-related activities, and increasing wage growth for those who are employed. A recent report by the United States Government Accountability Office found the estimated cost to administer Medicaid work requirements ranged from \$6.1 million to \$271.6 million for the five states reviewed.¹³

Much of these costs are associated with enhancements to the states' IT systems necessary to implement and administer the programs. The work, premium, and copayment requirements described in the 1115 Waiver will likewise be complex for the state to administer, adding to the overall cost to the program. Reporting requirements for members can also be complex and burdensome. The 1115 Waiver would require beneficiaries to report their work status on a monthly basis, similar to some other states with approved Medicaid work requirements, including Arkansas, where its reporting requirements led to the loss of Medicaid coverage for nearly 17,000 individuals.

GHA encourages the Department to make the reporting of any work or community engagement requirements as easy as possible for both the state and the members. The Department has certainly considered this, in that if a member provides evidence of meeting the requirements for six consecutive months, the member is then exempt from the monthly reporting requirement. For these members, compliance would be reassessed during the annual re-enrollment period. Rather than require members to report that they are continuing to meet requirements through monthly reporting even for the first six months, the state could simply conduct random compliance checks.

sheet/where-are-states-today-medicaid-and-chip/ (last visited Nov. 24, 2019). Between 2016 and 2018, Georgia has had a 21% increase in the number of uninsured children in our state. Joan Alker and Lauren Roygardner, *The Number of Uninsured Children is on the Rise*, Georgetown University Health Policy Institute Center for Children and Families Report (Oct. 2019) available at: <https://ccf.georgetown.edu/2019/10/29/the-number-of-uninsured-children-in-on-the-rise-acs/> (last visited Nov. 24, 2019). Expanding access to health care coverage to their parents could help reverse this trend because children are more likely to be enrolled in a health plan if their parents are enrolled in a health plan. See, Julie L. Hudson and Asako S. Moriya, *Medicaid Expansion for Adults Had Measurable "Welcome Mat" Effects on Their Children*, *Health Affairs* 36, no. 9 (2017): 11643 – 1651.

¹³ GAO Report: Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements (Oct. 2019)

Based on the results of these checks, the Department may ultimately determine that additional reporting is required and the increased administrative costs to the state are justified. However, the Department may also determine through its compliance reviews that the cost of developing additional systems and procedures for monthly reporting are not needed. For members participating in certain qualifying activities that typically have a defined time period for completion (*i.e.*, vocational educational training or enrollment in an institution of higher education), the member could be required to report back at the time qualifying activity is slated to end. Likewise, members enrolled in the HIPP program will lose their access to ESI if their work status changes so there may not be the same need to require HIPP participants to make monthly reports.

Elimination of Non-Emergency Transportation Disproportionately Impacts Rural Georgia

GHA encourages the Department to reconsider its waiver request regarding the provision of non-emergency medical transportation (NEMT) in the Georgia Pathways program. The elimination of NEMT services is likely to disproportionately impact Georgia's rural communities where individuals do not have access to public transportation. Individuals in rural communities often have to travel further to see their health care providers than they do for work or other community activities.¹⁴

More than half of NEMT trips are used to access preventative care and behavioral health services.¹⁵ According to the Medicaid and CHIP Payment and Access Commission (MACPAC), two thirds of Medicaid NEMT users were disabled or aged 65 years or older, and 42% of users were dually eligible for Medicare and Medicaid.¹⁶ This means the amount of cost savings the state would realize by waiving the requirement to provide NEMT is likely minimal compared to the potential impact on rural beneficiaries seeking preventative or behavioral health services.

Elimination of Retroactive Eligibility and Hospital Presumptive Eligibility Hurts Hospitals

In addition to the outreach and education provided by the state, hospitals often serve as the main point of entry for Medicaid enrollment. This means that it is not until after a Medicaid eligible individual has had a medical crisis and needs hospital services that he or she, with the help of hospital staff, enrolls in the Medicaid program. Currently, Medicaid compensates hospitals for these services because once approved, the individual's Medicaid coverage is retroactive to the first day of the month the enrollment application was submitted.

¹⁴ Increased access to telehealth services may also help mitigate the transportation issues in rural Georgia. However, Medicaid coverage for telehealth services would need to be expanded beyond what is currently covered. *See*, Georgia Department of Community Health, Telemedicine Guidance (2019).

¹⁵ Mary Beth Musumeci and Robin Rudowitz, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, Kaiser Family Foundation (2016).

¹⁶ MACPAC Issue Brief, Medicaid Coverage of Non-Emergency Medical Transportation (2019).

Under the 1115 Waiver, individuals' Medicaid coverage would begin on the first day of the month after their enrollment application is approved and they have paid their first month's premium, if applicable. GHA understands and supports the state's goal to provide members with "an experience similar to commercial insurance in order to better prepare them for their transition from Medicaid into a commercial health insurance plan."¹⁷ However, unlike other portions of the 1115 Waiver that promote personal responsibility,¹⁸ it is hospitals, not members, that are penalized when Medicaid coverage is prospective only. Hospitals will continue to provide care to eligible individuals prior to their enrollment being approved, but they won't get paid for it. The cost of the care provided will be uncompensated indigent and charity care in accordance with Georgia's Indigent Care Trust Fund program.¹⁹ **GHA respectfully requests the Department consider not seeking a waiver of retroactive eligibility for individuals covered under Georgia Pathways.** Retroactive eligibility for the waiver population will decrease the amount of hospitals' uncompensated care without negatively impacting the state's goals for the 1115 Waiver.

