# Medicaid Redesign Comprehensive Narrative

# HomeTown Health

# Final Release

# 02-29-2012

**HomeTown Health Recommendations for rural hospitals in Georgia**

1) **Maintain current managed care concept as follows except with named additions:**
    a. **Three CMO's**
        i. **Because it takes three to actuarially make the managed care concept work. Two is not enough for competition and four would dilute the actuarial basis for good cost management**
        ii. **Note: the fragility of the Georgia rural health care delivery system is so cash starved and fragile that it cannot support another major system implementation as precarious has been the last three implementations. Major health care access loss will occur to over one million Georgia residents.**
    b. **Revisit HB 1234 and add contractually strength to the oversight bill and require annual reports as to adherence to the bill by CMO's**
    c. **Establish physician retention criteria that maintains geographic access**
    d. **Establish CMO contractual requirements for state wide access based on physician sign up where CMO's have to attest that their network takes Medicaid without a closed or limited practice (note the current physician lineup in many cases includes physicians names but for whom have closed or limited their practice resulting in insufficient access).This results in an overstatement of coverage.**
    e. **Establish a public and monthly required dashboard of top ten cost drivers for each CMO**
    f. **Establish frequent flier identification and management for each hospital in the network**
    g. **Establish a Georgia standard claim form from which all CMO's would draw their information so that**
        i. **Providers have to only deal with one portal entry format**
        ii. **CMO's are required adopt the state system instead of vice versus**
    h. **Mandate Admin fees including profit not to exceed 10% net revenue**
    i. **Mandate that medical loss ratios not be below 90%**

j. **Add an independent provider ombudsman whose position reports to Commissioner and is funded by CMO's and has sufficient empowerment to resolve CMO issues brought forward by the provide community**
k. **Adopt a provider satisfaction survey (for both physicians and hospitals and all other providers by class) with contractually required satisfaction levels where penalty for underachievement is liquidated damages**
l. **Assign patient homes under three CMO's**
m. **Require same case management and utilization review doe rural hospital as is done with large hospital systems, e.g., frequent flier management**
n. **Eliminate the use of Prudent Lay Person Language. This is a means of ambiguously denying claims**
o. **Contractually incentivize gainsharing but to insure that savings gained by Critical Access Hospitals are not required to be repaid to federal government due to violation of cost to charge constraints**
p. **Implement a permanent CMO Advisory Council made up of various providers, patients and CMO's that reports to the Commissioner to advise on problems and opportunities for improvement with managed care**
    i. **Leave ABD as currently covered except with the expansion of SOURCE, the home and community based waiver programs, because**
        1. **The remaining $110 million or so UPL money would be lost. While Texas has applied and received a waiver to prevent loss of UPL, it is too early to tell how that will work in that all work currently is done based on interim payments. It is not proven and when lost, the UPL is a final loss.**
        2. **LTC as current for hospital based nursing homes is a major**
            a. **Certain Cash Flow stream for bill payments**
            b. **Major contributor to cross subsidization whose requirement stems from the underpayment of Medicaid at 85.6% of COST**
            c. **At least pays cost in cash**
        3. **There may be at least 5-6 different ABD populations that require different treatment programs meaning that a generic ABD policy under a CMO would result in erroneous treatment and management plans based on payments not needs**

2) **<u>Do NOT adopt or do NOT allow the following:</u>**
    a. **The North Carolina Model because**
        i. **The state of Georgia does not have the free clinic infrastructure in place that North Carolina had to start with. This would require extreme capitalization**
        ii. **North Carolina reportedly does not have same data banking requirements and quality measures as Georgia thus providing inconclusive data mining for patterns and trends**
        iii. **The current North Carolina model produces Medicaid per enrollee costs of $1000-$2000 per enrollee more than Georgia**

iv. **Georgia is among the lowest three payment states per enrollee for Medicaid meaning that saving opportunities are minimum without doing major damage to the whole system that is totally dependent on Cross Subsidization or payment source from area of treatment covering losses from another area of treatment due to governmental underpayments**

