
Colorado Department of
**HEALTH CARE
POLICY &
FINANCING**

JBC Hearing Presentation
December 21, 2010



PRESENTERS

- Joan Henneberry, *Executive Director*
- Chris Underwood, *Deputy Director, Budget & Finance Office*
- Sue Williamson, *Director, Client & Community Relations Office*
- Laurel Karabatsos, *Acting Director, Medical & CHP+ Program Administration Office*
- John Bartholomew, *Director, Budget & Finance Office*
- Phil Kalin, *CIVHC Director*



DEPARTMENT OVERVIEW

Joan Henneberry



DEPARTMENT OF HEALTH CARE POLICY & FINANCING

- Federally designated agency to receive federal funds for Medicaid and CHP+
 - Administers the following programs:
 - Medicaid
 - Home and Community Based Services (HCBS) Medicaid Waivers
 - Child Health Plan *Plus* (CHP+)
 - Colorado Indigent Care Program (CICP)
 - Old Age Pension State Medical Program (OAP-SO)
 - Comprehensive Primary and Preventive Care Grant Program
 - Primary Care Fund
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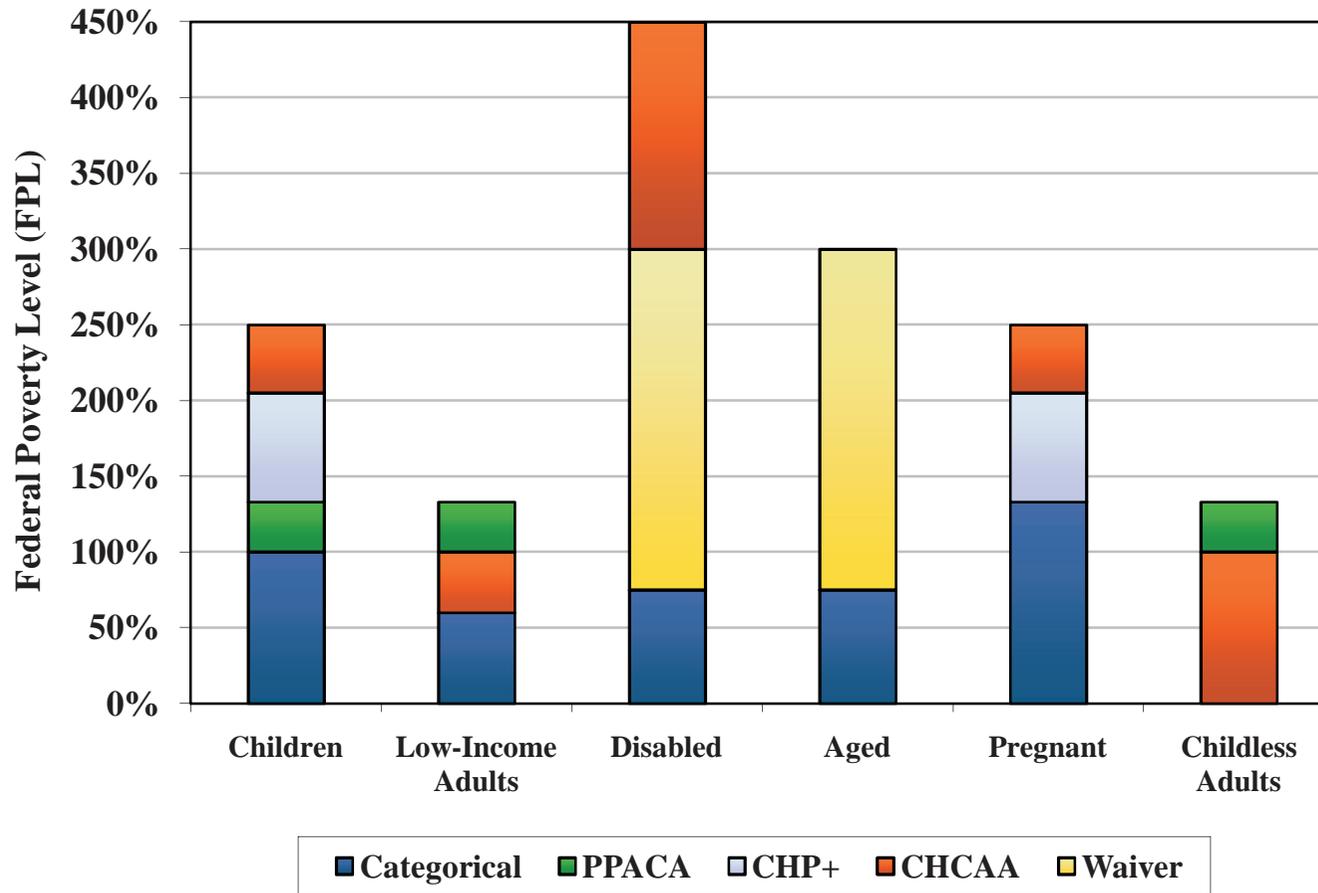


GOALS AND STRATEGIES

- Increase the Number of Insured Coloradans
- Improve Health Outcomes
- Increase Access to Health Care
- Contain Health Care Costs
- Improve the Long-Term Care Service Delivery System



ELIGIBILITY FOR COLORADO MEDICAID AND CHP+



PROGRAM ELIGIBILITY

Program	Income Eligibility	Other Requirements
Family Medicaid	0% - 133% FPL	Children age 0-5 up to 233% FPL, Children age 6-18 and parents with Medicaid eligible dependent children to 100% FPL
Persons with Disabilities Who are Under Age 64	Blind or disabled Eligible for Supplemental Security Income (SSI)	Under the age of 64 and do not have dependant children
Persons 65 and Older	Income limit is \$674 a month (\$2,022 a month if individual meets nursing facility level of care)	Eligible for SSI and/or OAP state supplemental payments Resources less than \$2,000/\$3,000/\$4,000 for individual/couples
Long-Term Care	Income limit is \$674 a month (\$2,022 a month if individual meets nursing facility level of care)	Under age 65 must meet the Social Security disability criteria either through SSA Resources less than \$2,000/\$3,000/\$4,000 for individual/couples



PROGRAM ELIGIBILITY

Program	Income Eligibility	Other Requirements
Child Health Plan <i>Plus</i> (CHP+)	250% FPL and below	Low income children (18 years of age and younger) and pregnant women (19 years of age and older) Not eligible for Medicaid Do not have other health insurance
Breast and Cervical Cancer Program	Less than 250% FPL	Diagnosed through a Women's Wellness Connection site Woman between 40 and 64 years old No mammogram or Pap smear test in the last year No health insurance or it does not cover breast or cervical cancer treatment Not currently enrolled in Medicaid and are not eligible for Medicare
Colorado Indigent Care Program (CICP)	Less than 250% FPL	Not eligible for Medicaid or CHP+ Must exhaust other insurance before CICP reimburses the health care provider



MEDICAID BENEFITS

“Mandatory” Items and Services

- Physician services and medical/surgical services of a dentist
- Lab and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning
- Pregnancy related services
- Rural and Federally-Qualified Health Center (FQHC) services
- Nurse midwife services
- Nursing facility (NF) services for individuals 21 or over
- Certified Nurse Practitioner services
- Home health care services
- Transportation*

*Medicaid programs must provide assurance of transportation

“Optional” Items and Services

- Prescription drugs
- Clinic Services
- Psychologist services
- Adult dental services
- Physical therapy and rehab services
- Prosthetic devices, eyeglasses
- Primary care case management
- Intermediate care facilities for the mentally retarded (ICF/MR)
- Personal care services**
- Hospice services

**Only covered as HCBS waiver service



COLORADO MEDICAID WAIVER PROGRAMS

- HCPF Waiver Programs:
 - Elderly, Blind, & Disabled (HCBS-EBD)
 - Children’s HCBS
 - Persons with Brain Injury (HCBS-BI)
 - Persons with Mental Illness (HCBS-MI)
 - Persons Living with AIDS (HCBS-PLWA)
 - Children with Autism (HCBS-CWA)
 - Pediatric Hospice Waiver (HCBS-PHW)
- DHS Waiver Programs:
 - Children's Habilitation Residential Program (HCBS-CHRP)
 - Supported Living Services (HCBS-SLS)
 - Persons with Developmental Disabilities (HCBS-DD)
 - Children's Extensive Support (HCBS-CES)