Presumptive eligibility is another option that hospitals can use to decrease uncompensated care. Hospitals go through extensive training to be eligible to participate in the presumptive eligibility program. Once a patient is determined presumptively eligible, that eligibility lasts for up to one month while his or her Medicaid enrollment application is pending. Like retroactive eligibility, presumptive eligibility allows hospitals and other health care providers to provide post-hospitalization follow-up care without the risk of not being paid. Patients benefit as well when they don't have to wait for medically necessary follow-up care. The 1115 Waiver indicates that it is not practicable for hospitals to evaluate whether patients meet the work activities necessary to be eligible for Medicaid coverage under the waiver. However, hospitals that participate in the presumptive eligibility program already gather financial documentation like pay stubs or tax returns to determine whether patients meet Medicaid's financial eligibility requirements. Hospitals would likewise be willing to help patients gather work-related documentation in order to determine presumptive eligibility. **GHA respectfully requests the Department consider allowing hospitals to determine patients' presumptive eligibility for Georgia Pathways.**

Penalties for Non-Payment of Premiums Harms Providers

The 1115 Waiver provides for a three-month grace period prior to disenrollment for members who may fall behind on their premiums. **GHA supports the inclusion of the grace period.** The hospital community appreciates the Department's recognition that this newly eligible population is often transient and may not always receive the monthly premium invoices. They are also not likely accustomed to paying monthly premiums for health care coverage, and it may take some

¹⁷ Georgia Section 1115 Demonstration Waiver Application, Section 3.

¹⁸ *E.g.*, premium and cost-sharing requirements.

¹⁹ *See*, Georgia Medicaid Provider Manual: Hospital Services, Appendix Q (requiring hospitals that participate in the Indigent Care Trust Fund Program to provide free care to patients with incomes below 125% of the FPL).

time for some members to understand the system. The grace period is similar to the process used when an individual receives premium subsidies for a health plan purchased on the federal Marketplace. The Georgia Office of Insurance and Fire Safety Commissioner issued guidance to federally qualified health plans in Georgia clarifying that the plans must provide notice to providers when an enrollee is in the grace period.²⁰ **In order to protect providers who may provide services to Medicaid members during this grace period, GHA respectfully requests the Department consider either: (1) instructing CMOs to hold providers harmless by paying claims for services provided during the grace period; or (2) requiring CMOs to notify providers of a member's suspended status and the possibility that claims may be denied so that the provider can help educate the member on the need to pay his or her premiums.**

Options to Increase Provider Reimbursement and Access to Care

Medicaid care management organizations (CMOs) currently cover only 88% of cost for hospital services provided under the current Medicaid program.²¹ However, federal regulations allow states to direct CMOs to adopt a minimum fee schedule or provide a uniform dollar or percentage increase in payments for their network providers.²² **GHA recommends that in calculating the budget neutrality of the 1115 Waiver, the Department should include provider payment initiatives under the state's contracts with CMOs for the newly eligible population.**²³ This will give the state more flexibility in ensuring compliance with budget neutrality and increase the percentage of cost covered by the CMOs for hospital services. When more of their costs are covered, hospitals have greater ability to improve access to care by expanding existing services or establishing new service lines.

²⁰ Georgia Office of Insurance and Fire Safety Commissioner, Directive 14-EX-4, Grace Period Notification Required by 42 CFR § 156.270(d)(3), Pending the Payment of Claims, and the Georgia Prompt Pay Law (O.C.G.A. § 33-24-59.5) (2014)

²¹ Department of Community Health, Disproportionate Share Hospital (DSH) Calculations (2017).

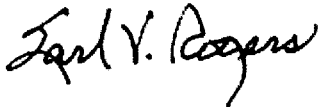
²² 42 C.F.R. § 438.6(c).

²³ GHA is closely analyzing the potential impact of the CMS Medicaid Fiscal Accountability proposed rule (CMS-2393-P) on the financing of Georgia's Medicaid program. Depending on the provisions of the final version of the rule, the state may be required to adjust how it finances these types of hospital payments.

GHA Comments on 1115 Waiver
December 3, 2019
Page 10 of 10

We look forward to continuing to work with the Department to help implement this important program in an efficient and effective manner. Please feel free to contact me at 770-249-4531 or erogers@gha.org with any questions or if you desire to discuss these comments further.

Respectfully submitted,

A handwritten signature in black ink that reads "Earl V. Rogers". The signature is written in a cursive style with a large, prominent "E" and "R".

Earl V. Rogers
President and CEO

cc: Blake Fulenwider, Chief Health Policy Officer, Department of Community Health
Kevin L. Bierschenk, Board Chair, Georgia Hospital Association