February 29, 2012

David A. Cook, Commissioner  
Department of Community Health  
2 Peachtree Street, NW  
40th Floor  
Atlanta, GA 30303-3159

Re: Medicaid and PeachCare Redesign

Dear Commissioner Cook:

We are writing to you on behalf of a diverse cross-section of physicians and hospitals in Georgia. We would like to address the report that Navigant prepared for the Georgia Department of Community Health (DCH) as it makes plans to redesign the Medicaid and PeachCare programs in the state. With the release of the Navigant report, the Medical Association of Georgia (MAG) convened a working group representing solo physicians, multispecialty large group physicians, health system physicians, specialists, rural and urban hospitals, as well as an academic teaching institution. We want to thank you for the opportunity to participate in this very important initiative as we seek to find health care solutions for the state’s neediest populations. We also look forward to working with you throughout the process.

As Navigant pointed out in its report, a number of states are looking at managed care models as they brace for the Patient Protection and Affordable Care Act-driven influx of Medicaid beneficiaries – including more than 600,000 in Georgia – in 2014, especially those with the chronic conditions. But we still view managed care, including the CMO system that is currently in place in Georgia, as largely experimental and unproven (i.e., it hasn’t delivered substantial value or cost savings). It was, indeed, unsettling to learn that Navigant discovered that dramatic cost overruns and deferred payments have been the norm among the 12 state managed care models it evaluated.

According to the latest information from the Henry Kaiser Foundation, the amount of money that Georgia currently spends on Medicaid patients per capita ($4,074) is already the third lowest in the nation. That means it is unlikely and unreasonable to think that we can squeeze much more out of the system, especially when you consider that both hospitals and physicians have already been decimated by the payment reductions and administrative burdens that have been imposed on them by the CMOs in the state.

Some important caveats notwithstanding – and in light of the fact that it is improbable that the Georgia legislature will abolish the CMO system in the state – we nevertheless view the fee-for-service and CMO systems that are currently in place in the state as the best-available option. We also believe that DCH should conduct several pilot programs to evaluate alternative models that physicians believe hold some promise. These models should be evaluated from a number of perspectives, including cost and benefits, practical implications, and the implications for unique areas and populations. This dual-pronged approach
will give physicians and other key stakeholders a chance to evaluate the concepts without disrupting the entire Medicaid program in the state in a permanent, wholesale way.

We believe that DCH should test 1) a Patient-Centered Medical Home (PCMH) model for children and adults who have chronic diseases or who have critical care needs that require more careful management and 2) a private, free-market care model (e.g., health savings accounts, defined private benefit plan), which might be a good fit for the new working-class beneficiaries who will become Medicaid eligible in 2014.

In redesigning the Medicaid and PeachCare programs, MAG also believes that DCH should…

- Use models that are diverse enough to account for the different Medicaid populations, geographic nuances, and disease nuances.
- Maintain the fee-for-service system for the aged, blind and disabled patient populations given their need for unhindered care. Children with chronic health conditions and disabilities would benefit from a PCMH based system rather than straight fee-for-service.
- Be cautious when it comes to co-pays, which can 1) discourage patients from getting the care they need and 2) result in financial losses for physicians and hospitals.
- Prohibit “all products clauses” in all physician contracts.
- Employ state-managed models rather than those that rely on contractors since the corresponding administrative costs increase from about three percent to nine percent or more.
- Adopt policies that will result in patients assuming more responsibility for their own care.
- Increase physician payments for Saturday and evening care to reduce the need for more costly hospital emergency room care.
- Increase the use of telemedicine.
- Reinstate the 20 percent copayment for dually eligible Medicare and Medicaid patients, and allow physicians to collect co-pays from patients who have private insurance as their primary insurance and Medicaid as their secondary insurance.
- Improve the uniformity of the “quality of care” reporting requirements for physicians. Reporting requirements for pediatricians should be specific to the care that they provide to children.
- Employ a clear and graduated formula for payments for physician office-based or clinic case managers under the “Patient-Centered Medical Home” model that is based on the severity of the patient’s disease and/or the extent of the management that is required.
- Create community-based, hospital, clinic, or physician service models that can be implemented at the local level and replicated in other areas.
• Form community-level adult and pediatric advisory groups that can oversee how the system operates at the local level and offer advice on ways to enhance Medicaid and PeachCare services.

• Standardize the provider contracts that are used by the CMOs so they have the same non-financial terms.

• Standardize the precertification and prior authorization requirements among the CMOs.