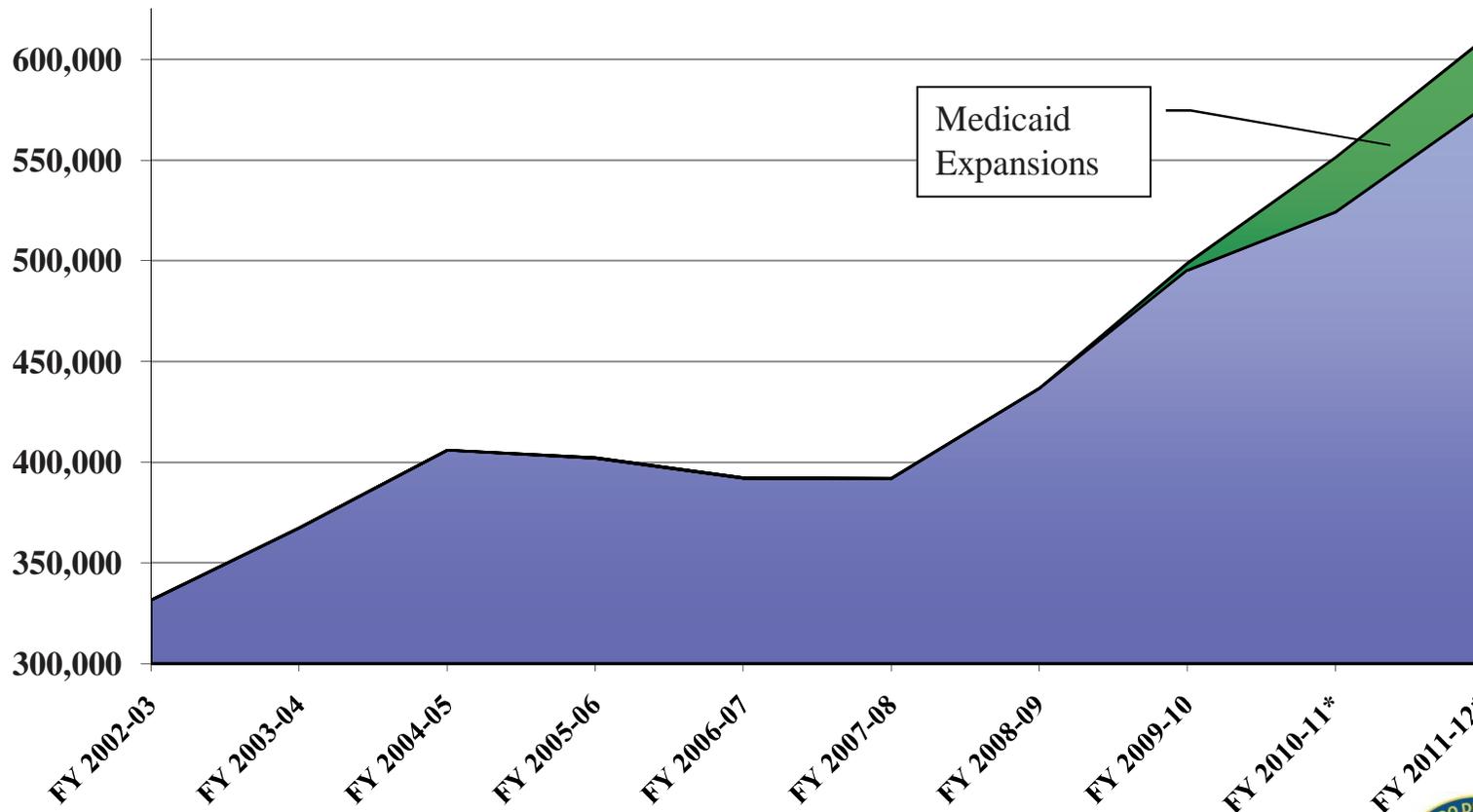


COLORADO MEDICAID WAIVER PROGRAMS

- Waiver participants must:
 - be medically qualified;
 - be certified for the waiver’s institutional level of care;
 - choose to enroll in the waiver as an alternative to institutionalization;
 - be in aggregate, cost Medicaid no more in the community under the waiver than clients would have cost Medicaid in an institution, and;
 - be financially eligible based on their income and assets.



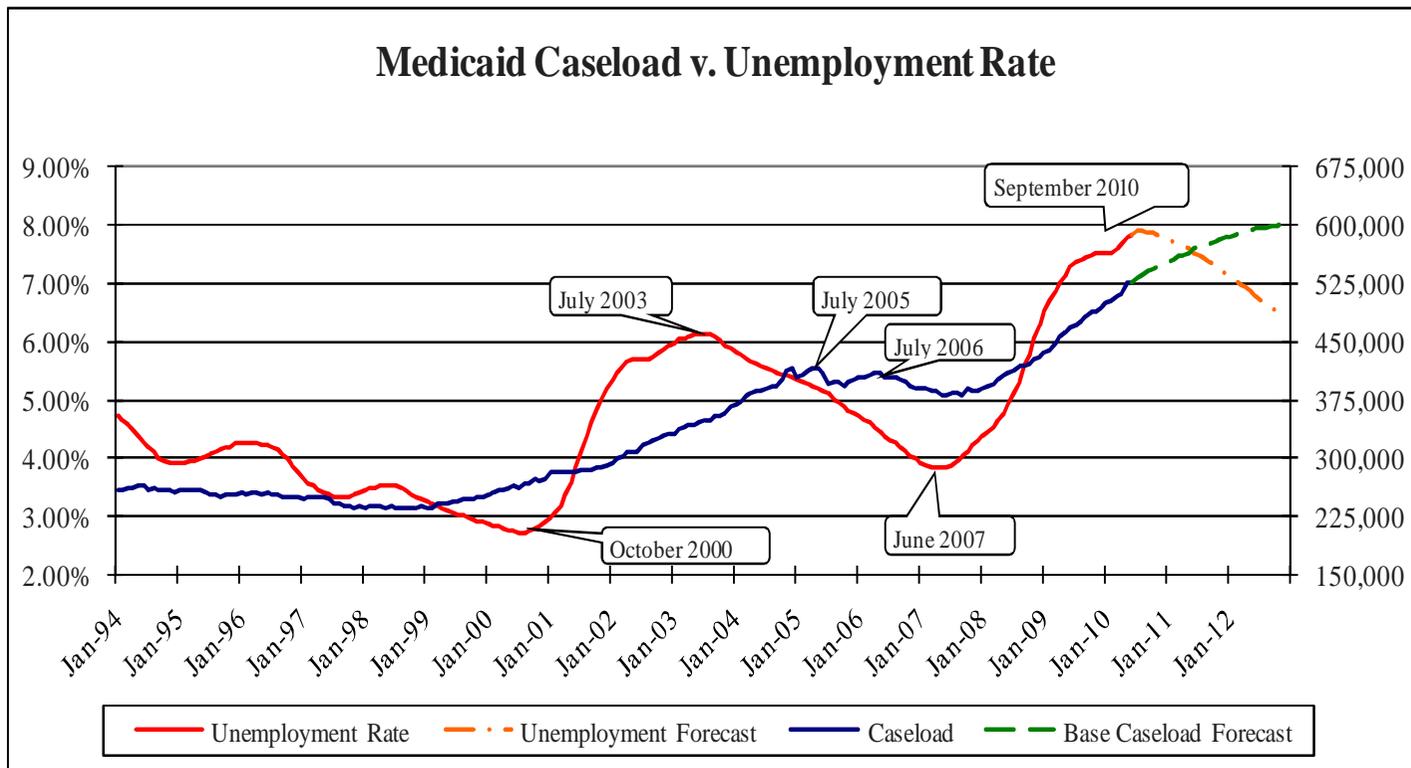
MEDICAID CASELOAD



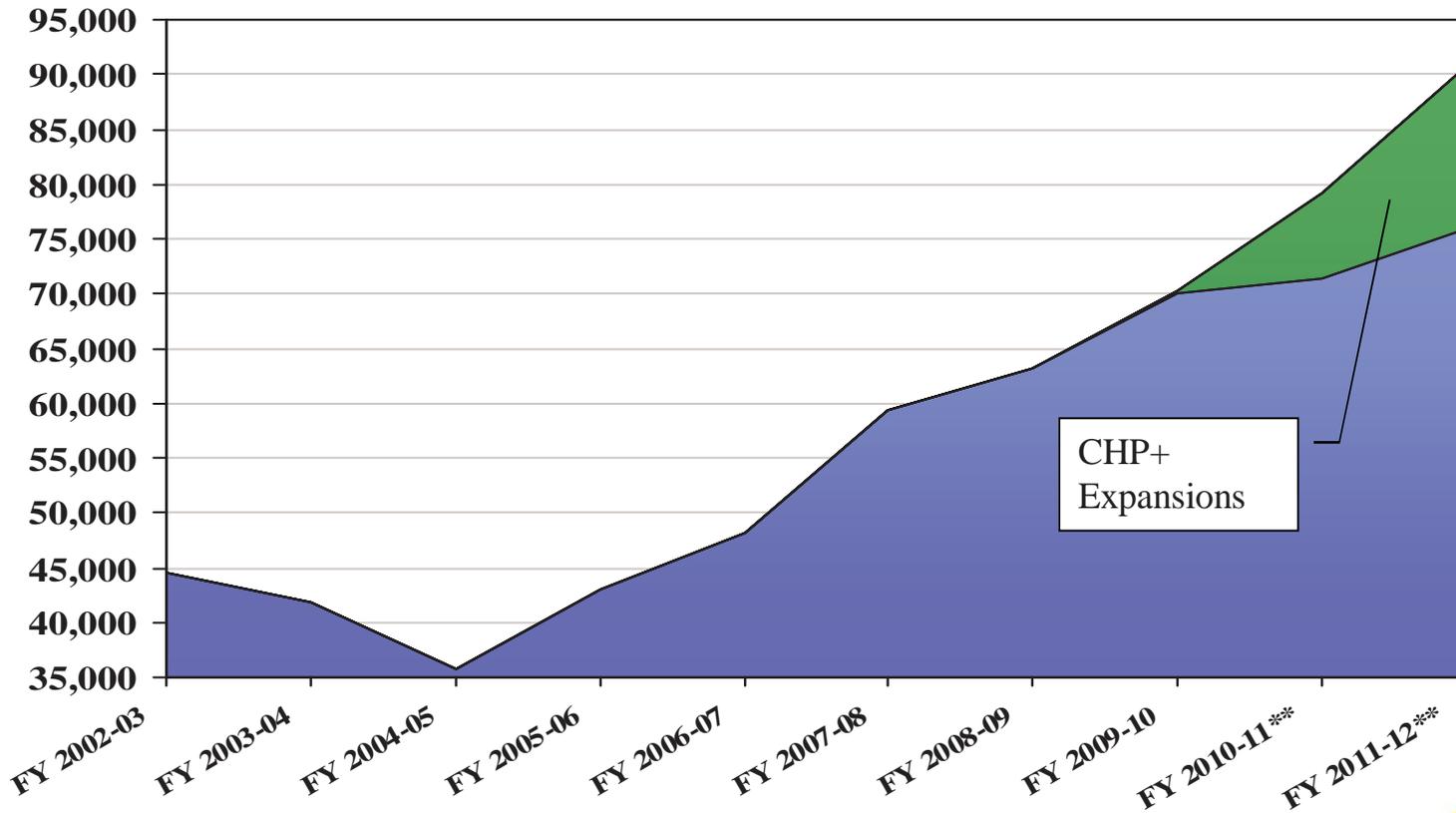
**Projections from the Department's November 1, 2010, Budget Request
 Expansions are a result of HB 09-1293, the Colorado Health Care Affordability Act*



MEDICAID CASELOAD



CHP+ CASELOAD



*Includes children and prenatal.

