

National Update

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Fast Facts

[10,484](#) kids were enrolled in Louisiana's Medicaid program in one night in February, using Express Lane Eligibility.

[35](#) states have high-risk pools. States must determine this spring how they will participate in the high risk pool program established by health reform.

[\\$267](#) million in funding has been awarded so far to 28 non-profit organizations to establish

Welcome to the first edition of HMA's National Update. This newsletter will be distributed electronically at least quarterly and will highlight current and emerging issues and opportunities of interest to HMA's clients, friends and colleagues. This initial issue focuses primarily on health reform.

Navigating Health Reform Implementation

For the entire health care sector, President Obama's signing of the Patient Protection & Affordable Care Act marks the beginning of a new phase of reform - an intricate, protracted, and complicated planning and implementation process. States, guided by federal rules, will be at the center of that process.

Some challenges will be common, like how to structure insurance exchanges and how to manage a Medicaid expansion. At the same time, the significance of federal reform will affect states differently. The two pillars of reform - an expansion of public health insurance coverage and the restructuring of the health insurance market - are areas in which prevailing conditions vary widely.

HMA understands that the challenges of implementation will not be met with simple, one-size-fits-all solutions. Within a defined federal framework, the consequences of reform, and the best ways to deal with them, will be necessarily unique to a state's circumstances. State innovation and creativity has been a force for change in health care for a long time, and now the execution of "national" reform provides another opportunity for states to drive health system change.

Since HMA was founded 25 years ago, our firm has been fortunate to have played roles with states, health plans, and providers in expanding access, improving quality, and controlling costs. As we have grown, we have recruited colleagues across the country who, as senior state officials, were responsible for devising state-based reforms and for putting policy into operation.

Now we face the most daunting and fascinating challenge of all. At HMA, as a firm and as a group of dedicated professionals, we have been preparing for this moment for decades. We look forward to

Health Information Technology (HIT) Regional Extension Centers.

Hospital rates of postoperative bloodstream infections increased [8 percent](#) in 2009.

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Events

"State Budgets and Health Care"

[Kathy Gifford](#), Panel Member
National Health Policy Forum
April 30, 2010
Washington, DC

Community Memorial Foundation Health Reform Briefing

[Tom Dehner](#), and [Matt Powers](#)
May 6, 2010
LaGrange, Illinois

"Medicaid and Managed Care"

[Vern Smith](#) with [Jim Frizzera](#)
Medicaid Managed Care Congress
May 17, 2010
Baltimore, Maryland

March of Dimes Public Policy Advisory Committee

[Tom Dehner](#)
June 4, 2010
Washington, DC

"Health Care Reform and Medicare/Medicaid: Implications for Health Plans"

[Vern Smith](#)
America's Health Insurance Plans
2010 Policy Institute
June 11, 2010
Las Vegas, Nevada

CBI's 3rd Summit on Managed Care Marketing Strategies

working with all of our clients to navigate health reform implementation.

Marilynn Evert, CEO

Now What? Medicaid Magnification



The process of implementing federal health reform looks complex, to the extent it looks like anything at all at this early stage. Planning is imperative, but an extended implementation period - with most of the largest changes beginning in

2014 - complicates both the identification of challenges and the clear assessment of opportunities. Some will get lost in the blizzard of summaries or the myriad timelines being produced. Others will try to predict how it will all turn out in the end. We think it is worth pausing to take stock of one of the most basic realities of the health reform bill - the magnification of Medicaid.

But first, the basics. Implementation of health reform will result in: 1) an expanded array of government programs, including an expansion of state Medicaid and CHIP programs to cover 16 million more people alongside a brand new federal program of tax-based premium subsidies to cover 19 million more; 2) a fundamentally restructured private health insurance marketplace, at its hub the requirement that everyone purchase insurance, with associated consumer protections to support the mandate; and 3) a new market force in the form of state insurance exchanges, through which federal subsidies are administered and potentially capable of exerting considerable pressure to meet reform objectives like improving quality and controlling costs or prices.