• Require CMOs to adopt one set of rules for claims auditing.

We also believe that DCH must simultaneously modify the current Medicaid/PeachCare programs in a number of ways, including credentialing, quality of care reporting, administrative efficiency, patient access, payment levels, patient education, and service denials.

The credentialing process should employ: a single, uniform, paperless process – one that pays physicians on a retroactive basis once the requisite credentialing information has been submitted; a process that lasts no more than six weeks; a single physician identification number vs. one per practice location; better, clearer instructions; a better way to contact administrators; more timely updates; and, finally, a confirmation.

If we look at the bigger picture, it is important to point out that physician pay for Medicaid in Georgia has remained flat for 10 years – despite rising costs and ever-increasing administrative burdens. The Medicaid fee-for-service payment rate, which is 86.5 percent of the Medicare rate, simply doesn’t cover the cost of providing the care. And matters have grown worse under the CMOs, which have phased out the majority of case management fees while significantly increasing the administrative demands. Change notwithstanding, the future looks especially bleak for primary care physicians in rural areas who have a disproportionately high number of Medicaid patients.

There is, of course, a relationship between physician pay and the number of physicians who participate in the Medicaid program. So it is no surprise that the DCH Board of Directors has reported that the number of physicians who participate in the Medicaid program in Georgia has dropped by more than 15 percent in the last five years. We consequently believe that DCH should establish a minimum/base level physician fee schedule for Medicaid to provide some stability.

Other factors that discourage physicians from participating in the Medicaid program in Georgia include excessive numbers of prior authorizations, required reports, and medical necessity reviews, as well as the overall complexity of Medicaid rules. What’s more, services are often fragmented due to interruptions in treatment that are caused when more expensive, though necessary, services like radiology, physical therapy, and other testing are denied. It is important for DCH to take steps to address these issues.

We are concerned about the accuracy and usefulness of quality reporting by the CMOs since it’s not standardized or easily accessible for review and tracking by health care clinics and physicians.

We also believe that the Medicaid/PeachCare system in Georgia needs to be better aligned with other children’s care programs in the state to avoid duplicity and facilitate better coordination of care.
Finally, we would like to see DCH put better controls in place (e.g., annual/one-year enrollment terms) to reduce the frequent eligibility changes that plague today’s system to ensure that patients get the best possible care (i.e., continuity). For example, enrolling all eligible children in Medicaid at birth and keeping kids enrolled in the appropriate program as family income levels change.

It is imperative for physicians in Georgia to secure some peace of mind and budget certainty as they assess whether it is feasible for them to participate in the Medicaid and PeachCare programs in the future. Therefore, we are encouraging DCH to address that gap in confidence as a deliverable to ensure that the state’s neediest patients continue to have access to the physicians and the medical care they need.

Please contact Donald J. Palmisano Jr. with MAG at dpalmisano@mag.org or 678.303.9250 in the event you have comments or need additional information.

Sincerely,

Sandra B. Reed, M.D., President
Medical Association of Georgia

Quentin R. Pirkle, M.D.
Quentin R. Pirkle, Jr., M.D., Chair,
Piedmont Clinic Board of Directors,
a subsidiary of Piedmont Healthcare

Richard J. LoCicero, M.D., President
The Longstreet Clinic, P.C.

Steven M. Walsh, M.D., President
Georgia Society of Anesthesiologists

Jose M. Tongol, M.D., President
Georgia Society of Clinical Oncology

Matthew J. Watson, M.D., President
Georgia College of Emergency Physicians

Robert N. Vincent, M.D., President
Georgia Chapter, American College of Cardiology

Leland C. McCluskey, M.D., President
Georgia Orthopedic Society
Howard M. Mazier, M.D., President
Georgia Psychiatric Physicians Association

Harold L. Kent, M.D., President
Georgia Society of American College of Surgeons

Michael Sharkey, M.D., President
Georgia Society of Dermatology and Dermatologic Surgery

Marvin A. Rachelefsky, M.D., Treasurer
Georgia Neurological Society

Malcolm S. Moore ("Sid"), Jr., M.D.,
Legislative Chair
Georgia Society of Ophthalmology

Arthur J. Torsiglieri, M.D., President
Georgia Society of Otolaryngology

Michael D. McEachin, M.D., President
Georgia Society of Pathology

CC: Jerry Dubberly, Pharm. D., Chief, Medical Division, DCH
    Terri Branning, Executive Medicaid Business Analyst, DCH