** Projections from the Department's November 1, 2010 Budget Request.

Expansions are a result of HB 09-1293, the Colorado Health Care Affordability Act.



CURRENT CASELOAD

- As of November 2010:
 - 551,168 Medicaid clients (historical high)
 - 42% caseload growth since January 2007
 - 68,047 children and pregnant women in CHP+
 - 43% caseload growth since January 2007
 - 277,000 clients with access to focal point of care



DELIVERED THE PROMISE

2007

- Established Preferred Drug List for Medicaid
- Launched Medical Home pilot program
- Expanded mental health benefits in the small group private market
- Invested in immunizations
- Launched anti-obesity & rural health initiatives with private sector partners

2008

- Expanded CHP+ eligibility
- Provided Medical Homes for Medicaid & CHP+ kids
- Began Eligibility Modernization
- Increased Medicaid reimbursement rates
- Established CIVHC
- Made Health IT investment through CORHIO
- Required standard health plan ID cards
- Established consumer resource website
- Launched CRICC program
- FY 2008-09 Budget Reductions of \$21.4M TF

2009

- ARRA
- Medicaid Program Efficiencies
- ACC
- CHCAA
- CO-CHAMP
- FY 2009-10 Budget Reductions of \$169.7M TF

2010

- ARRA HITECH
- Medicaid Efficiencies Act
- EGUR
- Benefits Collaborative
- False Claims Act
- FY 2010-11 Budget Reductions of \$276.3M TF



MOST-EFFECTIVE PROGRAMS

Joan Henneberry



MOST-EFFECTIVE PROGRAMS

- Colorado Health Care Affordability Act (HB 09-1293)
- HRSA State Health Access Program Grant
- Improving Value & Quality of Care



COLORADO HEALTH CARE AFFORDABILITY ACT

- Authorizes Department to assess and collect hospital provider fees
 - Creates a sustainable funding source
 - Increases Medicaid hospital rates and CICIP payments
 - Reduces cost-shift to private payers
 - Hospital quality incentive payments
 - Expands Medicaid and CHP+ eligibility, expand health coverage to the uninsured
 - Supports Department's ongoing operations
- Creates Oversight and Advisory Board
 - January 15 Annual Report



HOSPITAL PROVIDER FEE MODEL

- FY 2009-10 Model (5 Quarters)
 - Generated \$146 million in new federal funds for Hospitals
- FY 2010-11 Model
 - Expected \$159 million in new federal funds for Hospitals
- ARRA Funds
 - \$46 million in FY 2009-10 and \$53 million in FY 2010-11
- Expansion Populations
 - Effective May 2010 Medicaid Parents to 100% FPL and CHP+ to 250% FPL
 - November 2010 Caseload: 26,924 Medicaid Parents, 3,342 CHP+ children 228 CHP+ pregnant women
 - Medicaid Buy-In Program for People with Disabilities (Summer 2011) and Adults without Dependent Children (Early 2012)



HRSA STATE HEALTH ACCESS PROGRAM GRANT

- Colorado Comprehensive Health Access Modernization Program (CO-CHAMP)
- “Champions” of policies that promote access to cost-effective, high-quality health care services
- \$42.9 million over 5 years
- Eight discrete projects

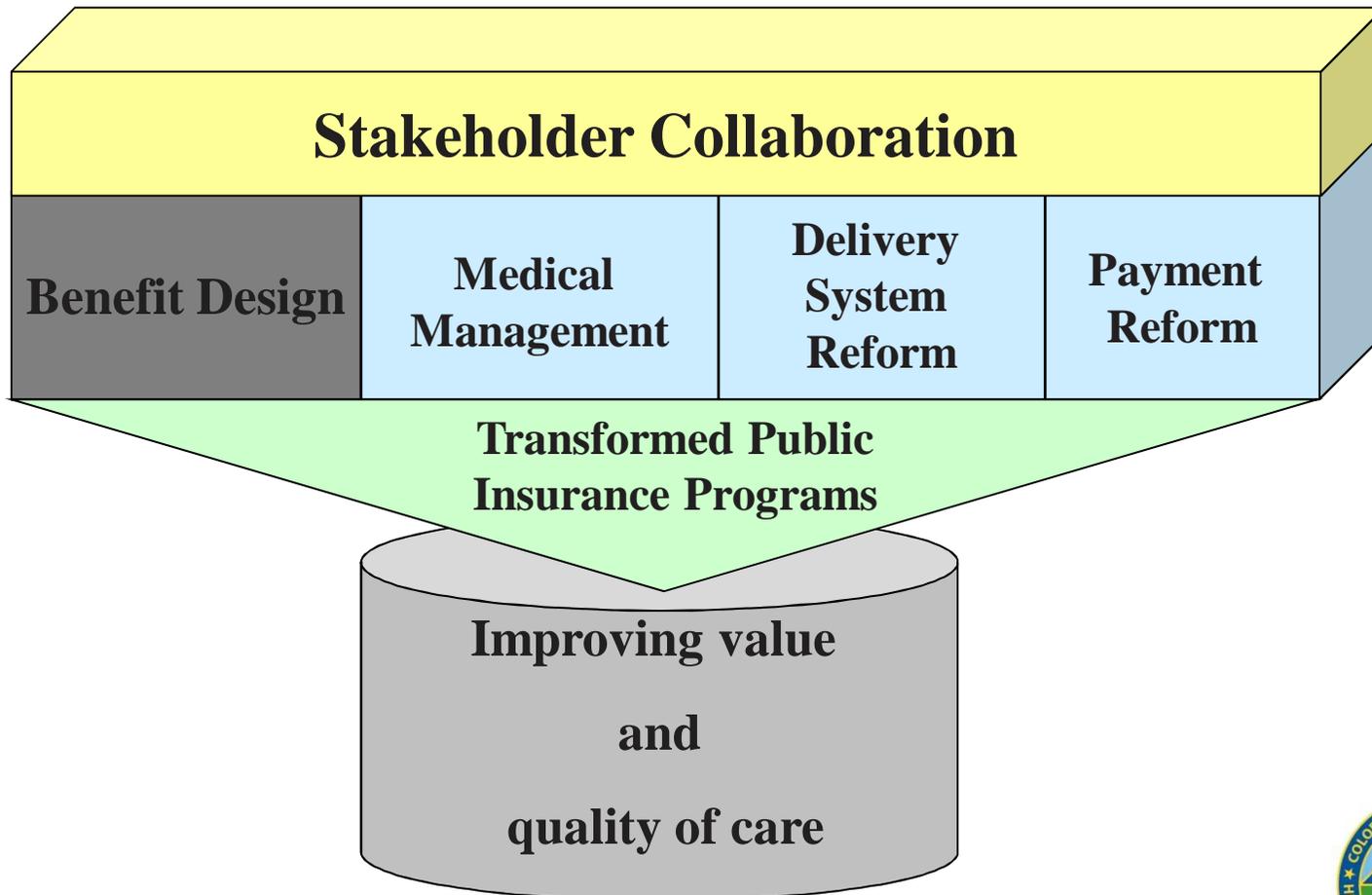


CO-CHAMP PROJECTS

- Eight discrete projects
 - CHP+ at Work statewide expansion (premium assistance)
 - Health Access Program: Pueblo (3-share community)
 - San Luis Valley Health Access Program (3-share community)
 - Evidence-Based Benefit Design Pilot (private insurance market)
 - Maximizing Outreach, Retention and Enrollment (“Health Care Affordability Act” (HB 09-1293) expansion populations)
 - Eligibility Modernization (HB 09-1293 expansion populations)
 - Benefit and Program Design (HB 09-1293 adults without dependent children and buy-in for people with disabilities)
 - Adult Multi-Payer Medical Home Pilot



IMPROVING VALUE & QUALITY OF CARE IN MEDICAID



BENEFIT DESIGN

- Objective: The process used to develop coverage policies for Medicaid services.
- Colorado's Benefits Collaborative develops benefit coverage policies based on clinical evidence and cost-effectiveness
 - Benefits Collaborative is transparent, stakeholder-driven



BENEFITS COLLABORATIVE OVERVIEW



BENEFITS COLLABORATIVE PROGRESS

- Request for Proposals posted January 2010
- Four vendors contracted to draft benefit coverage policies Spring 2010
- 36 draft benefit coverage policies submitted June 2010



BENEFITS COLLABORATIVE: PROGRESS TO DATE

Policies Reviewed by Stakeholders	Policies Near Completion	Approved Policies
Apnea Monitors	Speech Therapy & Audiology	Echocardiograms
Electrical Stimulation Devices	DME Oxygen	Maternity Services
Mattresses and Overlays	Low Back Imaging	Women's Health Services
Hospital/Specialty Beds	Bone Density	Abortion Services
Patient and Seat Lifts	Cardiac Stress Testing	Family Planning Services
Power Operated Vehicles/Power Wheelchairs		Children's Dental Policy
Augmentative and Alternative Communication Devices		
Diabetic Equipment and Supplies		
Intersex Surgery		
Bariatric Surgery		
Circumcision Surgery		



BENEFITS COLLABORATIVE: EARLY OUTCOMES

- Ultrasounds
 - Limited to three ultrasounds per normal pregnancy
 - Echocardiograms
 - Limited one per client and two test readings in a 12-month period
 - Cardiac Stress Testing
 - Limited to one procedure per year
 - Site of Service
 - Aligns payment methodology to encourage performing procedures in least costly setting
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BENEFITS COLLABORATIVE 2011 SCHEDULE

Policy	Public Meeting Date	Policy	Public Meeting Date
Radiology	Jan 7	Health Care Provider Services: Outpatient (except surgery)	Feb 18
Angiography	Jan 7	Telemedicine	Mar 4
Anesthesia	Jan 12	Dialysis Centers	Mar 4
Transplants	Jan 12	Ambulatory Surgery Centers	Mar 9
Breast Reconstruction	Jan 19	Non-Emergent Medical Transportation	Mar 23
Podiatry	Jan 19	Emergent Medical Transportation	Mar 23
CAT Scans	Jan 21	Autism Treatment	Apr 1
MRIs	Jan 21	Traumatic Brain Injury Treatment	Apr 1
PET Scans	Jan 21	Outpatient Substance Abuse	Apr 6
Physical and Occupational Therapy	Jan 26	Mental Health Services	Apr 16
Prosthetics	Jan 26	Case Management	Apr 16
Ultrasounds	Feb 4	Hospice Services	Apr 20
Laboratory & Pathology Services	Feb 4	Home Health Services	Apr 29
Office Visits	Feb 9	Private Duty Nursing	Apr 29
Office Administered Drugs	Feb 9	Adult Daycare	May 4
Immunizations	Feb 9	Personal Care Services	May 13
Health Care Provider Services: Inpatient and Surgery Services	Feb 18	Homemaker Services	May 13



OXYGEN BENEFIT

- Define appropriate use
 - Develop evidence-based clinical criteria for benefit
- Eliminate double billing practices
 - Identify and minimize billing errors
- Update reimbursement methodology
 - Control costs without affecting patient care

Policy Change	Annual Projected Savings
Appropriate use	\$230,000
Billing practices	\$200,000
Reimbursement methodology change	\$450,000
Total Estimate	\$880,000



FLUORIDE VARNISH BENEFIT

- Allows trained medical personnel to apply and bill Medicaid for oral exams and fluoride applications up to age 5
- Anticipate 40% reduction in tooth decay treatment for children with four or more screenings and fluoride varnishes visits before age 5

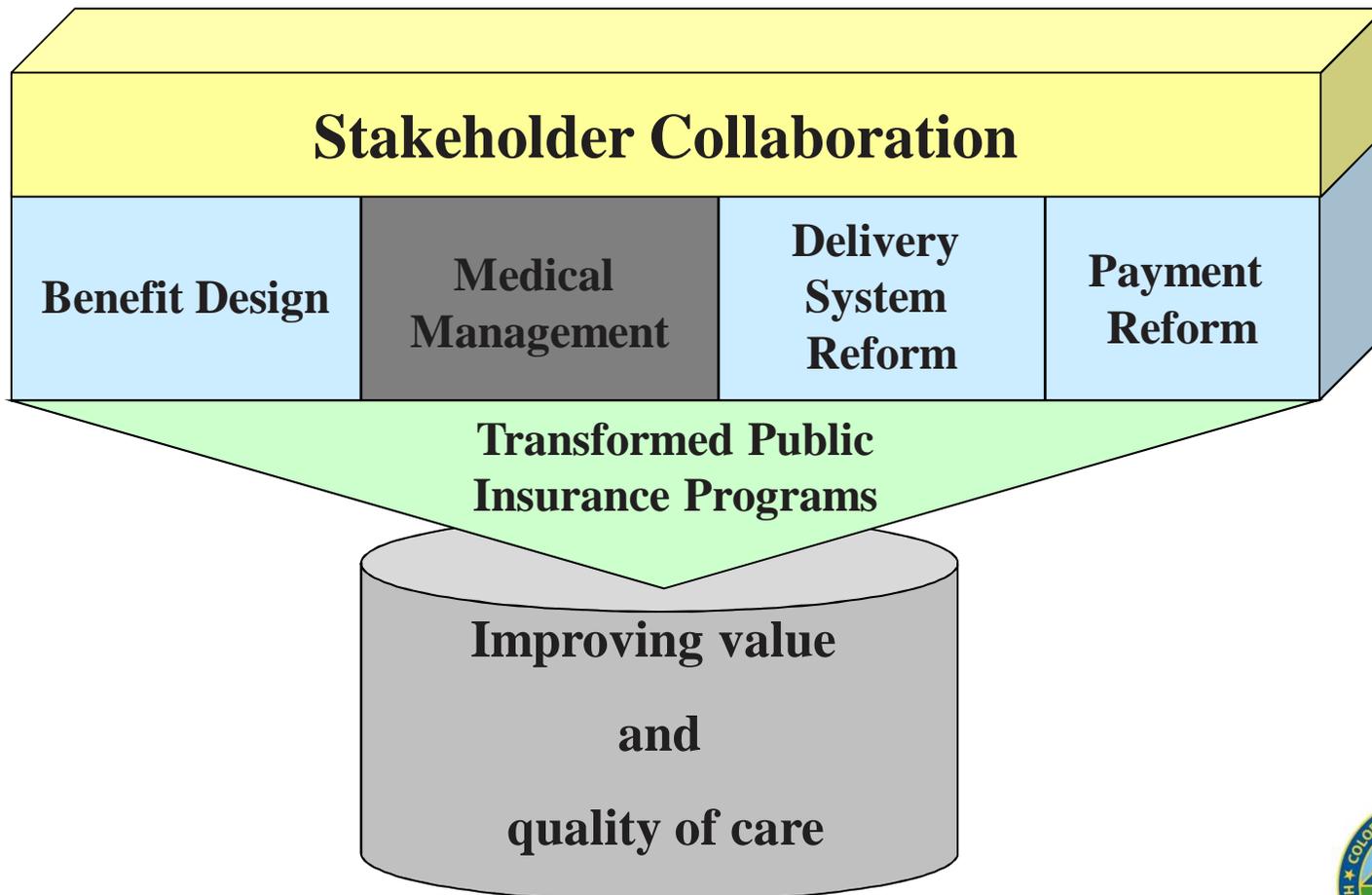


PHARMACY BENEFIT: PREFERRED DRUG LIST (PDL)

- Provide clinically appropriate medications to Medicaid clients
- Decrease medication expenditures
- PDL drugs based on safety, clinical efficacy, and cost-effectiveness
- 10 new drug classes in PDL
- FY 2009-10 estimated cost avoidance \$7 million



IMPROVING VALUE & QUALITY OF CARE IN MEDICAID



MEDICAL MANAGEMENT

- Objective: The process by which benefit delivery is planned, organized, directed and controlled so that variations in care are reduced and client safety and health outcomes are maximized.
- Evidence Guided Utilization Review (EGUR) modernizes of Utilization Review systems to:
 - Increase access to care that improves health outcomes
 - Manage costs
 - Reduce the administrative burden on clients and providers
- Other Initiatives

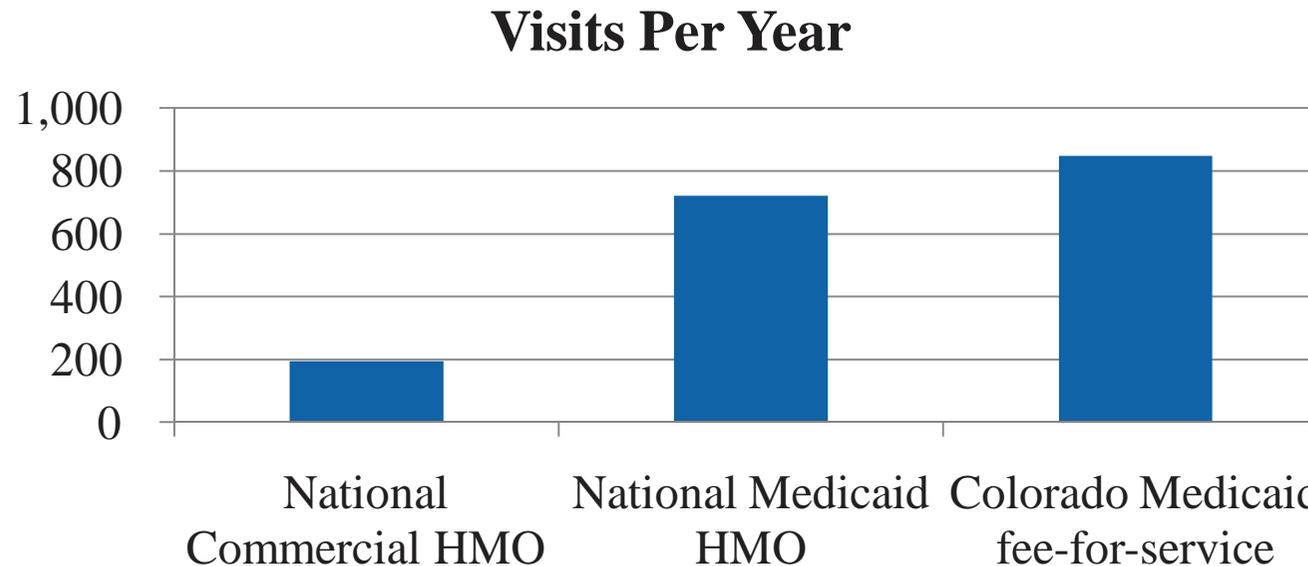


EGUR: PROGRESS

- Utilization Review
 - Hired consultant to assist in program design
 - RFP has been drafted with an anticipated contract award date of Spring 2011
- Expanded Procedures for Dental Hygienists
 - Allows additional procedure codes to be billed independently by dental hygienists with anticipated implementation January 2011



REDUCING UNNECESSARY EMERGENCY ROOM VISITS



- National data above from 2009, Colorado Medicaid fee-for-service data from 2010
- Expenditures on ER visits in FY 2007-08: \$73,000,000
- Approximately 40% of visits could have been done in less intensive setting



HOSPITAL READMISSIONS

- FY 2007-08 30-day hospital readmission rate is 12.6%
- Over \$30 million per year
- Progress
 - Implemented 24-hour readmissions policy
 - Included performance standards for readmission rates in managed care plan contracts
 - Evaluating 48 hour readmission policy



AUTOMATIC PRIOR AUTHORIZATION

- Electronically approves pharmacy claims that would otherwise require prior authorization
 - Uses medical and pharmaceutical claim data
 - Benefits
 - Less potential for drug therapy interruption for clients
 - Less burden on providers
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PHARMACY GOLD STANDARD

- Create benchmarks to measure progress and efficiency, allows comparison to other Medicaid programs
- Minimize the average prescription cost
- Encourage appropriate medication usage
- Improve healthy outcomes
 - Tobacco cessation
 - Family planning
 - Prenatal care



HEALTH PROMOTION INITIATIVES

- Dental Caries
- Depression
- Obesity
- Tobacco use

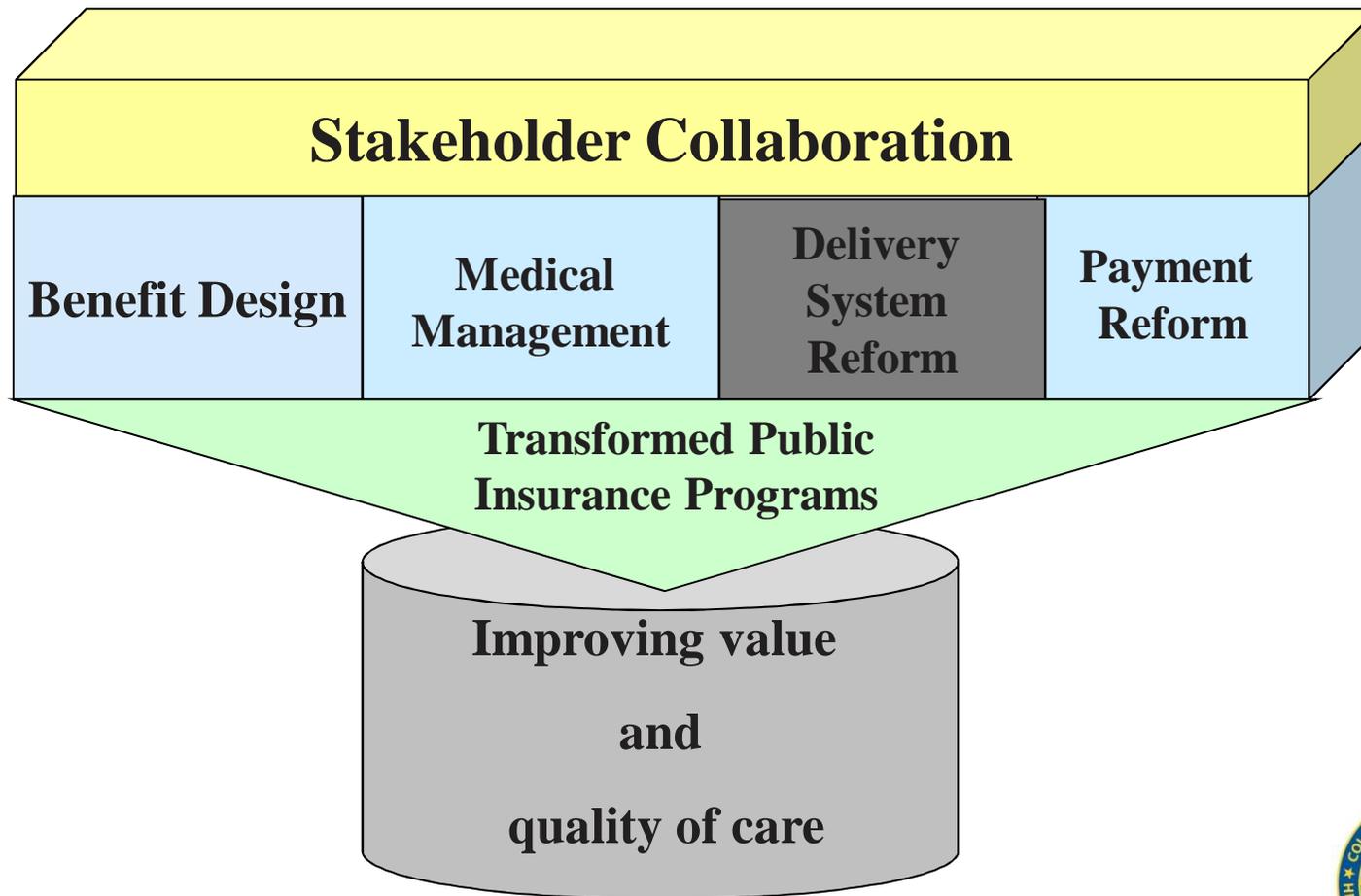


HEALTH PROMOTION INITIATIVES PROGRESS

- Increased dental benefits for children
- Enhanced screening for teen depression
- Improved screening for Body Mass Index (BMI)
- Expanded tobacco cessation benefits
- Initiated study on encouraging clients to seek preventive care



IMPROVING VALUE & QUALITY OF CARE IN MEDICAID



DELIVERY SYSTEM REFORM

- Objective: Improving the infrastructure used to provide care in order to obtain more coordinated, effective, client-centric care that improves access while containing costs.
- Accountable Care Collaborative (ACC)
- Money Follows the Person grant



ACCOUNTABLE CARE COLLABORATIVE (ACC): PURPOSE

- Designed to improve health outcomes
 - Community collaborations
 - Actionable information
- Reduce costs
- Improve the client and provider experience



ACC PROGRAM

- Accountable Care Organizations (ACO) is key terminology used in national health care reform discussions
 - Colorado recognized as leader by CMS and other states for Accountable Care Collaborative Program
 - NCQA (National Committee for Quality Assurance) creating ACO standards



ACC PROGRAM: KEY COMPONENTS

- Regional Care Collaborative Organizations (RCCOs)
 - Seven Primary Care Case Management organizations
 - Care coordination
 - Provider and member support
 - Accountability
 - Implementation date
 - Three regions April 1, 2011
 - Four regions June 1, 2011



ACC PROGRAM: KEY COMPONENTS

- Statewide Data and Analytics Contractor (SDAC)
 - ACC data repository
 - Evaluates cost effectiveness
 - Core and advanced analytics
 - Continuous feedback loop of critical information
 - Accountability and ongoing improvement among RCCOs and provider stakeholders
 - Nine proposals received and evaluated
 - Award to be made in early January 2011



ACC PROGRESS

- Amending existing contract(s)
 - External Quality Review Organization (EQRO)
 - Enrollment Broker
 - Ombudsman
 - Developing client attribution process
 - Developing Member Education materials
 - Developing RCCO Readiness Review
 - System changes
 - MMIS system modifications
 - Enrollment Broker system modifications
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ACC ROLL-OUT

- Initial enrollment goal is 60,000 total Medicaid clients
 - 40,000 adults
 - 20,000 children
 - Plan to expand to remainder of fee-for-service clients after meeting budget goals
 - Effectively apply an unprecedented level of data and analytics functionality
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MONEY FOLLOWS THE PERSON

- Institutionally-Based to Community-Based
 - Strengthen Home- and Community-Based Services (HCBS)
 - Increase housing options
 - Increase options for independent living
 - Focus on Person-Centered Care
 - Increase client choice
 - Reduce administrative burden
 - Streamline access to HCBS Services
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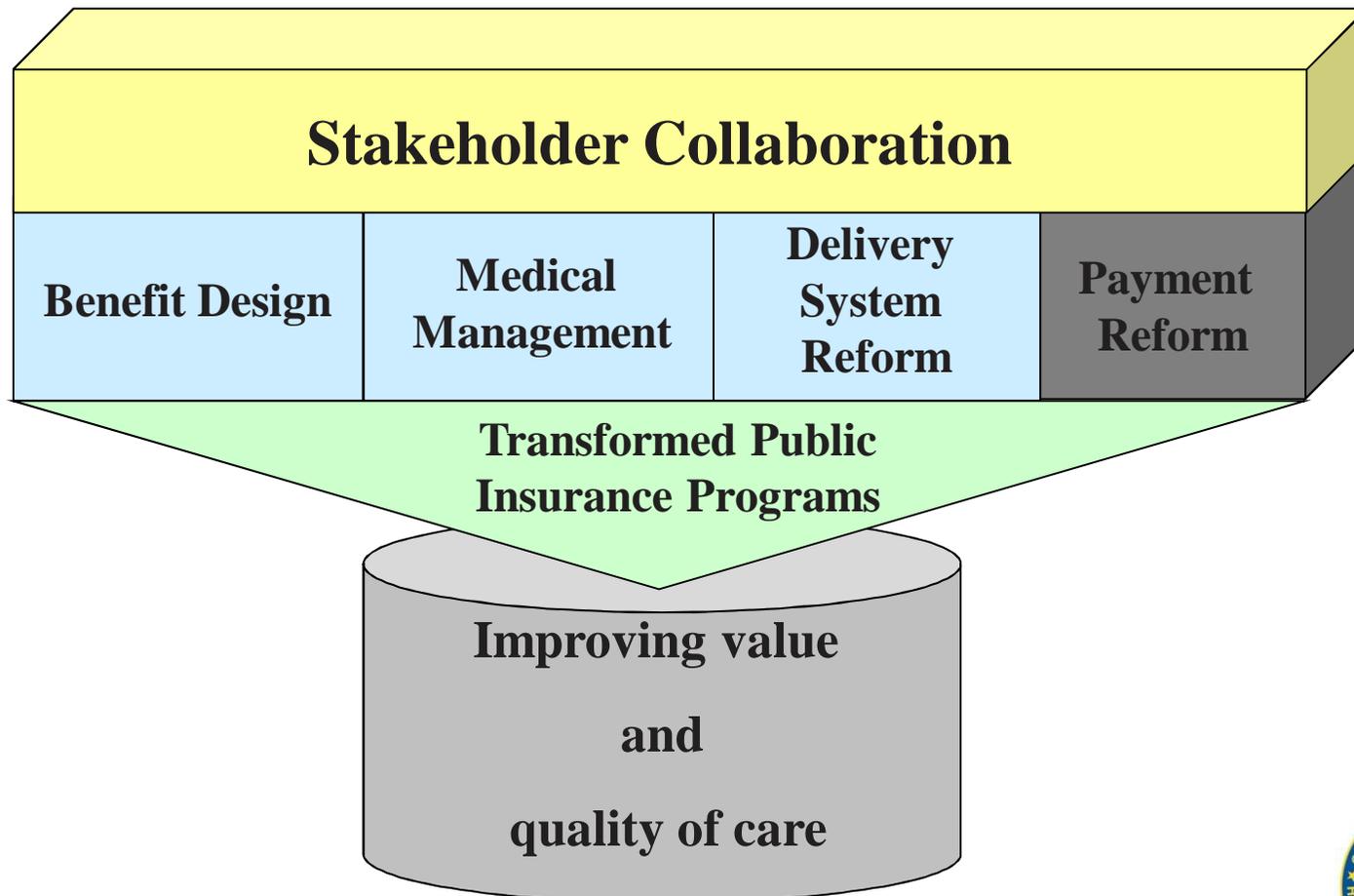