Other provisions of the legislation address provider workforce issues, long-term care supports, quality initiatives and new investments in fraud detection and prevention. Still other components of the legislation encourage government and provider innovation in reimbursement, aimed at sowing the seeds for (believe it or not) an even more fundamental reformation of the health care market than the one being talked about today.

Now, back to Medicaid. In 2014, when most of the legislation's changes will take place, the Medicaid and CHIP programs will grow to cover 45 million non-elderly people and will expand by an additional 4 million individuals in 2015. Medicaid/CHIP will cover more than 18 percent of insured people under age 65 across the nation. Even more,

[Matt Powers](#)

June 23-24, 2010
Philadelphia, Pennsylvania

**"Medicaid Long Term
Care Program
Comparisons and
Rating Issues"**

[Susan Tucker](#)

Society of Actuaries 2010
Health Meeting
June 28-30, 2010
Orlando, Florida

**National Association of
State Budget Officers
Annual Meeting**

[Vern Smith](#), Keynote
Speaker

July 28, 2010
Portland, Oregon

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Medicaid/CHIP will grow as a percentage of national spending on health care, from 16 percent in 2007 to almost 21 percent in 2019. Together with Medicare, it will constitute almost 40 percent of national health expenditures. Whether viewed as a coverage vehicle, as a market participant, or as a business opportunity, the importance and relevance of Medicaid will be amplified.

Perhaps the most obvious example of forthcoming change relates to how people get health insurance. The bill envisions a seamless process, whether you are low-income and qualify for Medicaid or CHIP, moderate-income and qualify for federally-funded premium support, or you are otherwise and simply shopping for an insurance plan. While state insurance exchanges are the portal for people seeking insurance coverage, they are obligated also to interface with Medicaid - and Congress specifically authorizes exchanges to contract for the function of eligibility determination with state Medicaid agencies. That is exactly what happens in Massachusetts, the test bed for much of this reform. The Medicaid agency determines eligibility for all public programs using one form, with support available to apply through an online "Gateway" at provider sites. Other states may develop alternative methods of streamlining eligibility, but success will require Medicaid working alongside exchanges and providers to ensure that every person without insurance gets enrolled into the appropriate program.

Medicaid's abruptly expanded share of the market also spells opportunity for providers, health plans and businesses in or exploring that market. Full-risk managed care is already commonplace and, although every state is different, it is likely that there will be more lives in Medicaid managed care plans when the expansion is complete. Safety net provider systems will welcome a lower burden from the uninsured, while proposed reductions in the Medicaid DSH program and potential competition for the newly-insured present challenges. With Medicaid covering more individuals, the entire provider community will focus attention on the adequacy of Medicaid reimbursement levels and the degree to which there are disparities between public and commercial payers.

That scrutiny is inevitable as Medicaid grows, but with greater market presence comes potential for greater influence. The health reform bill encourages delivery system reforms like the formation of accountable care organizations, medical homes that manage high-risk populations, and risk-sharing reimbursement arrangements. Medicaid programs that work to innovate alongside or ahead of other payers will see even greater influence.

With continuing state budget shortfalls, longtime policy challenges will take on even greater importance. The

adequacy of provider networks in Medicaid programs, and the relationship between provider participation and rate levels, is a longstanding concern that will be amplified. Many states are already looking for methods to manage high-cost members, particularly by integrating care between Medicare and Medicaid for dual-eligible individuals. Health reform institutionalizes a new office of Coordinated Care, and every indication is that Medicaid collaboration with Medicare will be strongly encouraged. Driven both by budget realities and the dysfunction in the Medicare-Medicaid relationship, integrated care for duals will increase opportunities for new managed care approaches and will create new opportunities for comprehensive delivery system reform led by government payers.

Medicaid, commonly termed the "workhorse of the health care system," is going to have to turn into a thoroughbred - one that works seamlessly with state insurance exchanges, manages a growing share of the market, and continues, under even more pressure, to address broad reform goals of quality improvement, cost containment, and reimbursement reform.

For more information, contact [Tom Dehner](#), Principal, at (617) 720-7800.

