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Healthcare

January 18, 2017

Senator Johnny Isakson
SR-131 Russell Senate Office Building
Washington, DC 20510-1008

Dear Senator Isakson,

The Woodruff Health Sciences Center at Emory University welcomes the opportunity to provide you with our unique perspective during the current health care policy deliberations. In particular, I seek to articulate policy elements in this letter that would provide states with greater flexibility in implementing their Medicaid programs, while simultaneously improving access to care for a larger number of Georgia residents. We believe strengthening Medicaid and ensuring consistency and efficiency of this program are critical and necessary components to a replacement solution as Congress and the new administration contemplate options for the Affordable Care Act (ACA). Specifically, we ask you to consider the following:

- **Improve sustainable access to quality health care for Medicaid participants by raising Medicaid reimbursement to levels commensurate with Medicare.** The Medicaid-to-Medicare Fee Index, representative of how much providers are reimbursed for provision of services to Medicaid vs Medicare recipients, is on average 0.66 across the United States². Translated, this means providers are only reimbursed 66¢ by Medicaid for every Medicare \$1.00 for equivalent services provided. According to a recent Kaiser Family Foundation survey³, 23% of Medicaid respondents reported problems finding a health care provider willing to accept their insurance, compared to about one in ten among those with employer-sponsored insurance or Medicare (9% each). Improving reimbursement for providers to levels equivalent to Medicare will help ensure necessary access to quality health care. Further, adequate reimbursement for provision of services is critical for rural providers and failure to do so will continue to result in risk of these providers shutting down or choosing not to locate their services in rural areas.
- **Allow for expansion of Medicaid coverage, based upon Federal Poverty Level (FPL), to those who may possibly lose exchange-based coverage.** The Medicaid expansion across 32 states undertaken pursuant to the ACA provides coverage for low-income adults with incomes up to 138% FPL. In the 19 states that have not expanded, the median eligibility limit is 44% FPL, with Georgia currently at 37% FPL. To qualify for the tax credits under the ACA, people

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generally must have household income between 100 percent and 400 percent of FPL and not have access to certain other sources of health insurance coverage (such as “affordable” coverage through an employer, as defined in the ACA, or coverage from a government program, such as Medicaid or Medicare). To qualify for the cost-sharing subsidies, people must have household income below 250 percent of the FPL. Expansion of Medicaid above FPL current levels towards 250-400% combined with tax incentives would be a uniform solution for ensuring a consistent and equitable replacement mechanism.

- **Expand Medicaid dollars for Graduate Medical Education (GME) to develop our necessary workforce pipeline and strengthen access to care.** Medicaid plays a critical role in funding GME. Approximately \$5 billion is provided via state and local governments for medical school training annually⁴. Most states choose to allocate a portion of their Medicaid budget to fund direct graduate medical education (DGME), indirect medical education (IME), and other special services provided by teaching hospitals. State budget shortfalls and the prevalence of Medicaid managed care organizations present serious concerns that fewer Medicaid funds will be available to train future physicians. Stagnation or cuts to GME funding jeopardize the ability of teaching hospitals to train the next generation of physicians at a time when the nation is already facing a critical shortage of physicians. Expansion of federally-supported Medicaid dollars will strengthen our needed workforce.
- **Call for standardization and improved efficiency of Medicaid eligibility determination and claims processing.** Much debate exists over the efficiency or inefficiency of Medicare and Medicaid administrative costs⁵. While advances in eligibility determination have been seen, these improvements are not being initiated consistently across the United States. Twelve states, including Georgia, do not provide real-time determination and an additional twenty states perform real-time determination less than 50% of the time⁶. Medicaid approval is largely income and asset based, and electronic systems are readily available to provide reliable and efficient service. Promotion of a fully electronic eligibility system could save currently wasted time and money for all parties involved – patients, providers and payers. Further efficiencies could also be gained by adoption of a common claims settlement process with Medicare, using common payment rules and claims adjudicators.
- **Support for continuation, and where appropriate, expansion of Medicaid Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments.** Hospitals that serve our neediest, including Academic Medical Centers such as Emory, depend upon DSH and UPL for financial sustainability. PPACA and the growth of managed Medicaid plans have negatively impacted these payments. The CMS final rule released today on restricting Medicaid pass-through payments is the latest such example; it is expected to adversely impact hospital finances by \$3.3 billion annually. As alternatives are considered, it is vitally important for these to be continued in appropriate scale and sustainability to ensure ongoing access to care.
- **Expansion of Medicaid coverage for vital patient care services.** There are several key services we feel are vital to those covered by Medicaid that should be expanded as solutions are developed. These include improving access and coverage for mental health services;

support for expansion of efficient and connected telehealth; coordination of care across the continuum including access to post-acute care resources, such as acute rehab and skilled nursing care; and rational coverage of key quaternary services such as transplantation. For instance, in the state of Georgia, heart transplant is covered by Medicaid up until the age of 21, after which time it is no longer a covered benefit. How is a provider to tell a patient that one day you are eligible for this life saving treatment and the next day you aren't simply because you are one day older?

As the largest contributor to Medicaid funding at 62.8%¹, the Federal government is uniquely positioned to help strengthen the program's current deficiencies as health care solutions are contemplated. I recognize the discussions and deliberations will be tense, with many opinions and perspectives by various parties. As a national leader in academic health care and the only comprehensive academic health system in Georgia, Emory's Woodruff Health Sciences Center is pleased to offer our collective expertise on these and any other matters as we move towards the restructuring of our national health care federal support. We would welcome the opportunity, at your convenience, to discuss these recommendations with you and your staff.

Sincerely,

A handwritten signature in black ink that reads "Jonathan S. Lewin MD". The signature is written in a cursive, flowing style.

Jonathan S. Lewin, MD
Executive Vice President for Health Affairs, Emory University
Executive Director, Woodruff Health Sciences Center
President, CEO and Chairman of the Board, Emory Healthcare

¹ Source: Urban Institute estimates based on data from CMS (Form 64), as of September 2016.

² Source: Kaiser Family Foundation with credit to Stephen Zuckerman, Laura Skopec, and Kristen McCormack, "[Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?](#)" Urban Institute, December 2014.

³ Source: Kaiser Family Foundation Medicare and Medicaid at 50 Survey (conducted April 23 – May 31, 2015).

⁴ Source: AAMC

⁵ Source: <http://jhpl.dukejournals.org/content/early/2013/02/11/03616878-2079523.abstract>

⁶ Source: Kaiser Family Foundation Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey.