Grady

December 3, 2019

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To Whom It May Concern:

On November 4, 2019, the State of Georgia formally announced the release of Georgia's section 1115 demonstration waiver application called the Georgia Pathways to Coverage ("Georgia Pathways"). Authorized under the *Patients First Act*, the proposal intends to expand coverage to certain Georgians living below 100% of the federal poverty level ("FPL"). Grady Health System ("Grady") appreciates the State's willingness to expand coverage under Medicaid. However, we are concerned the proposal is insufficient to address the needs of the current uninsured and to respond to the healthcare crisis facing Georgia. We urge the state to embrace a more comprehensive Medicaid solution as detailed here.

As the state's largest public hospital and a safety net for many uninsured in Georgia, Grady has been an active and longstanding participant in the state's efforts to transform Georgia's Medicaid program. Since opening its doors in 1892, Grady has grown to play a vital role in Georgia's healthcare delivery system and maintained a strong commitment to the healthcare needs of the underserved. Grady is home to north Georgia's only nationally verified Level 1 Trauma Center, one of only two verified burn centers in the state, a Joint Commission certified Advanced Comprehensive Stroke Center that receives transfers from more than 70 hospitals, and one of the nation's best and largest infectious disease centers that serves one in four Georgians living with AIDS. Grady has over 700,000 patient visits annually, approximately 30% of which are uninsured. One quarter of the state's physicians train at Grady and we serve patients from every county in the state each year.

A majority of the health system's total operating revenue is generated by the Medicare and Medicaid reimbursement systems. In addition to the significant Medicare and Medicaid patient population, Grady provided over $338 million in indigent and charity care in 2018. Given our unique position in providing care to many of Georgia's neediest residents, we welcome this opportunity to comment on the proposal and, while we will offer constructive criticisms here, we will also provide tested solutions which could enhance the waiver application and begin to address the challenges identified.

1. ***Georgia Pathways should be amended to more comprehensively address the health care challenges facing many Georgians.***

According to the Georgia Department of Community Health Waiver Project Georgia Environmental Scan Report ("Georgia Environmental Scan"), "...Georgia faces challenges with the rising cost of healthcare,

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high uninsured rates, closure of rural hospitals, and poor health outcomes[1]." The report goes on to detail these challenges:

- Georgia's uninsured rate is the fourth highest in the nation at 15%, and especially acute at 29% for adults between the ages of 18-64 living below 100% of the FPL.
- Over one-third (37.4%) of the uninsured live in the five-county metro Atlanta area.
- Georgia ranks 39 out of 50 in the 2018 America's Health Rankings, an annual assessment of 35 markers impacting Georgians' health outcomes. According to the rankings:
    - The state ranks 46th in "access to quality healthcare and preventive services, such as primary care physicians, dentists, and health screenings."
    - The state ranks 36th in all outcomes including "premature death, poor mental health days, poor physical health days, cancer deaths, cardiovascular deaths, diabetes, infant mortality, and disparity in health status."
    - The state ranks 38th in its community and environment, or the social determinants of healthcare, which "represents the broader impact the society and the economy have on an individual or community's ability to make healthy choices as well as where individuals live, work and play and their interaction with this space."
- Half of the reported Medicaid quality core measures, which assess healthcare access and quality for Georgia's Medicaid recipients, fall below the national median. These include the percentage of women who had a mammogram to screen for breast cancer, the percentage of women who had a doctor's visit within the recommended time frame after giving birth, the percentage of diabetics with controlled blood sugar levels, the percentage of people with hypertension who had controlled high blood pressure, the number of hospitalizations for people with diabetes complications, chronic obstructive pulmonary disease, asthma, and heart failure, and finally the percentage of people hospitalized due to mental illness that have a follow-up visit within the recommended time frame after discharge.

The challenges are not limited to people who lack insurance or have poor health outcomes. The healthcare system that serves Georgians is at risk. According to the report:

- Seven rural hospitals have closed in Georgia since 2010 and twenty-six (41%) of rural hospitals are at risk of closure.
- Hospitals reported providing $1.9 billion in uncompensated care in 2017. While 82% of the uncompensated care was provided in urban counties where 83% of the population resides, rural hospitals provided $342 million in uncompensated care.
- Uncompensated care provided by Georgia hospitals grew by 17% between 2013 and 2017.

All of these data illustrate the need to transform the healthcare delivery and payment system in Georgia to improve health outcomes, reduce healthcare costs, increase coverage and access, and assure the sustainability of rural and safety net hospitals. While the State's Section 1115 Demonstration Waiver

[1] Georgia Department of Community Health Waiver Project. Georgia Environmental Scan Report. July 8, 2019, slide 3, https://medicaid.georgia.gov/document/publication/georgia-environmental-scan-report-posted-71819/download

Application ("Demonstration") sets out a number of goals and strategies described below, they do not adequately respond to the needs identified in the environmental scan.

There are three primary components to the proposed Demonstration:

- A pathway to Medicaid coverage for working Georgians with household incomes up to 100% of the FPL. To initially qualify and then maintain coverage, an individual must work or perform work-related qualifying activities for a minimum of 80 hours per month.
- Consumer-engagement elements in the Medicaid program to prepare Medicaid members to transition into the commercial health insurance market once their income exceeds 100% of the FPL. These include requirements for beneficiary premiums, copays, surcharges, and member rewards accounts.
- Premium reimbursement to those who become Medicaid-eligible through Georgia Pathways and who have access to employer sponsored insurance ("ESI") through a mandatory Health Insurance Premium Payment ("HIPP") program.

The application provides that the goals for the Demonstration are to improve access, affordability, and quality of healthcare, including through strategies that improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities; increasing the number of persons who become employed or engaged in employment-related activities; increase wage growth for those who are employed; promote member transition to commercial health insurance; empower Medicaid members to become active participants and consumers of their healthcare; and reduce the number of uninsured Georgians.

2. ***The state should pursue a Medicaid Demonstration that is expected to cover all Georgians living below the federal poverty level.***

By year 5 (2025) of the Demonstration, the state's proposal is projected to only offer coverage to roughly 52,000 of the more than 408,000 eligible Georgians statewide who currently live at or below 100% of the federal poverty level and have no health insurance[2]. The proposed Demonstration does not significantly reduce the number of uninsured and, therefore, it is unlikely that the proposal will appreciably reduce the numbers of uninsured seen by Grady and other safety net providers across the state. Instead, as proposed, Georgia Pathways will only provide coverage for less than 13% of the healthiest uninsured in Georgia. This will continue to place the responsibility of caring for hundreds of thousands of Georgia's medically underserved on rural and safety net hospitals across the state. As noted in the waiver project's Georgia Environmental Scan, these institutions already struggle to keep up with the growing medical needs of a population that increasingly has no health insurance.[3]

As discussed in greater detail below, Georgia's proposal notably would be the first to condition eligibility for Medicaid on completing work or a qualifying activity, raising new challenges for the low income and uninsured. Eligibility for the new adult population with incomes between 50% FPL and 100% FPL is

[2] Georgia Department of Community Health Waiver Project. Georgia Environmental Scan Report. July 8, 2019, slide 17 and Georgia Section 1115 Demonstration Application, p.3

[3] Georgia Department of Community Health Waiver Project. Georgia Environmental Scan Report. July 8, 2019, slide 50

further conditioned on payment of premiums and copayments. Additionally, in the stated interest of better aligning with commercial health insurance, Georgia is proposing to waive longstanding Medicaid coverage mechanisms, including retroactive coverage and hospital presumptive eligibility. The combination of a work requirement, monthly premiums that vary by income, copayments, a new member account system, a healthy behavior incentive program, and employer premium assistance program will result in beneficiary confusion and increased administrative costs to the State. Rather than improve access and quality of healthcare, Grady fears these policies as proposed will only serve to limit access and utilization of services.

a. The state should not make access to Medicaid coverage contingent on work or employment-related activities.