Special Financing and Waivers

Creative financing strategies have long been a staple of state Medicaid programs. As part of state Medicaid plans and in conjunction with waivers, innovative financing arrangements have enabled states to keep pace with needed rate increases, support crucial safety net providers, implement quality initiatives, avoid eligibility cutbacks, and, in some cases, expand coverage to the uninsured. Health Management Associates (HMA) has played a critical role in working with the health care industry and states to sustain and increase Federal matching dollars to ensure quality and access are maintained during difficult economic times. For example, HMA has helped secure millions of dollars in increased Federal matching funds through the development of new hospital tax programs, including those recently approved in Arkansas, Mississippi and Colorado. These states have been able to avert substantial cuts to the Medicaid program and increase provider payment rates in a climate where new resources are otherwise nonexistent.

Such financing arrangements are equally relevant as states begin to expand coverage under national health reform. While expansions are not required until 2014, states may want to act sooner using a Medicaid state plan amendment. Earlier implementation may help states draw down

additional federal funds that can protect provider rates, assuring access and quality are maintained.

One such opportunity is to greatly expand the base on which provider taxes are calculated. With many states seeing unprecedented growth in their Medicaid rolls, the upper payment limit for hospitals and other health care services will rise in proportion to the increase. Thus, the impact of this Medicaid growth will create additional opportunity to increase Medicaid payment rates.

Another strategy for state flexibility is the section 1115 waiver. While the Obama Administration has not yet indicated its policy priorities with regard to section 1115, it is important for states and other interested parties to consider the implications of health care reform for existing waivers. In addition, there may be instances where a state would want to request new section 1115 authority to implement health care reform provisions in a more flexible fashion to better meet state policy priorities.

For more information, contact [Theresa Sachs](#), Principal, or [Jim Frizzera](#), Principal, at (202) 785-3669.

CHIPRA Sets the Stage for Child Quality Measurement and Improvement



The 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) will be familiar to most as the source of continued CHIP funding and for encouraging innovation in enrollment and renewal. Less well-known is that it creates a structure for child health quality measurement and public reporting for Medicaid and CHIP

that has been lacking in past legislation. Whereas the Medicare program has invested in measuring and reporting quality for many years, contributing to improved quality and lower costs, Medicaid and CHIP quality measurement and improvement activities have been as varied as the states themselves. A [2009 survey of states by HMA](#) shows just how divergent states' work on child quality has been.

Provisions in CHIPRA directed the Centers for Medicare and Medicaid Services (CMS) to recommend a set of core child quality measures based on the best available research and practice. An advisory group of state officials, researchers, clinicians, and other stakeholders met and reviewed hundreds of measures. They recommended a core set of 25, relying heavily on measures in use in states now, at least for some children, greatly facilitating states'

abilities to participate in voluntary reporting in 2011. CHIPRA also designated funding for additional measure development and testing over the next few years, in recognition that existing quality measures, including those in the core set, assess a somewhat limited range of the types of care states are funding. For example, they did little to describe the effectiveness of care coordination models, prevention and treatment for obesity, or the adequacy of dental care.

CHIPRA additionally called for CMS to fund ten demonstration projects to be led by state Medicaid and/or CHIP agencies; winners were announced in February 2010. The ten projects test strategies to: implement quality measures; develop a pediatric electronic health record; align child quality measurement and reporting with states' other HIT activities; and improve quality. Some of the funded projects emphasize certain high-risk pediatric populations, while others would create new data collection mechanisms inclusive of all children (i.e., not limited to managed care plans). An important element of all the projects is use of electronic data sources, including electronic health records and data from outside the Medicaid/CHIP agencies, to provide a more complete picture of children's health. A small number of the projects, including one HMA will work on with partners in Florida and Illinois, also include quality improvement components, such as testing various medical home models and improving perinatal care. A national evaluation will extract findings from the ten projects.

CHIPRA calls for the creation of an enhanced measure set by 2013, building on early lessons from the state demonstrations and on new measure development already underway. These new measures are broadly intended to meet the needs of stakeholders, including public and private purchasers, providers, and consumers. The legislation does not specify how CMS or the states are to use these new measures. Interest in pay-for-performance programs is very high among public and private payers, and consumers are increasingly looking for information on quality to guide health care decisions. If health care quality guru Dr. Donald Berwick is confirmed as CMS Director, an even greater emphasis on quality improvement can be expected.