MONEY FOLLOWS THE PERSON

- Establish sustainable financing
 - Examine regulatory barriers
 - Increase housing options
 - Better inform the community
 - Stabilize and grow the direct service workforce
 - Expand the service array
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IMPROVING VALUE & QUALITY OF CARE IN MEDICAID



PAYMENT REFORM

- Objective: Revising the methods used to reimburse providers to move to paying for value instead of volume
 - Coordinated Payment and Payment Reform (COPPR)
 - Waiver and physician services
 - Dual eligible financing alignment
 - State Maximum Allowable Cost (State MAC)
 - BHO “Case Rates”
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COORDINATED PAYMENT AND PAYMENT REFORM (COPPR)

- Reinforces delivery system reforms
 - Accountable Care Collaborative
 - Money Follows the Person grant
- Bundled payments
- Value-based purchasing
- Dual eligibility



STATE MAXIMUM ALLOWABLE COST (SMAC)

- State MAC program manages drug reimbursement to pharmacies
 - Sets a maximum reimbursement for drugs based on drug acquisition cost data
 - Caps the cost of drugs with wide cost variations to that with the lowest cost
- Total projected savings for FY 2010-11 is \$2,716,882



BEHAVIORAL HEALTH ORGANIZATION (BHO) RATE REFORM

- Lessons learned
 - Close collaboration with provider communities
 - Precursor to rate reform is data quality improvement
 - Can leverage current defects in the payment system as the motive and rationale for broader change
 - Work is never complete
 - The more we do, the more opportunities for improvement we find



FUTURE PAYMENT REFORM

- Leverage future federal funding
 - Money Follows the Person
 - Hospital Based Payment Bundling Demonstration
 - Medicare Accountable Care Organization Pilot Program
 - 90% Federal match for payments supporting ‘health homes’
 - State Demonstrations to Integrate Care for Dual Eligibles
- Need to finance provider work of integration and collaboration across delivery systems



LEAST-EFFECTIVE PROGRAMS

Joan Henneberry



LEAST-EFFECTIVE PROGRAMS

- Hospital Back-Up Program (HBU)
- Structure of HCBS Waivers
- Cash Fund & Transfer Constraints



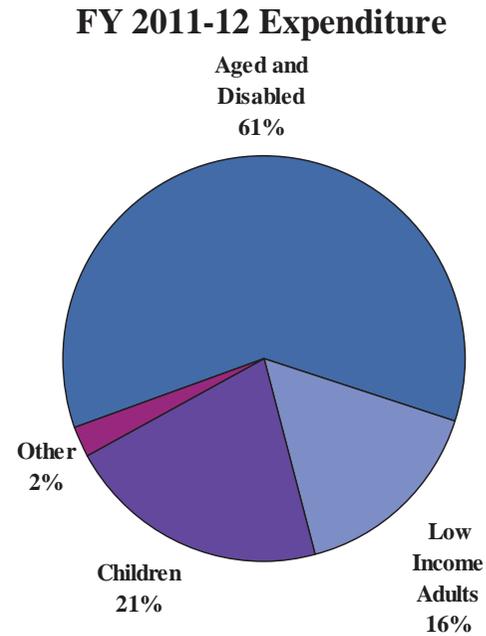
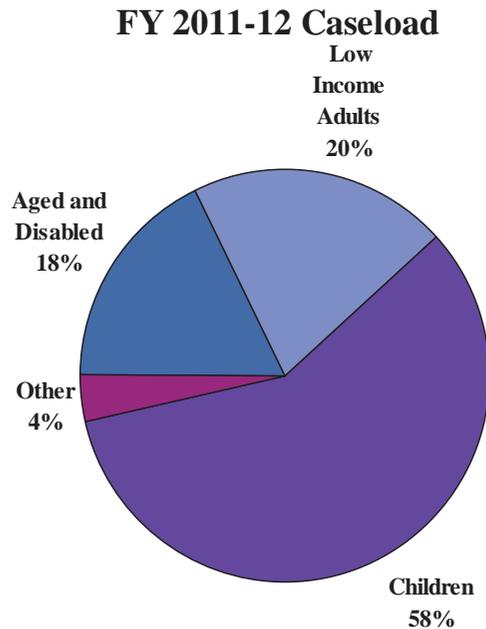
MANAGING THE BUDGET

John Bartholomew

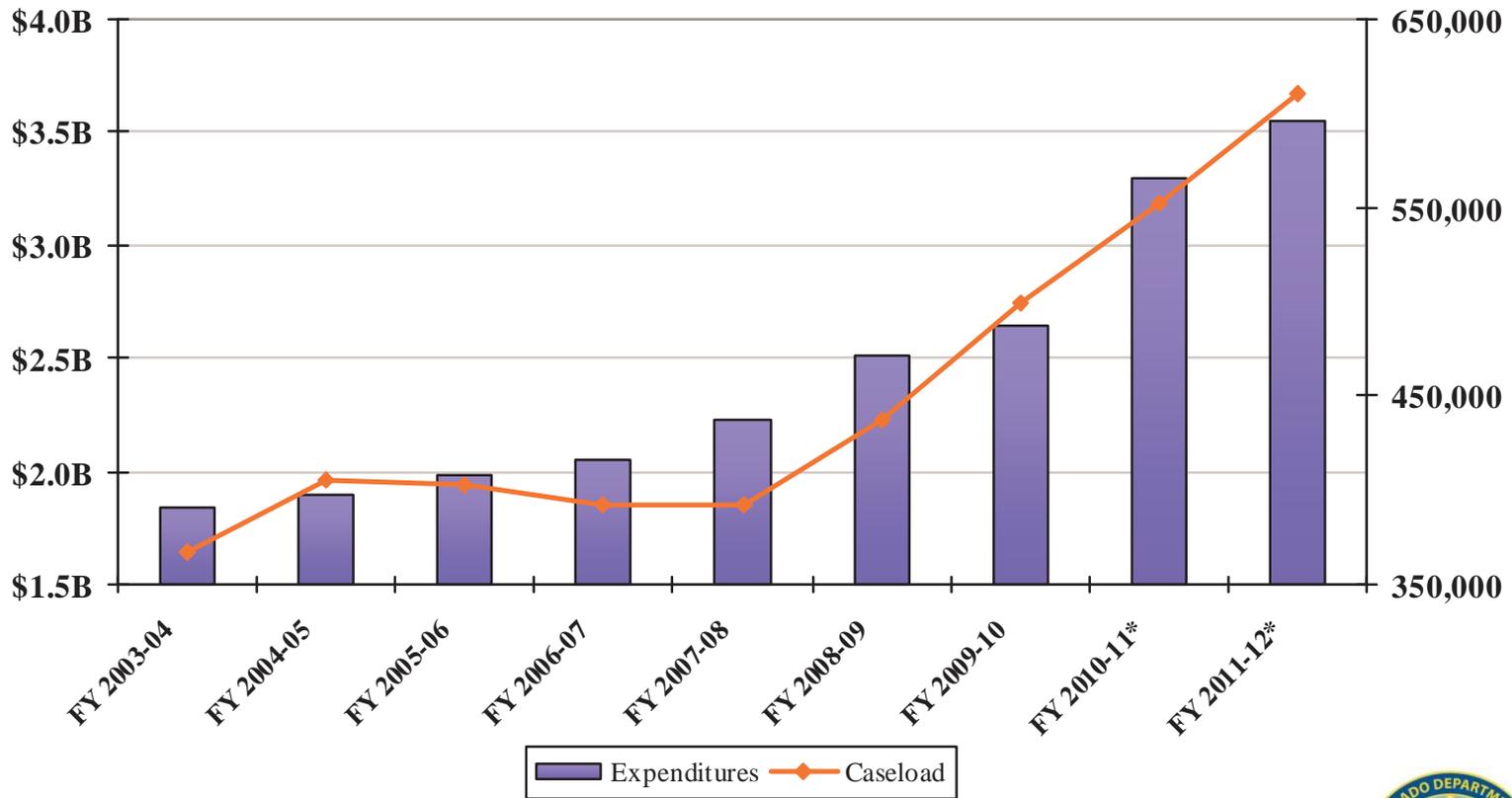


PROJECTED EXPENDITURE AND CASELOAD SHARES

	Aged and Disabled	Children	Low-Income Adults	Other	TOTAL
FY 2011-12 Caseload	109,296	354,449	124,443	21,837	610,025
FY 2011-12 Expenditure	\$1,850,755,035	\$645,075,332	\$480,349,169	\$75,072,597	\$3,051,252,133



MEDICAID EXPENDITURES



* Projections from the Department's November 1, 2010, Budget Request



MEDICAID EXPENDITURES

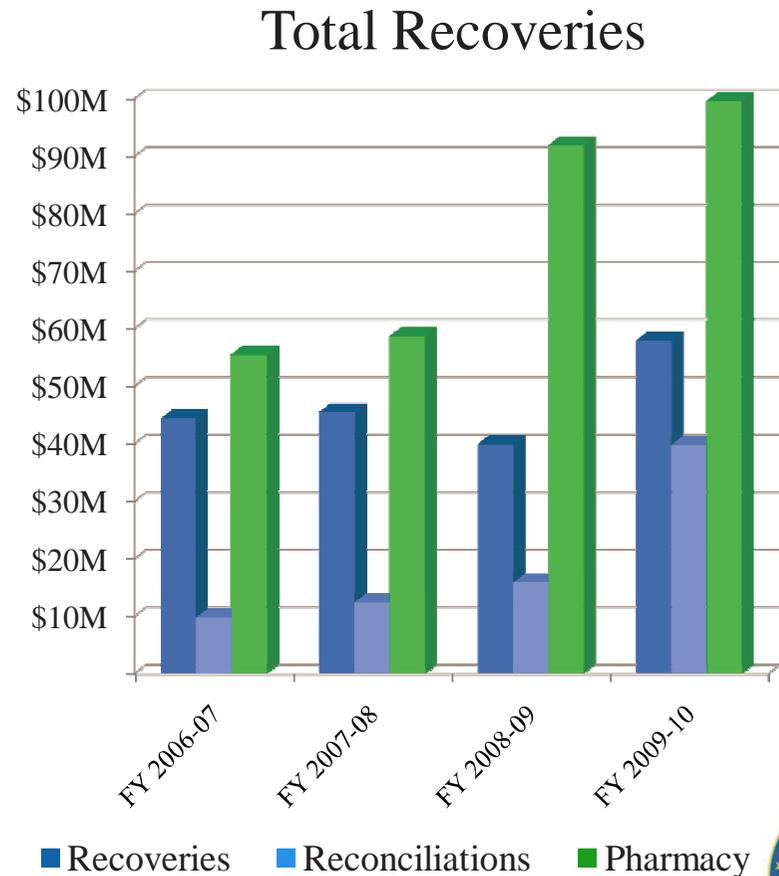
Medical Services Premiums Growth			
	Expenditure Growth	Caseload Growth	Per-Capita Growth
FY 2004-05	2.80%	10.46%	-6.95%
FY 2005-06	4.71%	-0.94%	5.71%
FY 2006-07	3.33%	-2.48%	5.96%
FY 2007-08	8.72%	-0.07%	8.79%
FY 2008-09	12.64%	11.44%	1.07%
FY 2009-10	5.34%	14.19%	-10.90%
FY 2010-11*	24.74%	10.58%	-0.26%
FY 2011-12*	7.69%	10.60%	-1.99%

* Projections from the Department's November 1, 2010, Budget Request



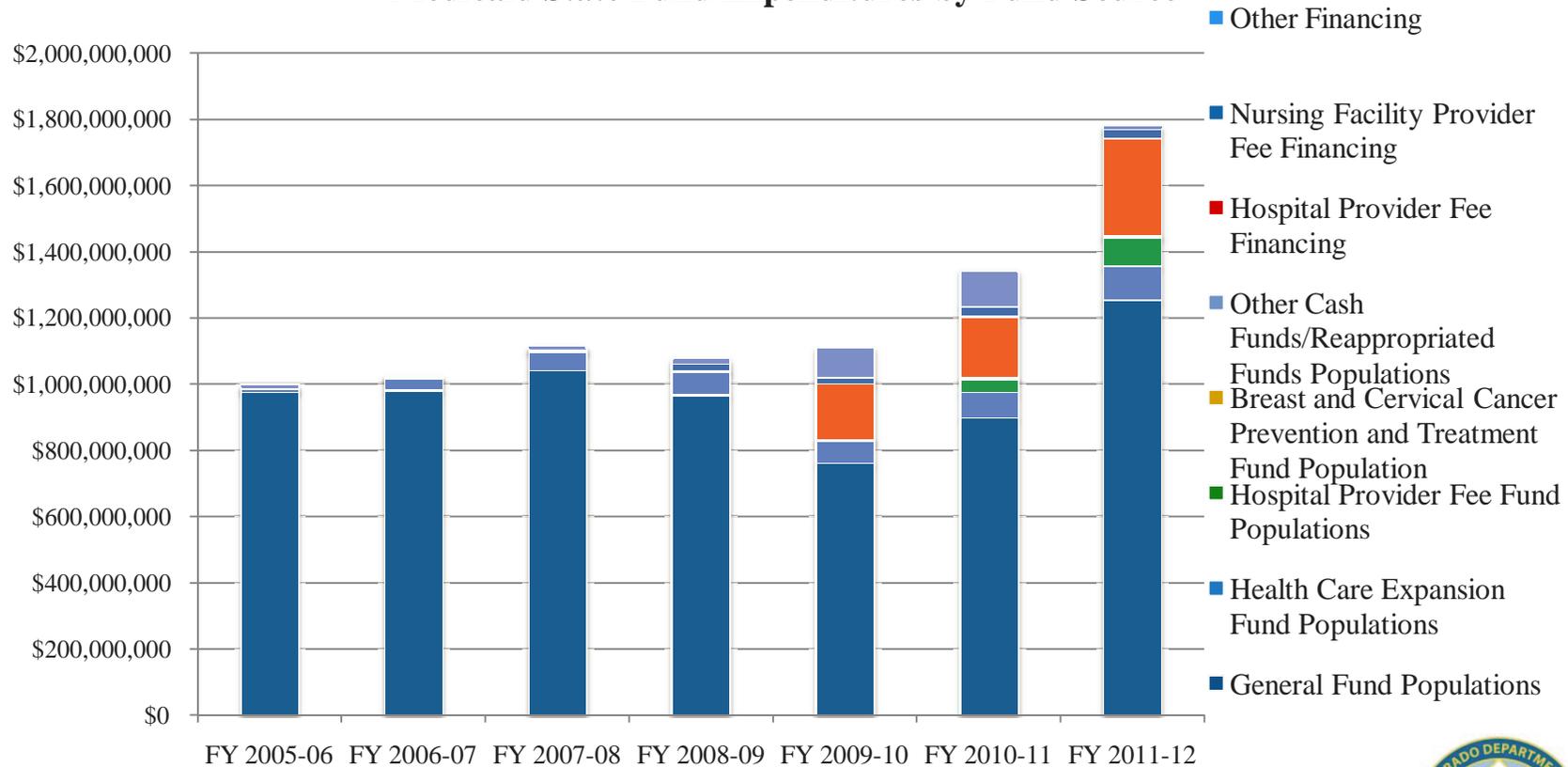
DEPARTMENT RECOVERIES

- Recoveries include:
 - Program Integrity Provider Recoveries
 - Estate Recovery
 - Trusts/Repayment
 - Tort/Casualty
 - Postpayment
- Reconciliations include:
 - HMO/PACE Recoveries
 - Hospital Cost Settlements
 - Mental Health Reconciliations
 - Nursing Facility Recoveries
- Pharmacy Rebates



