
HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup Trends in State Health Policy

IN FOCUS: WE REVIEW THE NEW JERSEY COMPREHENSIVE MEDICAID WAIVER CONCEPT PAPER

HMA ROUNDUP: TEXAS RFP RESPONSES WERE DUE MAY 23, CALIFORNIA GOVERNOR'S PLAN TO CONSOLIDATE HEALTHY FAMILIES INTO MEDI-CAL MEETS WITH RESISTANCE; ILLINOIS, MICHIGAN BUDGETS APPROACHING RESOLUTION;

OTHER HEADLINES: KAISER POLL HIGHLIGHTS OPPOSITION TO BLOCK GRANTS; UNITEDHEALTH CONSIDERS DC MEDICAID EXIT; MONTANA DROPS MEDICAID MANAGED CARE PROPOSAL; VERMONT GOVERNOR TO SIGN REFORM BILL TOMORROW

MEDICAID MANAGED CARE RFP CALENDAR: THIS WEEK, WE ADD THE MASSACHUSETTS BEHAVIORAL HEALTH RFP TO THE TIMELINE

MAY 25, 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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IN FOCUS: NEW JERSEY

COMPREHENSIVE MEDICAID WAIVER

CONCEPT PAPER

This week, our *In Focus* section reviews the State of New Jersey concept paper outlining the framework for a comprehensive Medicaid waiver to be implemented over the next several years. The paper, released Monday, May 16, 2011, details the actions that will be taken and policies implemented if the state is granted the waiver authority by the Centers for Medicare and Medicaid Services (CMS). The waiver seeks to consolidate the Medicaid and CHIP programs under a single waiver authority and grant New Jersey the flexibility to balance enrollment and eligibility, cost-effective services and benefits received, payment rates, and administrative efficiencies. In this section, we delineate the key points and changes proposed in the concept paper, providing additional analysis and observations where applicable. For the full concept paper and additional materials, please see the Comprehensive Medicaid Waiver page on the New Jersey Division of Medical Assistance & Health Services (DMAHS) website: [\(Link to Website\)](#).

Eligibility and Enrollment

- The state would freeze enrollment for adult parents with incomes up to 200% FPL. These enrollees are authorized under the current Section 1115 waiver.
- The state would eliminate retroactive eligibility for certain groups of new applicants; coverage would no longer be provided prior to the date of Medicaid application. New Jersey would continue to provide a full quarter of retroactive eligibility for Supplemental Security Income (SSI) individuals, as well as those at the institutional level of care, including home and community based services (HCBS) waivers.
- The state would require new MCO enrollees to select a plan within 10 days or be auto-assigned. There is an additional 90-day window to change plans without cause.
- The state proposes several improvements to the eligibility determination process in return for the increased eligibility flexibility requested under the comprehensive waiver. The most significant proposed change is to automate the redetermination process using IRS, State tax, child support, and other sources of income, residency and eligibility information. Doing so would require the mandatory collection of social security numbers from all enrollees.
- Under the current Health Insurance Premium Payment (HIPP) program, for those enrollees with access to commercial coverage through an employer, the state may determine if commercial coverage is cost effective for an enrollee and allow Medicaid to subsidize the commercial insurance premiums instead of paying for services directly. New Jersey is looking to move to a more aggressive HIPP program like those operated in Pennsylvania, Iowa and Texas. The following changes are proposed:

- 1) Determine cost-effectiveness in the aggregate by eligibility category and managed care rate code;
- 2) Eliminate wraparound coverage for adults only, not including the ABD population; and
- 3) Improve administrative ability to identify availability of employer-based coverage, particularly for members with chronic conditions and other high-cost enrollees.