v. **The current North Carolina Medicaid program is under great pressure for mismanagement and budget breaking overpayments. Not a program to emulate**

vi. **Extreme amount of state FTE's may be required to support this program**

b. **Adopt ACO's for that would encourage the incorporation of small hospitals into large hospitals that subsequently will close many small hospitals and delete access from rural communities**

c. **Commercial programs that increase deductibles or incentives such as co-pay increases since co-pay increases are a cost shift to bad debt that has to be borne by the local hospital or community**

d. **Allow "all products" marketing and insurers to occur with insurers who have commercial business that can lead to monopolies or duopolies commercial payment suppression.**

e. **Unilateral contractual violation by CMO's for any provider under penalty of liquidated damages**

f. **Use risk-based capitation to manage the care of Aged, Blind and Disabled members**

**HomeTown Due Diligence**

1) **27 hospital visits by HomeTown Health Summer Fall 2011**
2) **Investigative meetings with CMO and CMO potentials**
    a. **WellCare 3 visits – 6 hours – December – February**
    b. **Peach State – I hour visit with Patrick Health and his management team – 1 hour 02-07-2012**
    c. **Blue Cross – I hour visit with Caroline Womack and BCBS management team on contract and network – 02-07-2012**
    d. **Amerigroup – 1 hour visit with Francesca Gray, COO, and Amerigroup management team – 02-07-2012**
    e. **United Health Care – 1 hour visit Don Schmidt VP – 02-29-2012**
    f. **Coventry = 1 hour visit with Joe Eckert, VP Network Development**

3) **HomeTown established three work groups and have conducted surveys on pertinent questions**
    a. **Work Group one – 15 hospital CEO's, CFO's Rev Cycle VP's ;Begin Jan 2012**

   b. **Work Group – Navigant Research team – 3 CMO Contract specialist ( represent 45 hospitals and 20 CSB's), 2 Hospital CFO's, 2 HomeTown Executives; Begin December 2011**
4) **Met with MAG Medical Association of Georgia to discuss attributes of Navigant Report ; February 4, 2012**
5) **Had conversations with Nursing Home Principal 02-06-2012**
6) **Had conversations with SOURCE principal**
7) **Had conversations with CSB Principal**

**Given:**

1) **Georgia hospitals have been paid at 85.6% of cost since 1999 with a further inflationary loss of 13 years compounded or an additional 30% loss thus hospital payments at 50% of cost inflation adjusted to 1999**
2) **Eligibility expansion is the culprit of increased cost not increased per enrollee cost, e.g.**
   a. **Medicaid Cost Per Enrollee 2004 $5532**
      **2009 $4835**
3) **Georgia is among bottom three lowest Medicaid reimbursement per enrollee at $4835 each ( 2009 data) may be lower currently.**
   a. **When Georgia is third lowest from the bottom , the opportunity for cuts is negligible**
4) **Georgia hospitals gave up $90 million already in UPL in 2006 with NO replenishment when CMO's began to cover pregnant women and children**
   a. **State Treasury was going to make money on Provider Tax on CMO's until CMS said NO unless and only if all insurers were taxed equally. Then state relinquished the cash flow from CMO Provider tax. ZERO GAIN TO STATE.STILLCOST HOSPITALS $90 MILLION ANNUALLY.**
   b. **This is the equivalent of a 3%-5% rate cut to hospitals**
5) **CMO's currently cover only Pregnant Women and Children in Georgia– no ABD**
6) **CMO's currently provide rural hospitals with no gatekeeper, nor case management thus no management of frequent fliers while providing this in larger hospital systems**
7) **Inaccessibility to hospital data due to it being proprietary to CMO**
8) **It takes five years to "digest " and implement and debug a "system change"**
   a. **ACS – 04-01-2003 – still have 300-500 cost reports outstanding**
   b. **CMO's 05-2006 still cannot process claims without major denials**
   c. **HP 11-2010 - no " HS&R's and 835"**
9) **"Prudent Lay Person" language is a shield for CMO's to avoid disclosure of their denial criteria**
10) **CMO's conduct Unilateral contract change with no recourse but to sue but have no money to sue**
11) **There is no provider based denial system public to ascertain where denial problems are**