Georgia's proposal would be the first in the nation to precondition eligibility for Medicaid on completing work or a qualifying employment-related activity. This unique prerequisite is one reason so few Georgians are projected to receive coverage. We believe the waiver hypothesis misinterprets the directional link between work and health. Based on the stories and lives of our patients, a person must be healthy in order to work rather than the other way around. By making employment or employment-related activities a prerequisite to access to health insurance and consequently healthcare, many Georgians living below 100% FPL will be left out of the Demonstration. These include many Georgians living with persistent and severe mental illness, substance use disorders, multiple chronic conditions, and extreme social barriers such as homelessness. Some of these individuals may qualify for Medicaid through the Social Security disability process, but the eligibility process is slow and cumbersome, requiring extensive documentation of the medical condition which can be difficult for an individual to assemble without coverage. During this process, the individual's health often deteriorates further.

The Demonstration's hypothesis states, "[e]mployed individuals are both physically and mentally healthier than those who are unemployed."[4] The proposal cites studies demonstrating that employment improves health. It is worth noting, particularly in the context with which these reports are cited, that the results of these studies are not limited to low-income individuals. Further, a separate yet recent literature review found mixed results about the effects of employment on overall health.[5] Because health is the strongest predictor of employment, access to affordable health insurance promotes an individual's ability to work.[6] Corroborating these findings, studies of the implementation of Arkansas's recent Medicaid waiver establish that its work requirements did not provide an additional incentive to work or result in significant changes in employment.[7]

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[4] Georgia Section 1115 Demonstration Application, Section 1.4, p. 3 (citations omitted).

[5] *See* KAISER FAMILY FOUND., The Relationship Between Work and Health: Findings from a Literature Review (Aug. 7, 2018), https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/ [hereinafter KAISER LITERATURE REVIEW]. Additionally, studies have shown that any health benefits from volunteering are weaker when individuals are compelled to volunteer. *Id.*

[6] *See* KAISER FAMILY FOUND., Understanding the Intersection of Medicaid and Work: What Does the Data Say? (Aug. 8, 2019), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/ [hereinafter KAISER DATA REPORT]; KAISER LITERATURE REVIEW. For instance, in Ohio, Medicaid expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment and to continue working. KAISER LITERATURE REVIEW.

[7] KAISER DATA REPORT.

b. If the work requirement stays in place, additional exceptions to the eligibility requirement should be granted and additional activities, such as behavioral health treatment, should be considered as qualifying employment or employment-related activities.

While the state recognizes that there are circumstances that limit or prevent a member from being able to participate in qualifying activities that meet the hours threshold, the Demonstration's limited and short-term exceptions for a member's inability to meet the hours and activities requirements fail to recognize the barriers to stable employment. The Georgia Department of Community Health Waiver Project National Environmental Scan Report provides examples of populations that other states have exempted from work requirements or community engagement activities.[8] These include the disabled, physically or mentally unfit to work, temporarily ill/incapacitated, medically frail/receiving cancer treatment, pregnant women, students, caregiver of a dependent child/disabled dependent, individuals in substance use disorder treatment, homeless/former foster youth, victims of catastrophic events (domestic violence, natural disaster) and those incarcerated within the previous six months.[9]

Significantly, most of these populations are not granted exemptions or are only granted temporary exemptions. For example, serious illness or hospitalization is included but only as a short-term exception, not as an exemption from the eligibility requirement. If an individual is working but develops a long-term illness that prevents work, the person will lose access to coverage. Moving forward, we urge the state to consider allowing eligibility to be open to those with long-term illnesses or disabilities who are unable to participate in any significant employment.

At the very least, the State should consider amending the proposed list of qualifying activities to better account for the challenges facing the populations list above, as many eligible Georgians or enrollees could be unjustly penalized and/or disenrolled due to the narrow list of qualifying activities. Specifically, the State should consider full-time caretaking as a qualifying activity. We would argue that caretaking is work and mirrors the obligations of employment. Caretaking prevents any significant outside employment while contributing to the improved health of Georgians. For example, a mother continuing to care and support her disabled adult child is preventing the disabled adult from ending up in an institution.

Additionally, the State can move the needle on specific public health outcomes by including strategies to tackle them in the Demonstration. For example, engagement in behavioral health treatment – whether care for severe and persistent mental illness or substance use disorders – either should be an exemption from the eligibility requirement or should be considered a qualifying activity. Grady had over 107,000 behavioral health visits in 2018 alone – more than any other healthcare provider in Georgia. Mental illness and substance use disorders can prevent significant employment. Treatment enabled by healthcare coverage can change that. Like caretaking, we would argue that behavioral health treatment is work and mirrors the obligations of employment. Importantly, the cost impact of including behavioral

[8] Georgia Department of Community Health Waiver Project National Environmental Scan Report, July 8, 2019, slide 19

[9] In a recent study, 34 percent of unemployed individuals lived with multiple chronic conditions, while 51 percent had functional limitations, limiting their ability to work. *Id.* Among individuals with good health, 41% did not work because of caretaking responsibilities. *Id.*

healthcare as a qualifying activity could be minimal as the state may be able to leverage funds it is already expending on behavioral health as the source of state Medicaid matching funds.

c. The state should pursue a Medicaid demonstration that guarantees Georgia will benefit from enhanced federal funding.

The Affordable Care Act (ACA) provides enhanced federal matching funds to states that expand Medicaid to nonelderly adults up to 138% of the FPL. While a few states have sought Section 1115 demonstration waiver authority to receive the enhanced match while limiting coverage to individuals at 100% FPL, CMS has allowed states to receive the enhanced Medicaid matching funds only if the entire expansion group is covered. To this point, CMS issued a public statement on July 29, 2019 providing that,

> a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare...While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy.[10]

Additionally, a recent Georgia Budget & Policy Institute analysis indicates that in 2022 Georgia's two waiver proposals - 1115 waiver and 1332 waiver - will cost the state about $215 million to cover roughly 80,000 people.[11] In contrast, through a Medicaid demonstration that includes Georgians living up to 138% FPL, the state could provide coverage to between 487,000 and 598,000 people at a cost of between $188 million and $213 million in state funds.[12] Notably, when comparing the cost per additional covered individual under the 1115 waiver and 1332 waivers (approximately $2,700) and the full Medicaid expansion (approximately $356-$386), the full Medicaid expansion would cover far more individuals at significantly lower cost to the state per additional covered individual.

d. The state should invest in robust Medicaid reforms to reduce the number of uninsured Georgians and further address the high insurance premiums in the commercial insurance marketplace.

Comparing the two waiver applications reveals a missed opportunity to further reduce commercial insurance premium costs by reducing Georgia's low-income uninsured population. In year two of the Demonstration, the state cost of the 1115 waiver on a per person basis is approximately $1,414 versus $4,592 for the 1332 waiver. The 1332 waiver application notes that the new enrollment will largely be

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[10] CMS Statement on Partial Medicaid Expansion Policy (July 29, 2019), available at https://www.cms.gov/newsroom/press-releases/cms-statement-partial-medicaid-expansion-policy.

[11] Georgia Budget & Policy Institute, *State Health Care Proposals Fall Short and Undermine Comprehensive Health Plans* (Nov. 11, 2019) (citing Center on Budget and Policy Priorities), *available at* https://gbpi.org/2019/georgia-health-care-proposals-fall-short-undermine-comprehensive-health-plans/.

[12] Center on Budget and Policy Priorities, *Georgia Waivers: At Least as Costly to Cover Far Fewer People Than Medicaid Expansion* (Nov. 14, 2019) (citing Letter from Georgia Department of Audits and Accounts to Honorable Bob Trammel (Jan. 18, 2019)(providing fiscal estimates for House bill LC 46 0015)), *available at* https://www.cbpp.org/blog/georgia-waivers-at-least-as-costly-to-cover-far-fewer-people-than-medicaid-expansion.

among unsubsidized individuals with incomes over 400% FPL. We recognize the real affordability challenges faced by our fellow Georgians living in high premium regions of the state and the need for the state to address this issue. Importantly, a comparison of the heat map of counties with high rates of uninsured living under 100% FPL and the counties with the highest premiums as identified by the 1332 waiver application shows significant overlap[13]. Many of the high premium counties also have high rates of uninsured individuals with incomes below 100% FPL. The cost of providing care to the uninsured is a key factor driving premium costs in the commercial market not being addressed in the 1115 waiver proposal[14].

3. ***The state should amend its draft application to include the "Healthy Georgia Solution" (concept paper enclosed), which would increase the number of Georgians with coverage, improve health outcomes and bend the healthcare cost curve at no cost to the State.***

The current proposal does not take into consideration an innovative and scalable model developed by Grady Health System, in partnership with other safety net providers across the state, to improve health outcomes and reduce the high costs of healthcare. When Georgia officials originally discussed modernizing Medicaid coverage several years ago, Grady saw an opportunity to improve Georgians' health, reduce healthcare costs, and solve a growing healthcare crisis. As mentioned previously, this crisis was highlighted in the waiver project's 2019 Georgia Environmental Scan examining the state's health rankings[15]. Grady and its partners devised a plan to increase access to care, control costs to the state, ensure the sustainability of rural and safety-net hospitals, and most importantly, create a healthier Georgia.

Since developing the plan, communities in Georgia have successfully redesigned how care is delivered and seen remarkable results. During the last two years, Grady has tested a pioneering initiative to transform care for the highest risk populations statewide. By providing stronger care coordination and case management, we are driving better outcomes at lower costs. In 2017, the first year of our efforts, Grady showed a 48% decrease in average monthly total cost, a 42% reduction in emergency department visits, and a 38% reduction in inpatient stays. Furthermore, rural hospitals in Georgia have seen similar results. Studies show that giving the medically needy access to the right care results in positive outcomes and encourages healthier behaviors.

When integrated into Georgia Pathways, the Healthy Georgia Solution will enable the scaling and sustainability of these successes, many of which are grant funded and time limited. **It will also allow the state to test additional hypotheses, including the feasibility of new payment methodologies – such as value-based payments and global capitation at the provider level, the ability to lower healthcare costs, the ability to reduce cost shifting to the commercial market, and the impact of delivery system**

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[13] Georgia Department of Community Health Waiver Project. Georgia Environmental Scan Report. July 8, 2019, slide 22 and Georgia Section 1332 Demonstration Application, Appendix B (citations omitted).

[14] Georgia Hospital Association, *Hospitals 101* (2019) available at https://www.gha.org/Hospitals101, p. 14. Hospitals must collect 128% of cost from commercial payors to cover losses in Medicaid, Medicare and the uninsured.

[15] Georgia Department of Community Health Waiver Project. Georgia Environmental Scan Report. July 8, 2019, slides 49-60, https://medicaid.georgia.gov/document/publication/georgia-environmental-scan-report-posted-71819/download

transformation on the health of populations. Participating providers will absorb all costs that the state might incur and rural and urban communities throughout Georgia have expressed interest in participating. The recommended "Healthy Georgia Solution" will help urban and rural hospitals that care for the state's uninsured population. It is a proven model that delivers better outcomes and lower per capita costs.

We believe that Georgia is in an ideal position to take a more comprehensive approach to the challenges of caring for the uninsured. Otherwise, our patients will continue to suffer the consequences of a piece-meal approach that costs more and is less efficient and effective. On behalf of our patients and the communities we serve, we urge you to make the changes outlined in this comment letter and include the Healthy Georgia Solution in the proposed waiver.

We appreciate this opportunity to share with you our concerns and recommendations. If we can provide any further information, please contact Matthew Hicks, Grady's Chief Policy Officer, at (404) 616-5977 or mhicks@gmh.edu.

Sincerely,

John Haupert, FACHE
Chief Executive officer

Enclosure

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DISCUSSION DRAFT APRIL 2018 DISCUSSION DRAFT

Healthy Georgia Solution

Meeting the Medical Needs of Individuals in Poverty in Georgia through Coverage, Delivery System and Payment Reform

Proposed Section 1115 Demonstration Project
Submitted for Consideration by the State of Georgia

This paper provides a detailed description of how the Healthy Georgia Solution could be presented to the Centers for Medicare and Medicaid Services as a Section 1115 waiver demonstration project. The Atlanta Safety Net Collaborative originally designed the Healthy Georgia Solution in response to the ongoing medical needs of individuals within DeKalb and Fulton counties who live in poverty and are uninsured. The collaborative recognized the need to transform the healthcare delivery and payment systems and create a model that could be replicated throughout the State of Georgia. **[add other counties as appropriate]** This proposal was first presented to Governor Nathan Deal, Commissioner Clyde L. Reese III and other senior officials of the Deal Administration on July 16, 2015. Based on those and subsequent discussions with Georgia lawmakers, the Healthy Georgia Solution now incorporates an optional intensive care management component to improve the quality of care and lower the total cost of care provided to individuals living in certain urban and rural communities who presently qualify for Medicaid under various aged, blind, and disabled categories.

EXECUTIVE SUMMARY

The Healthy Georgia Solution ("Healthy Georgia") is a Section 1115 waiver demonstration project (the "Demonstration Project") intended to create an integrated network of care in identified urban and rural communities through the development of demonstration sites that would consist of a "hub hospital" and "spoke network" of affiliated community health providers. These networks would be called Community Health Organizations ("CHOs"). A defined population of patients would be provided a primary care medical home integrated with a coordinated system of specialty care and other support services. Over the duration of the demonstration period, each qualified CHO would transition from a traditional fee for service model into an alternative payment model based on capitation. The goal for each demonstration site would be to create a seamless system of care that would improve health outcomes, reduce per capita costs, increase access, and assure the sustainability of the safety net. Healthy Georgia would rely on networks of existing safety net providers and is designed to minimize any burden on the state budget.

The Demonstration Project will consist of individuals aged 19-64 not otherwise eligible for Medicaid and with income at or below 100% of the Federal Poverty Level ($12,060 for an individual in 2017).[1] These individuals will be enrolled in a qualified CHO and will receive comprehensive benefits through the CHO. The CHO will provide services on a fee-for-service basis with incentives for quality and cost reduction in the first two years of the demonstration. The CHOs will take on risk increasingly from years three to five of the demonstration. A second Demonstration Group (Demonstration Group II) could be considered, applying the same concepts to low income seniors and individuals with disabilities already receiving Medicaid benefits. Demonstration Group II is described in an addendum to this concept paper.

[1] 82 Fed. Reg. 8831, 8832 (Jan. 31, 2017).

This paper describes the key components of a Demonstration Project—its purpose, eligibility, benefits, service delivery, financing, budget neutrality, and evaluation.

OVERVIEW

Healthy Georgia aims to expand and improve access for the Demonstration Group population by using CHOs in certain urban and rural communities as an alternative access network and care management organization. For the Demonstration Group, access to care through the CHO network will be in lieu of what is considered Medicaid expansion under the Affordable Care Act, or insurance coverage. By targeting and consolidating care for certain populations, we expect that Healthy Georgia will mitigate the need for cost shifting to pay for the uninsured and result in reductions in expenditures against a baseline of projected health care expenditures in the absence of Healthy Georgia. Moreover, by further investing in Georgia's rural communities, Healthy Georgia will transform rural healthcare delivery systems and will assist in alleviating the financial strain on participating rural hospitals.