Benefits and Provider Payments

- The state would impose a cost-sharing premium for enrolled parents above 100% FPL. This premium is not to exceed 5% of family income. Additionally, a \$25 copayment would be applied to non-emergency use of hospital emergency departments. This copayment is designed to act as a deterrent, redirecting care to primary care settings.
- With a goal of rebalancing the service delivery system toward primary care, and in an attempt to remedy the fact that physician Medicaid FFS rates are approximately 47% of Medicare rates, the state will:
 - 1) Redirect some savings from the comprehensive waiver to increase payments to primary care providers up to 100% of Medicare rates, phased in up to a full implementation in 2013;
 - 2) Encourage participation of specialists in ambulatory settings through implementation of an enhanced consult fee; and
 - 3) Through HMOs, implement add-on payments to health care homes.
- The state would pay out-of-state providers the lesser of New Jersey Medicaid rates or the servicing state's Medicaid rate when services are available from a New Jersey provider. Additionally, the state will coordinate with neighboring states and establish uniform payment rates for selected facilities that provide specialty services.
- Non-contracted hospitals will be paid 95% of the amount that they would receive from Medicaid for the emergency services and any related hospitalization as it would be paid under a FFS structure.
- In 2010, 9.6% of emergency department expenditures were deemed to be low acuity non-emergent visits that were preventable. Medicaid managed care capitation rates would be reduced to reflect the expectation that HMOs can further reduce unnecessary emergency department utilization of its members.
- New Jersey would seek to participate in two provider payment reform projects authorized under the Affordable Care Act (ACA).
 - 1) The state, if selected, would participate in the study of bundled payments for hospital and physician services under Medicaid (Sec. 2705). This demonstration would be effective January 1, 2012 through December 31, 2016.

- 2) The state, if selected, would participate in the CMS Innovation Center Medicaid Global Payment System (Sec. 2704). This would transition the current payment structure for safety net hospitals from a FFS model to a global capitated payment structure. This demonstration would operate through 2012, but does not currently have any federal funding appropriated.

Delivery System Innovations

- Beginning July 1, 2011, most Medicaid populations, including dual eligibles and ABD enrollees, would be transitioned into the current Medicaid HMOs. Pharmacy services for the ABD population, previously carved-out, would be carved-in.
- Effective July 1, 2012, the state would amend existing HMO contracts to manage all long-term care services including HCBS and nursing facility services for the elderly and physically disabled.
- Between now and July 1, 2012, New Jersey would amend current HMO contracts to accommodate changes in delivery and payment. However, the state would seek authority to streamline contracts and competitively bid managed care in two or three years. Managed care changes would include:
 - 1) Pilot accountable care organizations (ACOs) within a managed care framework. Savings would be shared among the state, federal government, HMOs, ACOs, and providers.
 - 2) Require HMOs to pilot health care homes and ACOs to obtain 90% federal match available under ACA.
 - 3) Implement member rewards and responsibility program as a partnership between Federally Qualified Healthcare Centers (FQHCs) and HMOs.
 - 4) Beginning January 1, 2012, HMOs would manage behavioral health services for low mental health and substance abuse needs.
- Beginning September 1, 2011, New Jersey would enroll dual eligibles into Medicaid managed care plans for primary and acute care. Effective January 1, 2012, the state would contract with Medicare special needs plans (SNPs) that are also Medicaid managed care plans. Under the comprehensive waiver, dual eligibles would be required to enroll in a single Medicaid HMO/Medicare SNP. However, this would apparently violate CMS authority on freedom of choice under Medicare. New Jersey would request the authority to auto-assign enrollees to a combined plan with the ability to opt out of Medicare. In this case, the state would limit Medicaid payment of Medicare cost-sharing to providers within the Medicaid HMO's network.
- The state would work with HMOs and behavioral health administrative services organizations to develop member reward initiatives for healthy behaviors and compliance with a treatment plan. HMOs would be given flexibility in their design of rewards programs and dollar incentives. Financial rewards would be restricted to health-related purchases.