12) **There has not been an advocate or ombudsman for providers in DCH or anywhere since DCH ombudsman was eliminated several years ago.**
13) **Three CMO payor platforms with no standardization equals overhead expansion instead of clinical care**
14) **Rural hospitals have on average 1-3 FTE's to process claims in the denial-appeal program. At an added 2 FTE average per hospital due to CMO inefficiency at $30,000 annually over 60 rural hospitals that is a $3.6 - $4 million waste annually or an imputed "waste" tax on hospitals or a cost hit from CMO's to hospitals for their inefficiency plus the unaffordable hospital cash flow loss**
15) **The $50 imputed ER fee is a cost shift to rural hospitals for the CMO's inability to case manage in rural Georgia**
16) **CMO's have individual proprietary payment platforms with individual software logic that is inaccessible to rural hospitals**
17) **North Carolina by comparison is $2000 per Capita more expensive for Medicaid than Georgia at $7275 vs. $4835 (CMS 2009 data) = $2440 per enrollee higher cost in NC with a questionable patient medical home application. More recent data may indicate lower per enrollee costs**
18) **Because co-pays are virtually impossible to collect in a smaller rural hospitals, co-pays are a cost shift from a state payment to a provider bad debt**
19) **CMO's have resorted to demographic access for physicians instead of a geo access to physicians which means that travel times are much greater thus limiting access**
20) **Many rural physicians have already capped their Medicaid practice or have gotten out of the Medicaid business altogether**
21) **Georgia's legislature attempted but failed to reign in CMO's abuses with HB1234 in 2009**
22) **Georgia is currently about 1000 physicians short and will grow substantially with 700,000 additional enrollees**
23) **The ABD population is a very non compliant population**
24) **The savings typically associated with the introduction of Medicaid is overstated by $675,000,000 annually due to original Medicaid cost cut being due to dropping eligibility by 100,000 unscreened eligible's and 50,000 duplicative babies on Medicaid roles and not CMO cost control**
25) **Total rural hospital rate cuts to date since 1999**
    a. **Budget rate cut** **14.4%**
    b. **$90 million UPL Los** **4.2%**
    c. **Inflation compounded since 1999** **30%**
    d. **Total rate cut since 1999** **48.6%**
26) **Total rural hospital rate cuts if ABD added to managed care with additional UPL loss since 1999**
    a. **Budget rate cut** **14.4%**
    b. **$90 million UPL Loss (2006 effective)** **4.2%**
    c. **$110 million UPL loss (2012 effective)** **5.1%**
    d. **Inflation compounded since 1999** **30%**

e. **Total inflation adjusted hospital rate cut since 1999 53.7%**

**Navigant proposes:**

1) **To place ABD under managed care**
    a. **Pros**
        i. **Unproven at this low Medicaid rate of a per enrollee in Georgia**
    b. **Cons**
        i. **Would cost the hospital industry a total of about $110 million in UPL loss by converting ABD to commercial equal to a 5.1% Medicaid rate cut to rural hospitals**
        ii. **Would disrupt Hospital and Nursing home cash flow due to denials where many hospital's cash days on hand are less than 5 days – could lead to hospital closure**
        iii. **Nursing home savings only available from per diem rate cuts**
        iv. **5-6 different ABD populations inside overall class**
        v. **Would fail to recognize the progress made in the SOURCE program as a means of continuity of care for a future model in rural Georgia.**
2) **Place some amount of population under ACO**
    a. **Pros none identified due to no real successful models to study**
    b. **Cons**
        i. **Unproven methodology**
        ii. **Managed car population would driven by lowest cost subcontractor which would lead to**
            1. **exacerbated level of claims denials**
        iii. **No proven model of ACO implemented on a large scale**
        iv. **Large implementation take 5 years to affect where Georgia's system is so fragile this could deteriorate access even more**
        v. **Rural hospitals could not survive since already low cost**
3) **Adopt commercial plan attributes - additional co-pay and incentives**
    a. **Pros - no models to compare against**
    b. **Cons**
        i. **Translates directly into a cost shift to provider bad debt**
        ii. **no proven models in this non compliant population**
4) **Market Place Concerns**
    a. **Loss of another $100 million UPL to hospitals**
        i. **equivalent loss of 10 rural hospitals in total**
        ii. **Could close 10-15 hospitals who already are near zero days cash**
            1. **And employ physicians with subsidy**
        iii. **If hospitals are not healthy rural physicians will not be as well**
    b. **Major Market share consolidated into a monopoly or duopoly if uncontrolled by state**

i. Commercial rate suppression from having combined high market share
ii. Cross subsidization created in 1999 when 85.6 % of cost payment was initiated by state pushed survival to commercial plans

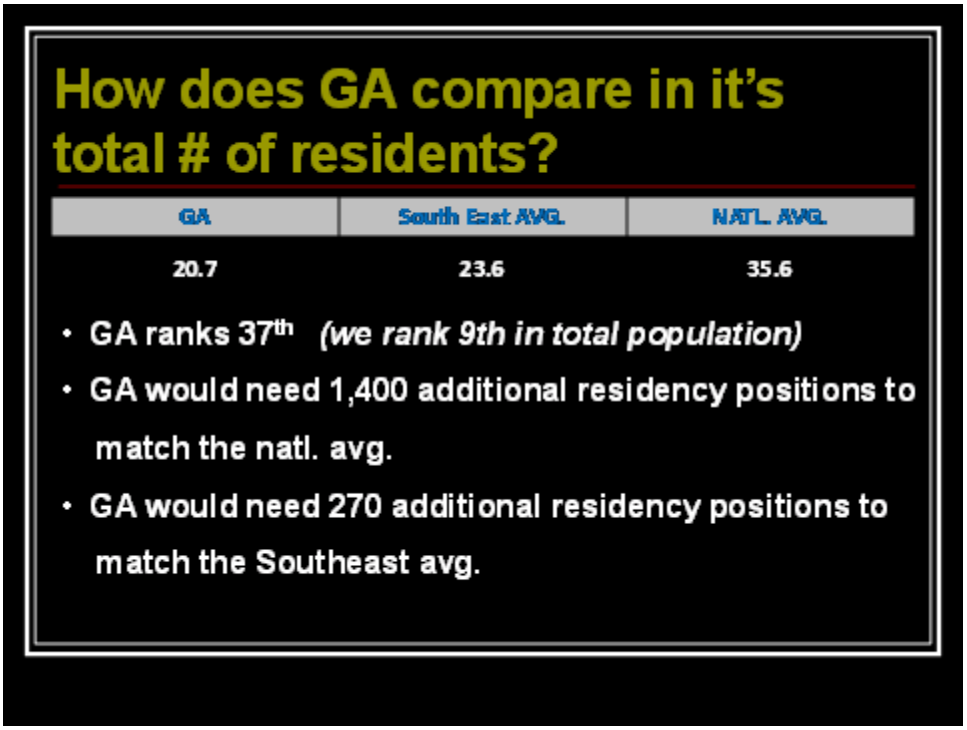
c. Since rural markets are usually highest Medicaid providers this generally will hit Rural Health hardest
d. Additional payor platforms adds to administrative burden in rural hospitals
e. Increase in denial processing that slows cash flow
f. ABD for nursing homes – moves a constant in cash flow and care to a variable in cash flow and an unproven denials management program
g. If Georgia is already among the lowest Medicaid payers how much more can be expected and keep providers involved - http://207.57.255.197/forum/?p=1207
    i. Personal spending trends very important http://www.cms.gov/MMRR/Downloads/MMRR2011_001_04_A03.pdf
h. Physician shortage for 700,000 newly eligible's may be 1000 current shortage plus 100's more
i. Loss of ICTF to insured population in Health Insurance exchanges will not have the gap filled as with current Medicare losses
j. Back to the CMMS report: Georgia ranked 49th in Medicaid personal health care spending. The national average was $6,826 per enrollee; Georgia reported $4,835 per enrollee, down from five years earlier when the state average was $5,532. Medicare personal health care spending per capita averaged $10,365 nationally two years ago; Georgia reported $9,836 per capita.
k. Who's in charge to appeal to since CMO's have had unrestrained market control for five years
l. Just how many non standard payor platforms can the system stand
m. Great care has to be taken in studying the NC Model because of various conflicts, $1000 - $2000 higher Medicaid cost per enrollee, and the cost to install the free clinic structure
n. ACO's are negative because of the "lowest bidder" and large system control over subcontractors – rural hospitals and rural doctors
o. Why does not Georgia pick the CMO's, keep the concept , spell strengthening operating rules of engagement, adopt a stronger HB1234

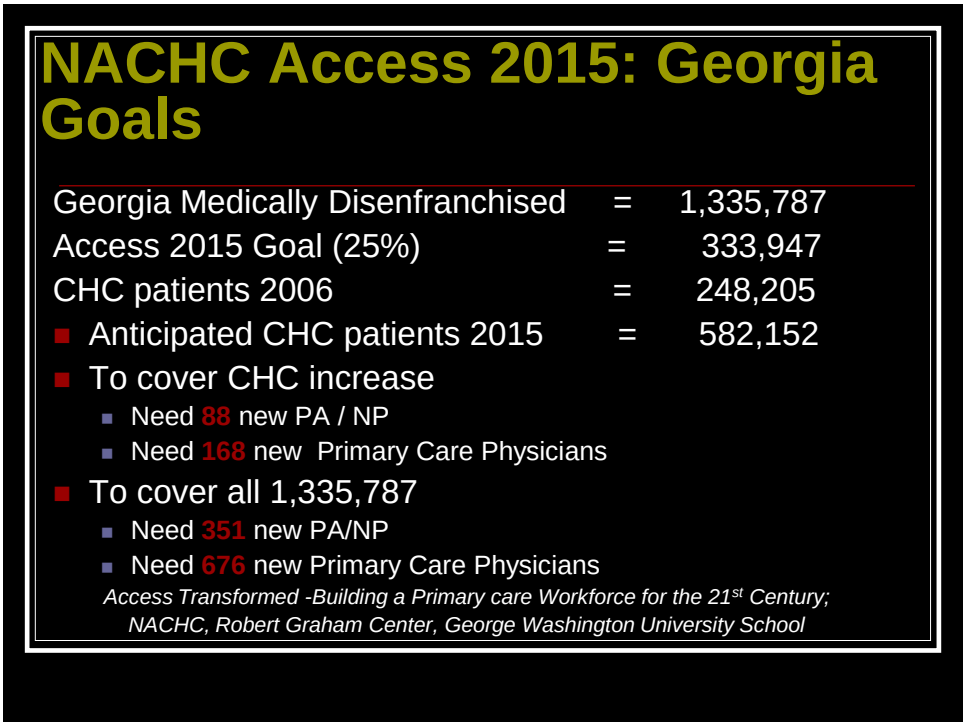
5) Scenario of engagement between now and Navigant implementation date 2014.
    a. The system can only handle so much change at one time. This is what is occurring during this Navigant proposed redesign. This is "change overload" to the already fragile rural healthcare delivery system
        i. Provider Tax Reinstatement – July 1, 2013 or
            1. 12%-18% Medicaid Rate Cut – per Senate Budget Office
        ii. Additional 700,000 newly eligible Medicaid at an additional $3.3 billion added cost at $4835 per covered life
        iii. EHR/EMR installation – cash disruption/Admin cost unbearable
        iv. ICD10 April 1 and thereafter

v. **HIPAA5010 cleanup**
vi. **Implementation of Health Insurance Exchange – while providing insurance it will eliminate DSH and replace with Medicaid underpayment at 85.6% of cost**
vii. **Health Information exchange**
    1. **Physicians will get hurt with overhead burden**
viii. **Reportedly 300-500 hospital cost reports unsettled**
    1. **Due to HS&R's late publication**
ix. **After the above comes Navigant and Medicaid redesign**

6) **Possible Options**
    a. **Do nothing**
    b. **Keep current Medicaid CMO concept w/o ABD inclusion**
        i. **Keep exact same CMO concept**
    c. **Keep current Medicaid CMO concept with new players - w/o ABD inclusion**
    d. **Same two as above but carve in ABD**
    e. **North Carolina Model at +$1000 per capita increase North Carolina in deep Medicaid trouble**
    f. **ACO's where large systems assume risk**
        i. **A total fiasco for all involved probably need a $100 million to start then to lowest bidder – equivalent to other industry dealing with Primes Contractors and sub Contractor**
7) **Fundamental questions**
    a. **Why is Georgia doing this?**
    b. **Is this a national boiler plate to pay for 700,000 newly eligible's**
        i. **Translates into a Medicaid population tax of $3.5 billion**
    c. **Expands the gap between haves and have not Health care providers, urban versus rural**
    d. **Physicians for 750,000 rural population = 300-400 rural Family Practioners and Internal Medicine physicians to be hurt with lower payments**

8) **For hospitals, Cross Subsidization from commercial and other service with margin are required to offset Medicaid losses is the foundation upon which Georgia's Medicaid is founded since the 1999-2000 conversion to 85.6% of cost.**
9) **Physician Shortage**
    a. **Georgia is1000 physicians short before Obama care's 700,000 newly eligible's**
        i. **http://hometownhealth.wikispaces.com/2010+Fall+Conference+Presentations+and+Materials**
            1. **Addressing physician shortages – click this title – Denise Kornegay MCG**
    a.




**10) Summary of CMO meetings**

a. **Problem solving and continued process improvement with CMO will be a function of data management, data mining, and patterns and trends from data to determine any outlier occurrences so as to problem solve the outliers identified**
b. **Although CMO's have been difficult to deal with in the past, they now have five years worth of data that a new CMO will not have that must be captured and used**
c. **New Payor Platforms take several years to debug and digest where rural providers have no safety net or cushion that allows them to handle the impact**
d. **All Products pricing from large insurers will drive the cross subsidizing margins to below cost and that will put providers out of business**
e. **There apparently has been a lot of quality and performance data development and data mining between CMO's and DCH that the provider community has not been made privy to**
f. **Movement to Gainshare**
g. **If indeed**
    i. **the CMO's can objectively show improvement in the quality of health outcomes of the population, and**
    ii. **CMO's can minimize claims processing abuse in payments like certain pre-certs and denials ER and elsewhere**
    iii. **Then bringing a new CMO into the market will force rural providers to have to start all over again with new payment platforms.**
    iv. **Which will take the industry longer to get to phase II of data management which is the difference in making things better. As the data shows, Georgia can't go any lower in cost per unit (price) without significant harm to the system and the safety net. Only way to make things better is to lower the numbers of units (utilization) and/or change the frequency of the high cost units (tertiary medical center) by improving the cost and quality at the primary and secondary level (PCP and rural hospitals) so rural hospitals can keep a little of those savings.**
h.

**Conclusion:**

1) **Georgia could probably never afford to go back to Fee for Service**
2) **The cost savings associated with the current CMO's may be highly overstated since most of the saving came from tightening enforcement of eligibility in 2005-2006**
3) **Given the fragility of the provider network, The current CMO concept may be the best concept because it now is the "devil we know versus the Devil we do not know" provided:**
    i. **Keep the current CMO concept without ABD, ACO or commercial and co-pay**
    ii. **Employ and expand Source as a regional home health care provider**
    iii. **Shake up the players with an RFP but keep current CMO concept**
    iv. **Have no more than three CMO's without having major commercial insurers provide care together to prevent a duopoly.**
    v. **Strengthen HB1234**
    vi. **Focus on gainshare**
    vii. **Create a communication forum for work done between CMO's and DCH**
    viii. **Appoint an ombudsman for providers within Legislature to balance control**
    ix. **Establish communication tools that make the CMO operation transparent including proper dashboard reports and advisory councils**
    x. **Conduct a major housekeeping cleanup project with CMO's and providers before June 30, 2012**