Coverage Gaps Remain in Georgia

As of 2016, 86% of the nonelderly population in Georgia had health care coverage compared to 90% nationally.[2] The 3 year poverty rate average in Georgia, 17.6%, was higher than the national average of 14.8%. The majority of our citizens, 55%, were privately insured through their employers or purchased coverage on the individual market (8%). Medicaid and other public programs covered 24% of the population.[3] According to the latest report from the U.S. Census Bureau, the uninsured rate declined to 12.9% for Georgia in 2016. The uninsured rate for Atlanta was 15.4%, slightly higher than the state average.[4] **[add other counties as appropriate]**

Individuals with income greater than 100% of the federal poverty level ("FPL") are eligible for tax credit subsidies to purchase coverage from Qualified Health Plans ("QHPs") through the federal Marketplace.[5] However, since Georgia has exercised its option to not expand its

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[2] The Henry J. Kaiser Family Foundation, State Health Facts: Georgia, *available at* https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22georgia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] *Id.*

[4] Press Release, U.S. Census Bureau, Atlanta Metro Area Uninsured Rate Down from 2013 (Sept. 17, 2015), *available at* http://www.census.gov/newsroom/press-releases/2015/cb15-r12.html).

[5] Under the Affordable Care Act (ACA), individuals with income between 100% and 400% of the federal poverty level (FPL) can receive advanced premium tax credits (APTC) to purchase Qualified Health Plans (QHPs) through a federal or state health insurance exchange ("Marketplace"). As of March 31, 2015, nearly 453,000 Georgians had purchased coverage through the Marketplace and 91% of these individuals received APTCs. Another 55,581 Georgians gained coverage through the Special Enrollment Period through June 30. *See* Centers for Medicaid & Medicaid Services, 2015 Special Enrollment Period - February 23 - June 30, 2015 (Aug. 13, 2015), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13.html.

Medicaid program, most individuals below the poverty level in Georgia are generally not eligible for Medicaid. It is estimated that 378,200 uninsured nonelderly adults with income less than 100% of the poverty level remain in the "coverage gap."[6]

Access Challenges Exist for those With and Without Coverage

Even among those who gain insurance coverage, many may not have access to the care they need. In 2014, the National Association of Community Health Centers ("NACHC") released a paper, "Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care" which describes an all too common concern among state Medicaid directors, namely, that coverage does not guarantee access to care:

> This year, millions of Americans will gain insurance coverage, many or most for the first time in years, if ever. That accomplishment, though historic, misses a key point: expanding health care coverage without addressing the need to provide access to high-quality preventive and primary care services addresses only part of the health care equation. **Access is more than just having an insurance card**.[7]

"Access Is the Answer" provides that, "… 62 million people nationwide have no or inadequate access to primary care given local shortages of such physicians."[8] In NACHC's June 2017 Community Health Center Chartbook, NACHC again reported that 62 million people nationwide have no or inadequate access to primary care given local shortages of such physicians.[9] Further, only 66% of primary care providers will accept new Medicaid patients compared to 97% of health center providers.[10] The Urban Institute has provided that access to care is further impacted by income; in 2011 almost one-quarter (23.3 percent) of adults with family incomes under $35,000 per year had no usual place of medical care, compared with 6 percent of those

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[6] The Henry J. Kaiser Family Foundation, State Health Facts, Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), *available at* https://www.kff.org/uninsured/state-indicator/distribution-by-fpl-2/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] National Association of Community Health Centers, *Access Is the Answer: Community Health Centers, Primary Care and the Future of American Health Care* (March 2014) at 1 (emphasis in original).

[8] *Id.*

[9] NACHC, Community Health Center Chartbook (June 2017), *available at* http://www.nachc.org/wp-content/uploads/2017/06/Chartbook2017.pdf.

[10] *Id.*

with incomes of $100,000 or higher.[11] By 2015, 27 percent of adults with family incomes under $35,000 per year did not receive medical care due to cost.[12]

However, individuals still access (and should access) the health care system even when there is no "immediate" medical care need for preventative care and recommended wellness check-ups. For example, a National Health Statistics Reports provides that "approximately 20% of U.S. adults seek health care at the emergency room ("ER") each year, a percentage that has remained largely unchanged in the last decade."[13] Notably, health insurance type has consistently been associated with ER usage for adults, with the highest rates of use among adults with public health coverage such as Medicaid, relative to adults who were uninsured or had private health insurance.[14] In 2013 and 2014, adults with Medicaid had the highest prevalence of a single ER visit in the past 12 months (16.7% in 2014), compared with uninsured adults (10.7% in 2014) and adults with private health insurance (10.2% in 2014).[15] Further, national data reveals that other demographic characteristics, including race and age, can be significant when determining use of the ER.

Researchers at the University of Wisconsin-Madison Population Health Institute analyzed utilization patterns after Wisconsin expanded Medicaid coverage to adults without children. Use of EDs and outpatient clinics increased after Medicaid expansion.[16] In contrast, Hennepin Health, a county based safety-net ACO in Minneapolis, Minnesota, reported that emergency department visits decreased 9.1 percent between 2012 and 2013, while outpatient visits increased 3.3 percent.[17] Clearly, Medicaid coverage does not necessarily mean there will be a reduction in the use of EDs, however increased coverage with care coordination can impact utilization patterns for newly enrolled patients. In addition, even though use of the ED in Wisconsin increased, hospital admissions from the ED declined, which suggests that a strong community-

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[11] Urban Institute, How are Income and Wealth Linked to Health and Longevity (April 2015), *available at* https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf.

[12] Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2015, Vital and Health Statistics, Table P-9a, *available at* ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-9.pdf.

[13] Reasons for Emergency Room Use Among U.S. Adults Aged 18–64, National Health Interview Survey, 2013 and 2014 (Feb. 18, 2016), *available at* https://www.cdc.gov/nchs/data/nhsr/nhsr090.pdf.

[14] *Id.*

[15] *Id.*

[16] University of Wisconsin Population Health Institute, Evaluation of Wisconsin's BadgerCare Plus Core Plan for Adults Without Dependent Children Report #1: How Does Coverage of Childless Adults Affect Their Utilization (Dec. 2011), *available at* http://uwphi.pophealth.wisc.edu/publications/other/core-plan-utilization-final-report.pdf.

[17] Shana F. Sandberg, et. al., Hennepin Health: A Safety-Net Accountable Care Organization for the Expanded Medicaid Population, Health Affairs 33, No. 11 (2014), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0648.

based safety net system can meet a substantial part of medical needs for adults below the poverty level.

Many Medicaid Hospitalizations are Avoidable

Hospitalization utilization among patients covered by Medicaid differs significantly from other coverage. Six of the top 10 diagnoses for Medicaid hospitalizations were for conditions for which good outpatient or preventive care can potentially prevent the need for hospitalization, so-called ambulatory care sensitive conditions ("ACSCs").[18] Researchers found that:

> Pneumonia, asthma, diabetes mellitus with complications, epilepsy, acute bronchitis, and chronic obstructive pulmonary disease (COPD) ranked among the top 10 diagnosis for Medicaid hospitalizations. Together, these diagnoses are considered *ambulatory care sensitive conditions* (ACSCs)—conditions for which good outpatient care can potentially prevent or reduce disease progression and the need for hospitalization. These six ACSCs accounted for 15.6 percent of all nonmaternal and nonneonatal Medicaid hospital stays. In contrast, among uninsured stays, only pneumonia (ranked tenth) and diabetes mellitus with complications (ranked third) were among the top 10 diagnoses, together accounting for 6.0 percent of hospitalizations. Among privately insured hospitalizations, pneumonia was the only ACSC among the top 10 diagnoses (ranked fourth), accounting for 2.6 percent of hospitalizations (emphasis in original).[19]

Alternative Payment Models and Networks are Part of Healthy Georgia

As part of the ongoing quest to improve access to care while also lowering the per capita cost of health care, Medicare, Medicaid, and commercial payers have developed and implemented a variety of alternative payment models ("APMs"). The efforts include full risk capitation, pay-for-performance, care management fees, enhanced care management fees, patient-centered medical homes, accountable care organizations, bundled payments, disease management, population management, value-based purchasing, utilization management, pharmacy benefit managers, and global payments. Additionally, some specialty provider groups such as the American Society of Clinical Oncology have developed their own proposals to "support higher quality, more affordable care."[20]

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[18] AHRQ, Healthcare Cost and Utilization Project, Characteristics of Medicaid and Uninsured Hospitalizations, 2012 (October 2014), at 7, *available at* http://www.hcup-us.ahrq.gov/reports/statbriefs/sb182-Medicaid-Uninsured-Hospitalizations-2012.pdf.

[19] *Id.*

[20] American Society of Clinical Oncology, Patient- Centered Oncology Payment: Payment Reform to Support Higher Quality, More Affordable Cancer Care (Mary 2015), *available at* http://www.asco.org/sites/www.asco.org/files/asco_patient-centered_oncology_payment_final_2.pdf

CMS funds a number of projects with the explicit purpose of lowering per capita costs.[21] In doing so, CMS has put a particular focus on the so-called "super utilizers" who account for a disproportionate share of the cost of Medicaid. Super-utilizers are individuals with complex needs and high health care costs, and often account for large numbers of ED visits and hospitalizations. Nationally, it has been estimated that just one percent of the Medicaid population accounts for 25% of total health care expenditures and five percent of Medicaid enrollees account for 54% of total Medicaid expenditures.[22] These individuals have two things in common. First, they have multiple chronic conditions: 83% of individuals in the top one percent have at least three chronic conditions and more than 60% have five or more chronic conditions. Second, many of these individuals do not receive coordinated care. As noted above, in FY 2014 alone, the ABD population in Georgia accounted for 29% of Medicaid enrollees and 57% of expenditures. Medicaid spent $4.8 billion on their behalf.

The Demonstration Project Will Address Access Needs and Lower Per Capita Costs

The Demonstration Project will address the access needs of the uninsured population in identified urban and rural geographic areas. DeKalb and Fulton counties are two of the most populous counties in Georgia. They are also minority-majority counties; less than 35% of DeKalb residents are white,[23] and in Fulton, only 45.6% are white. In 2013, nearly 132,000 DeKalb residents and 156,000 Fulton residents were enrolled in Medicaid and PeachCare. More than 30,000 residents of DeKalb and more than 41,000 residents of Fulton were eligible through the ABD categories.[24] **[add other counties once identified]**

In addition to addressing the access needs of the uninsured population in the above identified communities, Healthy Georgia will lower per capita costs against a baseline of health care expenditures and will contain existing hospital cost shifting and cross subsidization to compensate for services provided to the uninsured. By consolidating and coordinating care for the demonstration groups in proposed demonstration sites, costs for services will be directed to providers participating in the CHO.

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[21] CMCS Informational Bulletin, Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality (July 24, 2013), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-01.html.

[22] *Id.*

[23] U.S. Census Bureau, Community Facts: DeKalb County, Georgia, *available at* http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF.

[24] Georgia Department of Community Health Decision Support and Reporting Unit, Medicaid Enrollment - CY 2013 (July 10, 2013) at 2, *available at* https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/GA_Medicaid_Membership_by_County.pdf.

Demonstration Group

Healthy Georgia proposes to meet the medical needs of [**XXX**] uninsured adults in the Atlanta region by enrolling these individuals into Medicaid through the Demonstration Project's Demonstration Group I. CMS has previously approved section 1115 demonstration projects that are limited to specific regions and populations. For example, in 2013 Ohio received approval for the MetroHealth Care Plus Demonstration Project in Cuyahoga County ("Ohio MetroHealth Care Plus").[25] Ohio MetroHealth Care Plus was a safety-net institution based coverage expansion, providing coverage to uninsured adults with income at or below 133% of the FPL, who reside in Cuyahoga County, and who are not otherwise eligible for comprehensive benefits under Ohio Medicaid. The MetroHealth System and its community partner network providers provided enrollees with access to coordinated care through primary care medical homes. Ohio MetroHealth Care Plus has been viewed as a success in producing better health outcomes at a substantially lower per capita cost than originally projected.

CMS has also approved limited demonstration projects in Louisiana and Missouri; CMS approved a demonstration project for Louisiana, which limited eligibility to the Greater New Orleans region, as well as a demonstration project for St. Louis, Missouri. While Louisiana's Greater New Orleans Community Health Connection ("GNOCHC") waiver expired on June 30, 2016, the Missouri Department of Social Services ("DSS") submitted a section 1115 demonstration extension application on November 9, 2016. On September 1, 2017, CMS approved the demonstration for an additional 5 year period without any changes to eligibility, the delivery system, benefits, or cost sharing, thus continuing coverage for uninsured individuals ages 19-64 who reside in the St. Louis region with incomes at or below 100 percent of the FPL.[26]

As discussed above, Georgia will create a new provider-based coordinated care model called Community Health Organizations ("CHOs") to serve Demonstration Group I. These CHOs will be established through formal, mutual relationships between safety net hospitals and other qualified providers, including but not limited to nursing homes, charity care clinics, private providers, EMS agencies, and public health providers. The State will establish the qualifications of a CHO, including that a CHO contain a safety net hospital.[27]

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[25] Letter from Marilyn Tavenner, Acting Administrator of the Centers for Medicare & Medicaid Services, to John McCarthy, Director of Ohio Office of Medical Assistance (Feb. 5, 2013) (approving Ohio's request for Medicaid section 1115(a) demonstration, entitled MetroHealth Care Plus), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-metrohealth-care-plus-ca.pdf.

[26] Missouri "Gateway to Better Health" (Project No. 11-W00250/7) Approval Letter (Sept. 1, 2017), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mo/mo-gateway-to-better-health-ca.pdf.

[27] Pursuant to GA. Comp. R. & Regs. 111-2-2-.20(m), to be considered a safety net hospital, a hospital must meet at least two of the following: (1) the hospital is a children's hospital or a teaching hospital; (2) the hospital is designated by the Department of Human Resources as a trauma center; (3) Medicaid and Peach Care inpatient admissions constitute twenty percent (20%) or more of the total hospital inpatient admissions; (4) Uncompensated charges for indigent patients constitute six percent (6%) or more of hospital adjusted gross revenue; or (5) Uncompensated charges for indigent and charity patients constitute ten percent (10%) or more of hospital adjusted gross revenue.

The Demonstration Project will start with a fee for service model, to establish the foundational structure of the CHOs and the baseline data for the enrolled population. These entities will accept risk for the cost of care of the Demonstration Group I population, as reimbursement will not exceed the amount of funding allotted through the federal matching assistance program. After the first two years, the CHOs will work with the State to determine the appropriate timing for capitation based on the progress of cost and quality outcomes. The goal of the program will be to manage the population under a capitated model, providing each CHO with a "per member per month" (PMPM) fee for care coordination and care delivery. Demonstration Group I eligible individuals will be enrolled as a member of the CHO exclusively. An individual will not be allowed to receive services outside the CHO networks. Georgia will phase-in enrollment over time with an enrollment cap of [**INSERT**] in Demonstration Years 1 through 5.

Consistent with CMS' general policy that all demonstrations should be "budget neutral" to the Federal government, the Demonstration Project would be budget neutral to the federal government and to the State over the five year period, with a proposed July 1, 2019 start date. Traditionally, states and CMS previously would establish what the cost to the federal government would have been without the waiver and adopt policies to ensure that the waiver will not exceed those costs. However, since the enactment of the optional Medicaid expansion through the Affordable Care Act ("ACA"), CMS has consistently held that the cost of new populations could be added to a state's Medicaid program under a state plan amendment, without seeking a waiver. Notably, in calculating budget neutrality for the MetroHealth System waiver, CMS treated the optional expansion population as a hypothetical population and therefore concluded that the State could use the potential cost of expansion as the source for budget neutrality.