- Additionally, the state has applied for grant funding of \$5 to \$10 million under the ACA for providing incentives to Medicaid enrollees of all ages who participate in prevention programs and can demonstrate changes in health risk and outcomes. The proposal was submitted in partnership with FQHCs and HMOs in the state.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Governor Brown's May Revised Budget was unveiled last Monday, May 16, and proposed several significant points related to the Medi-Cal program. Among the most significant has been a plan to consolidate the Healthy Families (CHIP) program into Medi-Cal. As we discussed last week, the budget proposal stipulates that effective January 1, 2012, all children in the Healthy Families Program (HFP) will begin to be transitioned into the Medi-Cal Program, for an overall savings of \$31.2 million General Fund in 2011-12.

The savings is based on a PMPM of about \$100 in HFP and a cost per child in Medi-Cal FFS of about \$70. The state has said that this program will now become an entitlement and these children will be able to keep their existing primary care provider and will receive increased benefits under Medi-Cal, including the EPSDT benefits. A major challenge will be that Medi-Cal does not have a child PMPM rate for this category of children, rather these children are reimbursed at a blended family rate. To achieve this savings there will need to be a new rate that assumes a flow of new enrollees into that plan who are lower cost and reduce the overall family PMPM by that amount or the state will have to blend this enrollment into the existing family rates.

Resistance to this plan has emerged from a number of stakeholders including potentially some Medi-Cal managed care organizations. In general, Healthy Families is considered a more popular public program than Medi-Cal. At the same time the Governor is proposing to extend the gross premium tax on Medi-Cal managed care organizations, requiring a 2/3 vote in the legislature. Medi-Cal plans proposed this tax as a means to continue funding for the Healthy Families Program.

Illinois

HMA Roundup – Jane Longo / Matt Powers

The latest legislative proposal would avoid a Medicaid provider rate cut through deferred payments. The provider community has supported this proposal, however, deferred payments could have significant negative impacts on cash-flow for safety net providers. As mentioned last week, there is still a great deal of uncertainty, but there is likely to be a resolution before the legislative session ends on Tuesday, May 31. After Tuesday, any action on the budget will require a super majority vote.

In the news

- **Dentists hesitate to treat kids on Medicaid: study**

Dentists were less willing to see kids who needed an emergency appointment if they were covered by Medicaid than if they had private insurance in a new study based in Cook County, Illinois. Even dental practices that were enrolled in the state's Medicaid and Children's Health Insurance Program were more willing to treat a kid with private insurance than one enrolled in the state's plan for low-income families according to the findings, which are published in Pediatrics. ([MSNBC](#))

Michigan

HMA Roundup - Esther Reagan

There is a strong possibility that the budget will be resolved by the end of the week, meeting Gov. Snyder's goal of Memorial Day for a final budget. The latest revenue projections have improved and, as a result, cuts to education are smaller than had been planned. There is still no plan to reduce Medicaid payment rates, however, there is likely to be a cut to Graduate Medical Education (GME) payments, representing a significant cut to hospitals. The issue is to be resolved.

The proposed replacement for the HMO provider tax – a bill that would place a 1% tax on all health claims – appears unlikely to be resolved by the end of the week.

Texas

HMA Roundup - Dianne Longley

The legislature passed Medicaid reform legislation last Friday, authorizing managed care expansion into several new regions. For further summary of the Texas Managed Care RFP, please see the April 13 edition of the Weekly Roundup.

Additionally, Medicaid managed care organizations' bids for the Texas RFP were due on Monday, May 23rd.

In the news

- **Texas Hospitals Face Dramatic Payment Overhaul**

The budget that state lawmakers are poised to accept attempts to eliminate wide variations in what hospitals are paid by Medicaid for performing the same procedures on similarly sick patients – a sweeping change in how Texas hospitals are funded. In a controversial move, the state budget sets the same base payment rate – called a standard dollar amount, or SDA – for most Texas hospitals starting Sept. 1. ([Texas Tribune](#))