For more information, contact [Jennifer Edwards](#), Principal, at (212) 575-5929.

Health Information Technology: Necessary but Not Sufficient

Two recent legislative changes, built on the historic cornerstones of the Social Security Act and Medicare and Medicaid programs, have brought our nation a step closer toward the vision of economic security and modern health care reform. The American



Recovery and Reinvestment Act of 2009 (ARRA), now more than an year old, and the Patient Protection and Affordable Health Care Act (PPAHC), signed into law on March 23, 2010, have establish broad policy changes in America's health care sector. Realization of these reforms is inextricably tied to the meaningful use of health information technology (HIT) as an essential enabler of change.

Information is the life blood of health and care. The effective communication, exchange and use of information is as critical to a patient's health as it is to advancing the vision of economic and clinical health that has been articulated by American leaders for more than seven decades. It is no coincidence that the two sections of the 2009 stimulus bill that focus on HIT are entitled the HITECH Act - Health Information Technology for Economic and Clinical Health.

The HITECH Act, itself, is comprised of Title XIII - Health Information Technology and Title IV - Medicare and Medicaid Health Information Technology, establishes the foundation for the adoption and meaningful use of electronic health record (EHR) technologies to improve health and care quality through access to information at the point of care. Meaningful use requires:

- the use of certified EHR technology in a meaningful manner, such as e-prescribing;
- the private and secure electronic exchange of health information to improve health care quality;
- and the capability to digitally submit clinical quality and other measures.

Much state level attention has focused on access to and early implementation of HITECH grants programs, including State Level Health Information Exchange Cooperative Agreements (SL HIEs), HIT Regional Extension Centers (RECs), HITECH workforce training, Beacon Communities and Strategic HIT Advanced Research Projects (SHARPs). In addition, many states have begun the public processes of planning and coordination of the State-Level Health Information Exchange and the State Medicaid HIT - EHR Incentive program plans and implementation activities.

While ARRA requires the progression of steps for eligible Medicare and Medicaid providers to access incentive funds for the meaningful use of certified EHR technologies, PPAHC also requires states to use health information technologies to reform core health care processes, such as:

- Expanding Medicaid eligibility and health insurance coverage;
- Implementing health insurance exchanges to support small businesses and uninsured individuals to purchase health care coverage;
- Implementing interoperable and secure standards and protocols to facilitate enrollment as well as grants to develop

or adapt HIT systems to support these changes;

- Creating new service delivery and innovative payment models that improve quality of care or reduce costs for chronic care coordination, chronic disease registry and home telehealth; and
- Testing the effectiveness of home health primary care team for the long term care population with high costs and chronic conditions utilizing electronic health information systems, remote monitoring and mobile diagnostic technology to improve health outcomes and reduce costs.

HMA is working throughout the health care industry to support the effective planning, implementation and meaningful use of policy-driven, technology support innovation. We have a long history of successful work with clients on exactly these types of complicated implementations. In the last year, we have broadened the scope of our work to realize the importance of health information technologies, including health information exchange (HIE) and EHRs in improving health outcomes, care quality and population health. Specifically, we are working with clients on:

1. State Level Health Information Exchange planning and implementation;
2. Medicaid Management Information System (MMIS) and Medicaid Information Technology Architecture (MITA) assessment, planning, procurement, and implementation support as well as Independent Verification and Validation; and
3. State Medicaid HIT planning, Implementation Advance Planning Document preparation, and EHR Incentive program planning and implementation.

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Developing Integrated Health Care Delivery Systems for Underserved Populations



Even though national health care reform will create new mechanisms to assure health care coverage for millions more Americans, there will still be a role for safety net providers to care for uninsured individuals in their communities, and others whom they have traditionally served.

Creative approaches to guaranteeing access for this population are being developed in cities and counties across the country, often bringing together public and private entities.

In the past, silos of health care delivery and competition among providers have been the norm. Increasingly, traditional roles in

providing health care services are being rethought and new alliances are being formed, resulting in coordinated and integrated models of care. Integrated approaches address key concerns of providers and payers alike, who understand that to be successful a plan must ensure that patients do not languish in expensive acute inpatient settings, or inappropriately utilize emergency departments when they could receive their care in primary care settings or in lower levels of acute care if they were available and accessible. They also understand that, if doctors or hospitals do not accept patients, there has been no improvement in access. These are issues that must be addressed by delivery system reform, not merely by extending accessibility to the current configuration of services. Initiated by local governments or philanthropic or provider consortia, unique partnerships are beginning to re-envision the community safety net and to build rational and cost-effective approaches to delivering health care services to targeted vulnerable populations. The most successful of these integrated delivery system models:

- are based on the health needs of the target patient population;
- build upon the core competencies and missions of the participating providers;
- establish a medical home for every patient and a sustainable network of providers;
- implement strategies that minimize duplication and avoid unnecessary services;
- prioritize and manage patients that are complex (e.g., the chronically ill);
- maximize all available federal, state and local dollars dedicated to health services;
- are monitored to address problems and adjust as health needs change; and,
- are convened and led by an entity with the broader community good in mind.

HMA's Approach

Health Management Associates (HMA) brings extensive experience in convening local government leaders, providers (hospitals, Federally Qualified Health Centers, physician groups) and other key stakeholders (e.g., philanthropic organizations, health plans, business and civic organizations) to develop new collaborative, efficient and effective health care delivery systems for the underserved in the community. HMA has assembled a team of senior health care administrators, clinicians, and finance specialists with extensive backgrounds in both developing and implementing creative solutions to the increasingly complex problem of delivering high quality and cost-effective health care services to the medically indigent and underserved. These individuals are uniquely qualified to guide and support collaborative processes to develop integrated networks of services.

HMA approaches this work by:

1. defining the target population by thoroughly documenting current demographics and health status issues as well as trends;
2. determining current health utilization patterns for the target population and identifying both gaps and duplications;
3. assessing the individual institutional missions of potential provider partners to better guarantee a plan that will be sustainable;
4. evaluating all financial and policy options to assure that the greatest level of available dollars are generated by maximizing any special revenue sources;
5. identifying any specific policy and/process changes needed to fit the financial incentives to the delivery system reforms;
6. identifying the legal and financial relationships between the participating partners;
7. developing approaches to system issues, such as the connectivity among provider information technology systems, to assure appropriateness and timely referrals and support efficient care management; and
8. establishing a framework for a delivery system-including its governance and management-that builds on knowledge of the population, the potential provider partners, financing options and system enhancements that can serve as an effective approach to assuring access to health care services in a designated community.

HMA has facilitated population-based delivery system development initiatives in communities across the county. Examples include:

- *Comer Science and Education Foundation* (Chicago, Illinois) The Comer Foundation engaged HMA to develop and implement a multi-provider network to provide comprehensive health care services for approximately 350,000 Medicaid recipients. That network proposal is now being implemented as a demonstration project by the State of Illinois with continued support from the Comer Foundation and HMA. (2007 - present)
- *San Mateo County* (Redwood City, California) Working for the San Mateo County Board of Supervisors, HMA assisted County leadership in defining and negotiating a "Community Health Network for the Underserved " that includes the public health and hospital systems and all private non-profit hospitals and medical groups in San Mateo County. The goal was to meet the health care needs of Medicaid and uninsured residents of the community through a collaborative network. (2007-2008)

- *Orange County Health Network Development* (Orange County, California) Engaged by the CEOs of all of the hospital systems serving the community; the Orange County Health Care Agency; CalOptima (the County's managed care plan); and a consortium of philanthropic funders, HMA is facilitating the development of a network of health care providers to optimally serve the approximately half-million uninsured. By enhancing the network and integrating with the efforts of CalOptima, this initiative is improving access for the 350,000 Medi-Cal patients in the County. (2009-present)

For more information, contact [Pat Terrell](#), Managing Principal, at (312) 641-5007.

[Health Management Associates](#) is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

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