DEMONSTRATION AUTHORITY

Section 1115 of the Social Security Act ("the Act") provides the Secretary of Health and Human Services (the "Secretary") authority to approve state pilot programs or demonstration projects that promote the objectives of the Medicaid program. These demonstrations are called "waivers" because compliance with specified state plan requirements in the Act is waived. To date, states have obtained demonstration waivers that make broad changes in Medicaid eligibility, benefits and costs sharing, and provider payments. These waivers often are approved for a period of five years, and can be renewed, typically for an additional three years. Waivers are governed by terms and conditions that are negotiated between the State seeking the waiver and CMS. Regardless of the service or benefit covered in the waiver, or the length of the demonstration project, it is CMS' policy that all demonstrations must be "budget neutral" to the federal government, and thus Federal Medicaid expenditures during the course of the project cannot exceed Federal spending without the waiver.

PURPOSE

The federal government and the states are in search of ways to lower the per capita cost of health care and health insurance. Many states, with the approval of the federal government, are pursuing a variety of APMs in hopes of lowering the cost of care. This proposed section 1115

Demonstration Project is designed to serve the State and national interests in health care delivery and financing reforms through the following:

1. provide an alternative coverage model that will meet the medical needs of the non-elderly, non-disabled adult population with income below the poverty level;
2. provide for an integrated provider-based service delivery system that advances from the traditional fee-for-service to the managed care organizations models;
3. demonstrate that enhanced care coordination can prevent avoidable hospitalizations among the low-income, elderly and disabled populations; and
4. provide an alternative coverage solution that is less costly in the aggregate to the federal government and the state than enrollment into traditional Medicaid.

Medicaid requires a state plan to be statewide, comparable in benefits, and allow individuals freedom of choice of providers. Typically, a section 1115 Demonstration Project will waive compliance with any or all three of these requirements.

Under Healthy Georgia, the State will likely seek a waiver of the following provisions:

1. Reasonable Promptness—to allow the State to implement a "first come-first served" reservation list as a tool to manage enrollment;
2. Amount, Duration, and Scope—to enable the State to offer a benefit package that varies from the Medicaid package;
3. Freedom of Choice—to allow the State to restrict care to be provided by only certain providers;
4. Retroactive Eligibility—to relieve the State from the obligation to provide coverage for any time prior to the date of enrollment in the demonstration;
5. Eligibility Standards—to allow the State to apply different eligibility methodologies and standards for individuals under the demonstration;
6. Statewideness/Uniformity—to allow the State to operate only in the designated regions;
7. Comparability—to enable the State to provide different benefits to those receiving services at CHOs; and
8. Methods of Administration—.

ELIGIBILITY

As previously described, there are approximately 378,200 individuals in Georgia with income below the poverty level and who lack insurance coverage. Under the proposed waiver, up to **[INSERT]** of these uninsured individuals will be served in the Demonstration Group, resulting in a significant reduction in the number of uninsured individuals.

Individuals eligible for the Demonstration Group:

- Are ages 19 through 64 years;
- Are not pregnant;

- Are screened and found not eligible for Medicaid, the Children's Health Insurance Program ("CHIP") or Medicare;
- Are a resident of DeKalb County or Fulton County [**add other counties if appropriate**];
- Have family income up to 100% of the FPL[28] based on the Modified Adjusted Gross Income ("MAGI") income determination methodology; and
- Meet the U.S. citizenship requirements.

If a Demonstration Group individual becomes eligible for Medicaid (for example, a woman becomes pregnant or an individual becomes disabled), he/she will be disenrolled from the Demonstration and enrolled into the appropriate Medicaid program.

BENEFITS

The benefit package for the Demonstration Group includes all of the current mandatory and optional benefits provided under the State Plan with a notable exception: care coordination, as defined below, will be included as a covered benefit.

As previously approved by CMS in the context of the GNOCHC demonstration:

> Care coordination includes services delivered by health provider teams to empower patients in their health and health care, and improve the efficiency and effectiveness [of] the heath sector. These services may include health education and coaching, navigation of the medical home services and the health care system at large, coordination of care with other providers including diagnostics and hospital services, support with the social determinants of health such as access to healthy food and exercise. Care coordination also requires health care team activities focused on the patient and communities' health including outreach, quality improvement and panel management.[29]

Properly understood, care coordination can significantly reduce health care expenditures and should be embedded as a benefit. For example, despite claims that Medicaid costs far exceed what a provider may receive in return for services provided, recent reports indicate that the Louisiana Medicaid program could spend as much as $650 million less than projected for the 2018 budget year.[30] Louisiana Health Department Chief of Staff Andrew Tuozzolo noted that

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[28] 82 Fed. Reg. 8831, 8832 (Jan. 31, 2017). (The federal poverty line for an individual in 2017 was $12,060 and $16,240 for a family of two.).

[29] GNOCHC Special Terms and Conditions at 6-7, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/la/Greater-New-Orleans-Community-Health-Connection/la-gnoch-stc-10012010-12312013-changes-102012.pdf.

[30] Melinda Deslatte, *Louisiana Medicaid Program Running Under-Budget This Year*, The Advocate (Dec. 6, 2017), *available at* http://www.theadvocate.com/baton_rouge/news/politics/article_f0772a5a-dad1-11e7-8cc0-5313a8a48f3a.html.

reforms to Louisiana's Medicaid program, including the development of care coordination services, have resulted in "driving people to cheaper primary care services and providing improved access to care for people who were previously uninsured."[31] Each participating CHO will adopt technologies and protocols that provide a next generation prototype of care coordination that is comprehensive, cost-effective, person-centered, data-driven, and team-managed. A CHO may enter into agreements with long-term services and supports (LTSS) providers to perform some care coordination functions as means to lower hospitalization rates.

Enrollment and Assignment

Enrollment into the Demonstration will be facilitated by submitting an application by telephone, on-line, through the mail, or onsite at community partner sites. Individuals must be screened for eligibility for other public assistance programs (Medicaid, CHIP, etc.). Individuals who do not qualify for other coverage and whose application has been completed and verified will be mandatorily assigned to a CHO. The individual will become a "member" of that CHO. Medicaid will not pay for services outside the CHO network for the Demonstration Group.

Upon completion of the enrollment process, the patient engagement process will commence accordingly:

- A health risk assessment and biometric screen will be performed within 60 days to assess needs and to better manage the individual's overall health and well-being.
- Those who are identified as moderate to high-risk individuals will be assigned to a care team and receive specialized condition management and health coaching services. The care team will work with the individual to establish a plan of care with person-centered metrics consistent with patient engagement and accountability described in the following section.

Patient Engagement and Accountability

While there have been some attempts to introduce incentives to change the behavior of Medicaid enrollees, there is a dearth of evaluations that conclusively point to success. Results have been mixed at best.

Qualified CHOs may offer alternative options for moderate to high-risk members to earn incentives through risk reduction activities to encourage such individuals to engage in their health care. Such activities and incentives may include the following:

- Participation in educational offerings
- Maintaining appointments
- Calling prior to emergency department visits for appropriate triage
- Medication compliance

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[31] *Id.*

- Lab testing compliance
- Biometrics outcomes
- Access to health clubs or other fitness resources
- Use of limited cellphone service to ensure and allow for communication between patient, physician, and health coaching team
- Additional data use for appropriate use of cellphone
- Reduction in cost-sharing

The State will ensure that any cost sharing will be nominal, as stipulated in 42 C.F.R. § 447.54. Standard Medicaid exemptions from cost-sharing would apply to the Demonstration population and a provider could not deny services to a Healthy Georgia eligible individual whose income is below the poverty level if the individual does not pay at the time the service was provided. That being said, in the interest of strengthening beneficiary engagement in their personal healthcare plan and promoting responsible decision-making, the individual would still be responsible for his or her cost-sharing obligations and payment could be collected at a later time.