OTHER HEADLINES

District of Columbia

- **D.C. Medicaid program could lose major contractor**

The District's Medicaid managed care program could be in jeopardy because one of its two contractors has threatened to pull up stakes amid piling losses, according to a memo to Mayor Vincent Gray obtained by the Washington Business Journal. Although the memo does not identify the contractor, UnitedHealthcare Community Plan, known as Unison Health Plan of the Capital Area until this year, has lost \$19.2 million in the last three years on its District operations, according to reports compiled by D.C. insurance regulators. ([Washington Business Journal](#))

Georgia

- **Deal vetoes bill on Medicaid audit contractors**

Last week's vetoes by Gov. Nathan Deal included a little-noticed bill related to Medicaid. House Bill 489 would have barred the state from paying a contingency fee to a contractor to recover Medicaid overpayments to doctors and hospitals. Implementing the bill would have put Georgia's Medicaid program in conflict with federal law, Deal said in his veto message. ([Georgia Health News](#))

Louisiana

- **DHH Posts Questions and Answers to Coordinated Care Network Requests for Proposals**

Tuesday, the Department of Health and Hospitals posted questions received on the Requests for Proposals for Coordinated Care Networks with answers. There are two Requests for Proposals, one for the prepaid networks and one for shared savings networks. The questions received for each with answers are posted with the respective Requests for Proposals:

[Link to Q&A - Prepaid Coordinated Care Networks](#)

[Link to Q&A - Shared Savings Coordinated Care Networks](#)

Montana

- **State drops managed-care Medicaid plan for 5 counties**

The Schweitzer administration has abandoned its controversial plan to set up a Medicaid managed-care demonstration project in Lewis and Clark, Cascade, Choteau, Teton and Judith Basin counties. Some administration officials had said they thought the demonstration project could cut Medicaid costs by 10 percent in those counties. ([Billings Gazette](#))

New Jersey

- **Christie Seeks Tighter Limits on Medicaid**

New Jersey is trying to deal with bulging Medicaid costs by trimming new eligibility for the government health-care program to the bare bones. The Christie administration

wants to cut the state's relatively generous program way back as part of a "waiver" it is seeking from the Obama administration. Overall, it's looking to save about \$540 million, including \$300 million through the waiver. The state wants to close the program to new adult participants who have an annual income of 25% to 29% of the poverty rate. ([Wall Street Journal](#))

Ohio

- **Nursing homes, governor at odds on Ohio budget**

The governor's \$55.6 billion state budget proposal cuts nursing homes' Medicaid funding by \$222 million over the two years beginning July 1. The financial impact on the industry is estimated at \$427 million, however, because costs and demand are expected to continue to rise. Medicaid is the state program for those who can't afford medical care. Gov. Kasich seeks to expand access to home care programs, such as PASSPORT, and increase quality incentives to nursing homes as part of a health care system overhaul led by the transformation office. ([Times Union](#))

Oregon

- **Gov. John Kitzhaber signs health insurance bills to help Oregon kids and simplify paperwork**

Gov. John Kitzhaber signed bills Monday that will give children year-round access to health insurance and require health insurers to use standardized forms to simplify paperwork for doctors and hospitals. Senate Bill 514, which goes into effect immediately, enables Oregonians who do not get insurance through an employer to buy insurance for their children at any time. ([Oregon Live](#))

Vermont

- **Vermont Health Plan Advances**

Vermont is moving one step closer to a goal of its Democratic governor: a state-run health plan that would insure most of its 625,000 residents. The bill Gov. Peter Shumlin plans to sign on Thursday would create a panel whose goal would be to figure out how to pay for a new system intended to reduce the rate of overall health-cost increases. Most residents under 65 would move to an insurance plan run by the state. State-run plan would be standard for all. Individuals and businesses would pay for the plan through higher taxes. Some people would stay in private plans. ([Wall Street Journal](#))

United States

- **Most Americans Oppose GOP Plan To Cut Medicaid**

Most Americans oppose the House Republicans' plan to overhaul and slash funding of Medicaid, the state-federal program that covers 56 million low-income people, according to a poll being released today. About 60 percent of Americans want Congress to keep Medicaid in its current form with the federal government guaranteeing coverage and setting minimum benefits for states to follow, according to the survey by the Kaiser Family Foundation. Just over half said they didn't want to see funds cut. Opinions varied along party lines, with 79 percent of Democrats and 39

percent of Republicans saying they preferred to keep the Medicaid structure "as is." ([Kaiser Health News](#))