SERVICE DELIVERY

The Collaborative recognizes that Georgia and the federal government have already made major investments in health care through the State's existing system of safety net hospitals and community health centers. In 2014, 32 health centers in Georgia provided primary care services to nearly 157,000 Georgians aged 18 and older who were uninsured.[32] The health centers provided care to more than 194,000 patients of all ages who lived below the poverty level. The State and local governments have also made significant investments in the safety net hospital system.

As stated above, the CHOs will create a new provider-based coordinated care model to serve the eligible Demonstration Group enrollees. Services will be delivered to the Demonstration Group population exclusively through the new CHOs.

CHOs would be established through formal, mutual relationships between safety net hospitals and qualified health centers. The state will establish the qualifications of a CHO, which must include a safety net hospital.[33] Additionally, qualified CHOs must:

- Demonstrate a clinical network of providers designed to ensure access through convenient locations and office hours.
- Have the ability to efficiently communicate patient records and other patient information to all members, their care teams, and other community partners within the network.

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[32] Health Resources and Services Administration, 2014 Health Center Data: Georgia Data, *available at* http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=GA

[33] *Supra* note 28.

- Employ sophisticated data analytics, evidence-based measures for wellness/preventive care, chronic disease management, and care coordination across multiple provider settings to reduce emergency department visit rates, reduce inpatient hospitalization rates, and reduce inpatient hospital lengths of stay.

To avoid unnecessary costs to develop new tools that will satisfy the requirements of patient engagement, population management, and care coordination, the state may pre-certify tools for CHOs to use to satisfy this requirement.

REIMBURSEMENT AND FINANCING

For the Demonstration Group, each qualified CHO will receive Medicaid fee-for-service payments for clinical care in DY 1 through DY2. The State will work with the CHOs to establish a baseline of clinical quality, utilization and cost. In the first two years, the CHOs may earn additional payment for achieving quality and cost target results. Funding to each CHO will be limited by the local match; therefore, each CHO will be at risk not to exceed that fund. Lower expenses may also result in a shared savings incentive. In DYs 3-5, the payment structure may move to a capitated payment per enrollee and the CHOs will bear risk based on these capitated payments. In DY4 and DY5, the CHOs will receive an increase (or decrease) equal to the change in the per capita change in the Gross Domestic Product (GDP). Per capita GDP is presently projected to increase from in a range between 4.4% and 4% during the period 2017-2020.[34] Per capita National Health Expenditures (NHE) are projected to increase in a range between 4.5% and 5.3% during this time. Thus, this part of Healthy Georgia could demonstrate that per capita health care expenditures can be held to grow at a level equal to GDP.

For care coordination of the Demonstration Group, each CHO will receive two types of payments:

1. A one-time [$100] payment for the initial assessment and care planning for a new enrollee.
2. A monthly payment of [$50] for care coordination of individuals with 2-9 medical conditions.

The State does not intend to seek an enhanced federal FMAP for services provided through the CHOs. In addition to traditional sources of state matching funds, a CHO may be able to provide matching funds through Intergovernmental Transfers (IGTs) to secure federal funding.

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[34] Centers for Medicare & Medicaid Services Office of the Actuary, National Health Expenditures (NHE) Projections 2014 - 2024, Table 1: National Health Expenditures ad Selected Economic Indicators, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

BUDGET NEUTRALITY

Section 1115 of the Act provides the Secretary with the authority to approve state pilot programs or demonstration projects that promote the objectives of the Medicaid program. To date, CMS has approved demonstrations similar to Healthy Georgia as budget-neutral using the "hypothetical" or "pass-through" population concept. Given CMS' prior approval of similar costs and populations in the context of calculating budget-neutrality, budget neutrality should not be an issue for Healthy Georgia. Regardless of the service or benefit covered in the waiver, or the length of the demonstration project, it is CMS' general policy that all demonstrations should be "budget neutral" to the Federal government, and thus Federal Medicaid expenditures during the course of the project cannot exceed Federal spending without the waiver. Accordingly, states and CMS previously would establish what the cost to the federal government would have been without the waiver and adopt policies to ensure that waiver will not exceed those costs. If a state were to propose additional costs, such as including coverage for an optional population, then the state would be required to find savings to offset those additional costs.

However, since the enactment of the optional Medicaid expansion through the ACA, CMS has consistently held that the cost of new populations could be added to a state's Medicaid program under a state plan amendment, without seeking a waiver. Therefore, states such as Arkansas, which expanded coverage under a section 1115 demonstration project rather than a state plan amendment, were not required to find other savings within their Medicaid programs to offset the cost of new coverage.[35] CMS has explicitly recognized this possibility in an optional waiver application template released in October 2012 that included a standard budget neutrality form that states can use when submitting a demonstration application.[36]

The Ohio MetroHealth Care Plus waiver, approved in 2013, may be the closest analog to the proposed Healthy Georgia Solution. The Ohio MetroHealth Care Plus waiver was one of a number of waivers CMS granted to states after passage of the ACA that allowed a limited network expansion in a local geographic area. The Ohio MetroHealth Care Plus waiver relied on the fact that the ACA had created an option for states to expand Medicaid before January 1, 2014.[37] These expansions did not receive the 100% FMAP. In calculating budget neutrality for the Ohio MetroHealth Care Plus waiver, CMS treated the expansion population as a hypothetical

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[35] *See* Government Accountability Office, Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns, GAO-14-689R (Aug. 8, 2014), at 3 ("HHS approved a spending limit for the demonstration that was based, in part, on hypothetical costs").

[36] CMS section 1115 demonstration budget neutrality form, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf, at 4 ("Some state proposals may include populations that could be made eligible through a State plan amendment, but instead will be offered coverage strictly through the Demonstration. These populations are referred to as "hypotheticals" and CMS is available to provide technical assistance to states considering whether a Demonstration population could be treated as a hypothetical population.").

[37] 42 USC § 1396a(k)(2).

population.[38] Since the population was an optional expansion population, CMS and the State could use the potential cost of expansion as the source for budget neutrality. Although "the state may not derive savings from this population,"[39] budget neutrality was not a problem.

Although the ACA, through 42 USC 1396a(a)(10)(A)(i)(VIII), imposed the Medicaid expansion requirement by adding a mandatory population, the Supreme Court has made this population into an optional population in the same way it was in 42 USC 1396a(k)(2). Since CMS previously treated an optional expansion implemented at a local level through a defined network as a pass-through or hypothetical population for budget neutrality purposes, there is no reason why they should not do the same for the proposed Demonstration.

EVALUATION

Section 1115 Demonstration Project is required to evaluate progress toward achieving their objectives and report the results.

Potential objectives under the Demonstration to be evaluated will include:

- Reducing the per capita cost of health care against a baseline;
- Reducing the rate of hospitalization for ACSCs;
- Substantially reducing the amount of primary care delivered in hospital emergency departments;
- Reducing the uninsured rate among adults with income at or below the poverty level;
- Improving the health status of individuals by improving quality of care;
- Increasing the number of adults with income at or below the poverty level who receive care from a regular source;
- Further developing and expanding models of care coordination;
- Utilizing PCMHs to ensure that appropriate services are provided in a coordinated and cost-effective manner for the Demonstration population;
- Evaluating the effectiveness of care coordination and incentives in changing behaviors in the Demonstration population;
- Securing the fiscal stability of rural hospitals, safety net hospitals, and safety net providers;
- Limit or even eliminate cost shifting related to uncompensated care provided to the uninsured; and
- Further refine the population and skills of the community health workers providing care coordination services to Medicaid and uninsured individuals.

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[38] Ohio MetroHealth, Special Terms and Conditions (STC), Par. 56.a.