- **Creating a New Competitive Marketplace: Health Insurance Exchange Establishment Grants Awards List**

May 23, 2011: HHS awarded "Exchange Establishment Grants" to Indiana (\$6.9 million), Washington state (\$22.9 million) and Rhode Island (\$5.2 million). States can use establishment grants for activities including: conducting background research; consulting with stakeholders; making legislative and regulatory changes; governing the Exchange; establishing information technology systems; conducting financial management; performing oversight; and ensuring program integrity. ([Link](#))

- **GOP Pushes To Let States Reduce Medicaid Rolls**

With their proposal to turn Medicaid into block grants all but dead, Republicans now are pushing legislation to let states tighten eligibility rules for the health program for the poor and disabled. While Democrats strenuously oppose the proposed Medicaid change, some advocates and physician groups worry that the issue could wind up as a bargaining chip in the partisan wrangling over the debt limit. ([Kaiser Health News](#))

PRIVATE COMPANY NEWS

- **Blue Cross and Blue Shield of Florida Names CareCentrix**

Blue Cross and Blue Shield of Florida (BCBSF), Inc. and CareCentrix, Inc., the nation's leading provider of home health benefits management services, together announce a new business partnership that will benefit BCBSF members across the state of Florida. CareCentrix will now become BCBSF's exclusive provider of home health services for its nearly 4 million members. BCBSF members will benefit from the relationship as CareCentrix provides a centralized solution that coordinates all of a patient's home health care needs, including skilled nursing services, home infusion therapies and durable medical equipment. Founded in 1996, CareCentrix has grown to become the leading provider of home health benefits management services to more than 30 million people across the country through its network of 7,000 credentialed home care providers. ([PR-USA](#))

- **Waud's Acadia Heads for Public Markets with PHC Deal**

Waud Capital Partners' Acadia Healthcare Co. has a deal in place with NYSE-listed PHC Inc. to merge in a deal that will result in the majority of the merged company's shares being controlled by Acadia backers. Later, Acadia will move the company to the Nasdaq market. ([PE HUB](#))

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order. This week we added the timeline for the Massachusetts behavioral health RFP.

Date	State	Event	Beneficiaries
May 1, 2011	Illinois ABD	Implementation	40,000
May 11, 2011	Kentucky	Vendor conference	460,000
May 23, 2011	Texas	Proposals due	3,200,000
May 25, 2011	Kentucky	Proposals due	460,000
June 1, 2011	California ABD	Implementation	380,000
June 2, 2011	Massachusetts Behavioral	Vendor conference	386,000
June 24, 2011	Louisiana	Proposals due	892,000
July 1, 2011	Kentucky	Implementation	460,000
July 1, 2011	New Jersey	Implementation	200,000
July 15, 2011	Washington	RFP Released	880,000
July 19, 2011	Massachusetts Behavioral	Proposals due	386,000
July 25, 2011	Louisiana	Contract awards	892,000
August 3, 2011	Washington	Bidder's conference	880,000
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
October 1, 2011	Arizona LTC	Implementation	25,000
July 19, 2011	Massachusetts Behavioral	Contract awards	386,000
October 17, 2011	Washington	Proposals due	880,000
December 19, 2011	Washington	Proposals due	880,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 1, 2012	New York LTC	Implementation	120,000
March 1, 2012	Texas	Implementation	3,200,000
July 19, 2011	Massachusetts Behavioral	Implementation	386,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000
January 1, 2015	Florida	DD RFP released	2,800,000
October 1, 2016	Florida	DD enrollment complete	2,800,000

HMA RECENTLY PUBLISHED RESEARCH

States in Action: States' Role in Promoting Meaningful Use of Electronic Health Records

The Commonwealth Fund

Principal Renee Bostick provided the following update to The Commonwealth Fund's April/May 2011 newsletter, *States in Action*:

This issue of States in Action discusses the responsibilities, opportunities, and challenges for state Medicaid agencies in implementing programs to encourage providers to adopt electronic health records (EHRs). It focuses on the Medicaid Electronic Health Record Incentive Program, established by the Health Information Technology for Economic and

Clinical Health (HITECH) Act in the American Recovery and Reinvestment Act of 2009 and jointly administered by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies. Rather than formal Snapshots of particular states' efforts, the issue includes lessons from states' early experiences in implementing the Medicaid EHR Incentive Program.

The EHR Incentive Program is just one of many health information technology (HIT) initiatives supported and encouraged by the federal government. With state Medicaid agencies facing competing demands as well as limited resources, states can benefit from aligning their efforts to promote health information technology, and collaborating with other agencies, states, and stakeholders to share or reduce costs, limit duplication, and avoid confusion for providers. ([Link to Brief](#))

Lessons from High- and Low-Performing States for Raising Overall Health System Performance

The Commonwealth Fund

Principal Sharon Silow-Carroll and former Senior Consultant Greg Moody (now Director of the Governor's Office of Health Transformation in Ohio) provided the following brief to The Commonwealth Fund, published May 5, 2011.

Silow-Carroll and Moody interviewed stakeholders in states with high-ranking and low-ranking health system performance, according to The Commonwealth Fund's State Scorecard on Health System Performance. They found that the health care market, political orientation, and local cultural can help or hinder health system improvement. High-performing states are more likely to have: a history of continuous reform and government leadership; a culture of collaboration among stakeholders; transparency of price and quality information; and a congruent set of policies that focus on system improvement. Regardless of starting point, state policymakers and proponents for health system improvement can work to align incentives to change provider, health plan, purchaser, and consumer behavior; frame health in terms of economic development to gain public and political support; engage purchasers and payers to drive value and quality improvement; bring stakeholders together to develop goals and build trust; and take advantage of federal funding, incentives, and reform opportunities. ([Link to Brief](#))

Reducing Hospital Readmissions--Lessons from Top-Performing Hospitals

The Commonwealth Fund - Why Not the Best?

Principals Sharon Silow-Carroll and Jennifer N. Edwards and Senior Consultant Aimee Lashbrook have contributed a series of readmission reports to the Commonwealth Fund's *Why Not the Best?* series.

At a time when health care leaders are driven to reduce waste and inefficiency, eliminating unnecessary readmissions has been identified as a desirable and achievable goal by both practitioners and policymakers. Significant variability in 30-day readmission rates across U.S. hospitals suggests that some are more successful than others at providing safe, high-quality inpatient care and promoting smooth transitions to follow-up care. This report offers a synthesis of findings from four case studies of hospitals with exceptionally low readmission rates: McKay-Dee Hospital in Ogden, Utah; Memorial

Hermann Memorial City Medical Center in Houston, Texas; Mercy Medical Center in Cedar Rapids, Iowa; and St. John's Regional Health Center in Springfield, Missouri. Hospitals' environments contribute to their capacity to reduce readmissions. The four hospitals studied are influenced by the policy environment, their local health care markets, their membership in integrated systems that offer a continuum of care, and the priorities set by their leaders. Successes of the four case study hospitals offer lessons for hospitals seeking to reduce avoidable readmissions, and payers seeking to influence hospital performance.[\(Link to Report\)](#)

HMA SPEAKING ENGAGEMENTS

AcademyHealth's Annual Research Meeting 2011: Topics in System and Payment Reform

Dr. Jennifer Edwards, Principal
June 12-14, 2011
Seattle, Washington

National Hispanic Caucus of State Legislators - 'Promoting Healthy Lifestyles' conference: Topic: Health Care Reform Financing at the State Level

Juan Montanez, Principal
June 17, 2011
Miami, Florida