[39] *Id.*

SUMMARY

As discussed herein, Healthy Georgia is intended to reform the way healthcare for the uninsured and underinsured is delivered and paid for in the state. Through the creation of CHOs in select communities, Georgia will be better able to meet the medical needs of and improve the quality of care provided to the uninsured and individuals living in poverty. Specifically, Healthy Georgia will create an integrated network of care that will consist of a "hub hospital" and "spoke network" of affiliated community health providers, in which a defined population of patients will be provided a person-centered medical home integrated with a coordinated system of specialty care and other support services. In addition to providing improved access to care, by transitioning to a more coordinated care model, Healthy Georgia will implement an APM for the CHOs and participating providers based on capitated payment methodologies. Notably, the CHO will move from fee-for-service in the first years to risk for all covered services.

In summary, the goal for each demonstration site will be to create a seamless system of care that will improve health outcomes, reduce per capita costs, increase access, and assure the sustainability of the safety net. By targeting and consolidating care for eligible populations, Healthy Georgia will not only provide increased access to cost effective care for individuals that were previously uninsured, but will also mitigate cost shifting to pay for the uninsured. In doing so, Healthy Georgia will rely on networks of existing safety net providers and is designed to minimize any burden on the State budget.

Ultimately, Healthy Georgia is designed to be of national significance in a number of ways including the prevention and reduction of hospitalizations for persons with ACSCs and for effective payment strategies for persons with complex medical needs.

Demonstration Group II

In addition to covering the newly eligible individuals enrolled under the above described Demonstration Group, Governor Deal's Administration has expressed an interest in improving care coordination for high risk, high cost populations. As part of the Demonstration, CHOs may also provide enhanced care management to low-income seniors and individuals with disabilities. This population is referred to as Demonstration Group II. The designated CHOs will provide services to these Demonstration Group II enrollees in the enrollees' communities, with a particular emphasis on lower costs and preventing avoidable hospitalizations. The CHO Demonstration Group II models and services will have features similar to patient-centered medical home ("PCMH") initiatives employed in other states.

Demonstration Group II will consist of individuals who are already eligible for Medicaid under any of the aged, blind, and disabled ("ABD") eligibility categories except those who are also eligible for Medicare.[40] Like the Demonstration Group, these individuals will be enrolled in qualified CHOs. The CHOs will receive enhanced case management fees ("ECMFs") for care coordination. The care coordination will be designed and intended specifically to reduce the use of Emergency Departments ("EDs"), avoid unnecessary hospitalizations, and reduce the average length-of-stay ("LOS") in institutional care. Performance will be assessed retrospectively. While the CHO will not be fully at risk for these services, the CHO may be required to rebate a portion of the ECMF if it does not meet performance goals. Moreover, while a state could pay ECMFs under a state plan amendment, a waiver will be needed in order to remove freedom of choice of providers and statewideness requirements.

For Demonstration Group II, the CHO will provide care coordination to improve access to care and the quality of care provided.

In a report for AHRQ, "Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions," researchers at Mathematica recognized the potential for managing the care of individuals with complex medical needs such as the aged, blind, and disabled population:

> Because complex-needs patients receive services from multiple health professionals and social service agencies, they are at the highest risk for fragmented care and poor outcomes. Examples include poor chronic disease management for those with persistent mental illness, inadequate preventive services for adults with developmental or physical disabilities, critical lapses in assessment of vulnerable elders, and poor comfort management for the terminally ill. A fully transformed PCMH practice should be able to address many of these shortcomings.[41]

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[40] In FY 2016, the ABD population accounted for approximately 27 percent of Medicaid enrollees and 56 percent of expenditures. Medicaid spent $5.1 billion on their behalf. *See* Georgia Department of Community Health, FY 2016 Annual Report, *available at* http://dch.georgia.gov/sites/dch.georgia.gov/files/2016AnnualReport.pdf.

[41] AHRQ, *Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions*, (Jan. 2012) at 4, *available at*

The report describes five programs in North Carolina, Massachusetts, Minnesota, and Wisconsin which serve patients who are disabled and have multiple chronic conditions.

Medicaid and other payers have expanded their use of PCMHs over the past several years. Researchers at the Harvard Medical School found that the number of initiatives featuring payment reform incentives had increased from 26 in 2009 to 114 in 2013 and that the number of patients served by these initiatives had increased from about 5 million to 21 million. [42] Payers continue to develop and refine their payment methodologies which include different combinations of Fee-for-Service ("FFS") payments, per member per month payments, pay-for-performance bonuses, shared savings payments, up-front payments, and separate payments for care coordination. The Harvard study found that 30% of Medicaid-only PCMH initiatives pays for care coordinators separately from other payments.[43]

Even with the progress that has been made in recent years, payers are still experimenting with the right blend of compensation to the PCMH. In the Mathematica review, the researchers concluded:

> Clearly, effective care of complex-needs populations requires primary care practices to devote more professional time and other resources to them than to their less complicated patients. While the care coordination payments offered in programs are relatively modest ($5 per month in one program), previous estimates by the Centers for Medicare & Medicaid Services (CMS) suggest much higher reimbursement may be needed to support medical home services for even moderately complex Medicare beneficiaries. One analysis estimated more than $100 per beneficiary per month for medical home services for Medicare patients with greater disease burden and higher predicted future costs to Medicare … . It was beyond the scope of this paper to determine how each example program targets complex patients for varying levels of care coordination and enhanced services. Also, it remains unclear how much payment is required to compensate PCMHs for the extra time and resources required to provide high-quality, appropriate care to patients with complex and varying needs, so these are critical research questions. In addition, it is important to determine how to structure payments to optimize PCP participation in comprehensive assessment, individualized care plans, consultation with patients and family members, facilitating access to health and social services, and coordinating care across settings and multiple providers.[44]

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https://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20for%20Adults%20with%20Complex%20Care%20Needs.pdf (internal citations omitted).

[42] *Patient-Centered Medical Home Initiatives Expanded In 2009–13: Providers, Patients, And Payment Incentives Increased*, 33 Health Affairs 1823-31 (Oct. 2014), *available at* http://content.healthaffairs.org/content/33/10/1823.full.

[43] *Id.* at 1828 (Exhibit 3).

[44] AHRQ, *Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions*, at 29-30.

In other words, this part of the proposed Demonstration Project, in particular, would be of national significance.

Individuals eligible for Demonstration Group II:

- Are currently eligible for Medicaid under one of the ABD categories;
- Are not eligible for Medicare;
- May reside in a skilled nursing facility;
- May participate in a Medicaid home and community based services waiver;
- Are residents of DeKalb County or Fulton County [**add other counties if appropriate**]; and
- Are screened by the state and found likely to be in the top 25% of highest cost individuals.

Demonstration Group II is already eligible for the full array of Medicaid benefits under the State Plan due to the fact that Demonstration Group II will consist of individuals who are already eligible for Medicaid under any of the ABD eligibility categories. However a care coordination benefit, as defined below, will similarly be added for the Demonstration Group II population.

For care coordination of Demonstration Group II, each CHO will receive three types of payments:

1. A one-time [$100] payment for the initial assessment and care planning for a new enrollee.
2. A monthly payment of [$50] for care coordination of individuals with 2-9 medical conditions.
3. A monthly payment of [$75] for care coordination of individuals with 10+ medical conditions or who is receiving treatment involving high cost specialty services and drugs such as Hepatitis C, oncology, and cardiology.

For Demonstration Group II, the success of a CHO will be measured in a number of key improvements, including the prevention of avoidable hospitalizations, shortening LOS, and medication adherence. Beginning in DY 2, if a CHO fails to meet the mutually agreed upon performance measures, it will rebate [five] percent of the fees it received.
The increase in fees for Demonstration Group II is not subject to budget neutrality as states have the authority to set rates for a variety of case management codes.