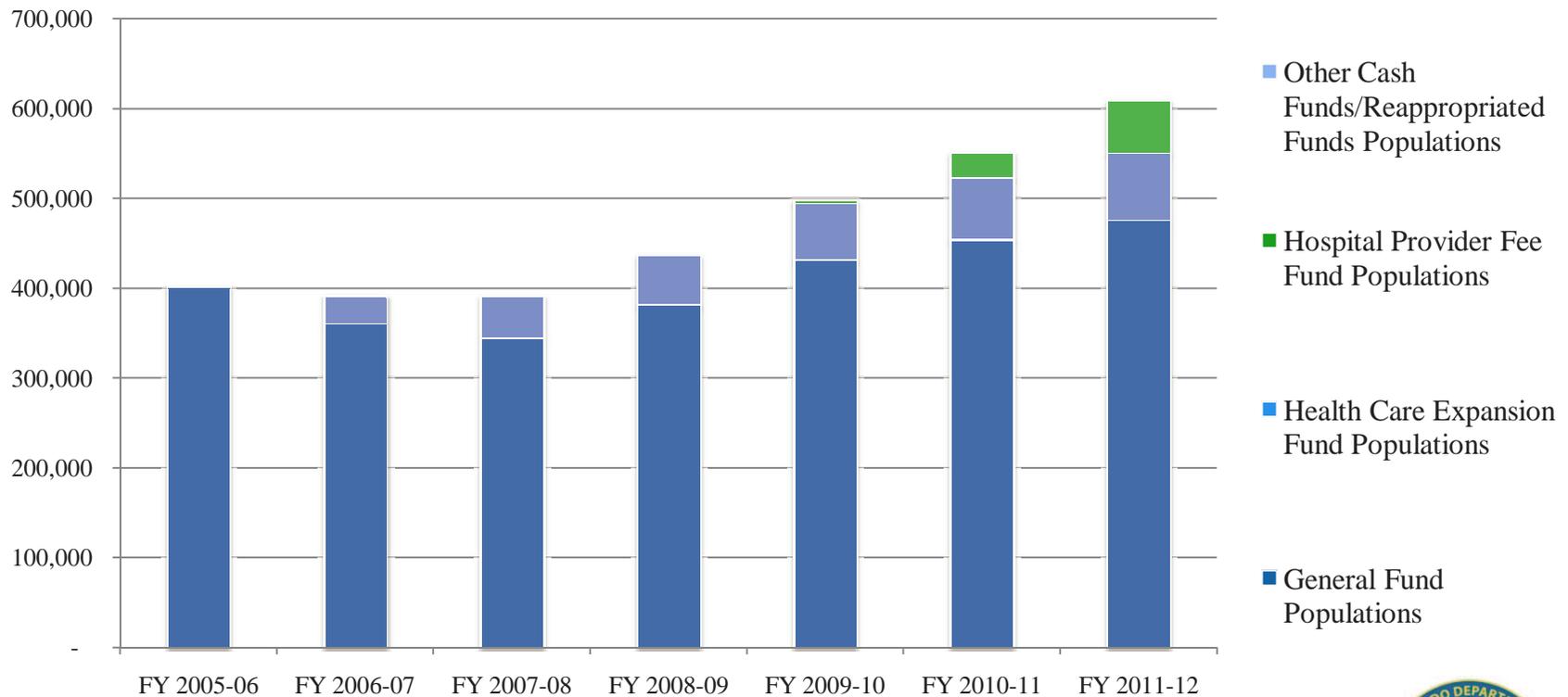
MEDICAID EXPENDITURES BY FUND SOURCE

Medicaid State Fund Expenditures by Fund Source



MEDICAID CASELOAD BY FUND SOURCE

Medicaid Caseload by State Fund Source



BUDGET REDUCTIONS

- FY 2008-09: \$21.4M TF, \$14M GF/CF
- FY 2009-10: \$169.7M TF, \$127.6M GF
 - Rate cuts: \$56.6M TF, \$23.5M GF
 - Program efficiencies: \$34.8M TF, \$8.8M GF
 - Payment delays: \$70.2M TF, \$25.2M GF
 - Financing: \$8.1M TF, \$70.1M GF relief
- FY 2010-11: \$276.3M TF, \$170.8M GF
 - Rate cuts: \$115.1M TF, \$46.3M GF
 - Program efficiencies: \$42.6M TF, \$12.3M GF
 - Payment delays: \$110.4M TF, \$42.2M GF
 - Financing: \$8.1M TF, \$70.0M GF relief
- \$467.4M TF, \$312.4M GF/CF over 3 years



BUDGET REDUCTIONS

- FY 2010-11 Payment Delays
 - Three-week fee-for-service payment delay (ES-2)
 - \$58.9M TF
 - \$27.0M GF
 - Managed Care payment delay from concurrent to retrospective (ES-3):
 - \$51.5M TF
 - \$15.2M GF
 - Total reduction due to payment delays
 - \$110.4M TF, \$42.2M GF



BUDGET REDUCTIONS

- FY 2011-12 Payment Delay Annualizations
 - Three-week fee-for-service payment delay (BRI-2)
 - \$7.8M TF
 - \$3.6M GF
 - Managed Care payment delay from concurrent to retrospective (BRI-6):
 - \$12.9M TF
 - \$4.8M GF
 - Total reduction due to payment delay annualizations
 - \$20.7M TF, \$8.4M GF



BUDGET REDUCTIONS

- FY 2011-12 Medicaid Reductions
 - Series of initiatives including rate adjustments to realign incentives, service restrictions, and financial efficiencies (BRI-5)
 - Reduce payment from Uncomplicated C-section to Complicated Vaginal; saves \$6.3M TF, \$3.1M GF
 - Reduce Mental Health Capitation Program; saves \$5.0M TF, \$2.3M GF
 - Restrict Adult Oral Nutrition Benefit to medically necessary; saves \$3.0M TF, \$1.5M GF
 - Total reduction due to Medicaid reductions
 - \$30.4M TF, \$14.8M GF



BUDGET REDUCTIONS

- FY 2011-12 Indigent Care Reductions
 - One-time Primary Care Fund redistribution to draw additional federal funds and reduce Pediatric Specialty Hospital (BRI-3)
 - \$3.0M TF
 - \$14.0M GF
 - \$4.2M cash funds
 - Five CHP+ reduction measures (BRI-4)
 - \$10.0M TF
 - \$3.5M cash funds
 - Total reduction due to Indigent Care Reductions
 - \$12.9M TF, \$14.0M GF, \$7.7M cash funds



BUDGET REDUCTIONS

- FY 2011-12 HCPF Reduction Totals
(including off-budget restorations)
 - \$92.1M total funds
 - \$115.3M General Fund



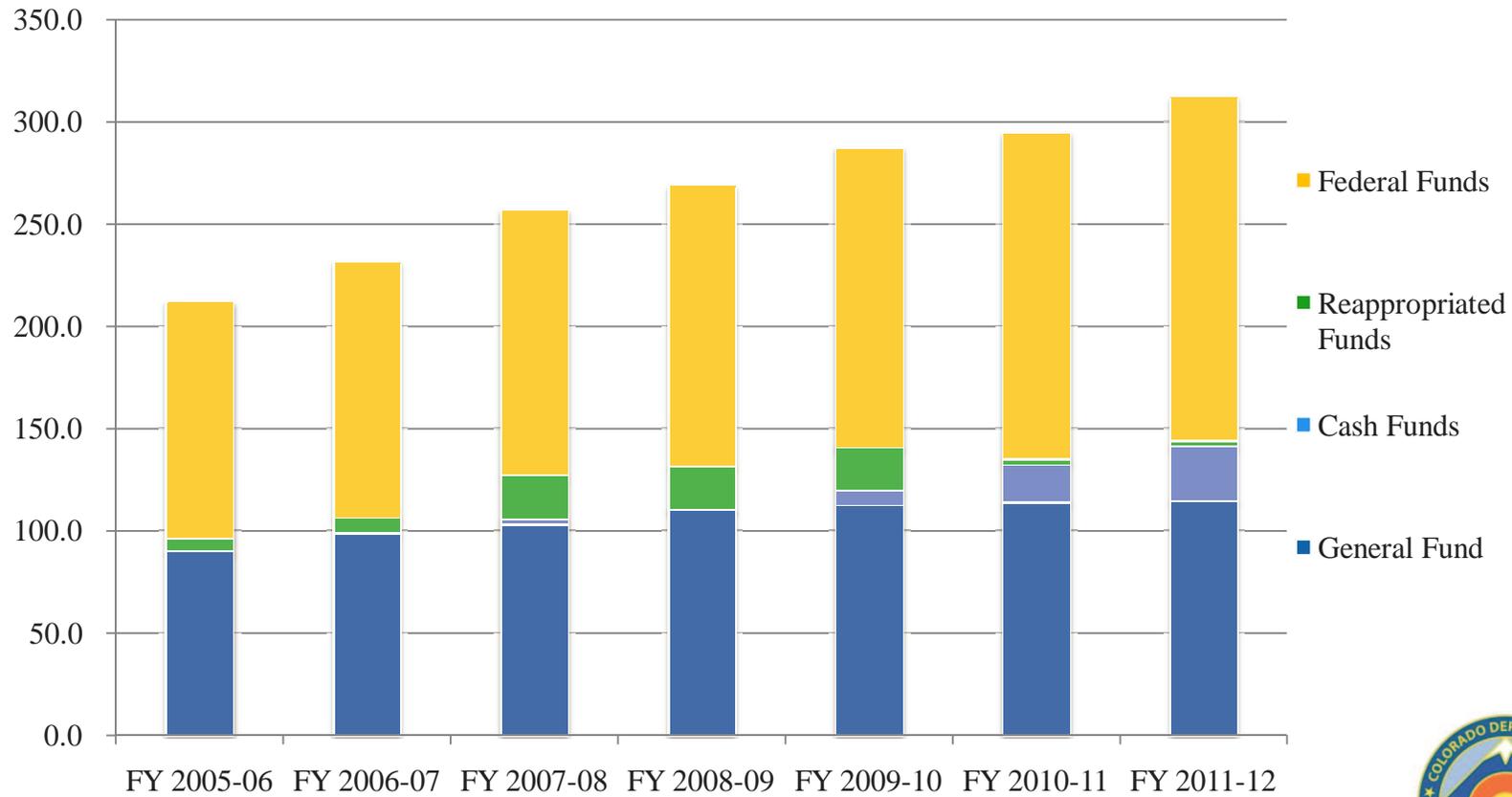
FY 2011-12 HCPF ADMINISTRATION BUDGET

- HCPF Budget Request without DHS Programs:
 - \$4.75B total funds, \$1.3B General
- Total HCPF Administration:
 - \$150.2M total funds, \$41.2M General Fund (3.2%)
- Total HCPF Payroll:
 - \$24.6M total funds, \$8.5M General Fund (0.5%)
- Medical Loss Ratio: 95.2%



FTE BY FUND SOURCE

Department FTE by Fund Source



CHIPRA BONUS STATUS

- Performance bonus payment federal fiscal year (FFY) 2011
 - Estimated to be \$26 million
 - Funding tied to growth in average monthly enrollment of children in Medicaid
 - Payment in two installments, December 2011 & April 2012
 - Performance bonus payments available through FFY 2013 or SFY 2013-14
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SYSTEMS CONSTRAINTS: MMIS

- MMIS pipeline is already full
 - Partial code freeze for HIPAA 5010 and ICD-10
 - General code freeze to implement the “New MMIS”
 - Additional money won’t solve the code contention concern
 - Next window of opportunity for new programs and priorities is 2013
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MMIS REPROCUREMENT

- Current MMIS is a mainframe design from 1970's
- Older systems have a higher risk of failure
- New MMIS will be more modular, flexible
 - Decrease paper and human interaction
 - Additional analytics and detailed client reporting
- MMIS Reprourement has begun
 - FY 2010-11 & FY 2011-12 Develop RFP
 - Department can learn from other states
 - July 2013: Begin Design of New MMIS
 - New MMIS Design and Development Costs range from \$50-\$100 Million spread over 3-years (90/10 FMAP)
 - July 2015 Implementation



LOOKING FORWARD

Joan Henneberry

Phil Kalin



IMPROVING HEALTH IN HEALTH CARE

- Center for Improving Value in Health Care (CIVHC)
- ARRA HITECH
- Federal Health Care Reform



CIVHC: FIVE KEY STRATEGIES FOR HIGH PERFORMANCE

- Extend affordable health insurance for all
 - Align financial incentives to enhance value and achieve savings
 - Organize the health care system around the patient to ensure that care is coordinated and accessible
 - Meet and raise benchmarks for high-quality and efficient care
 - Ensure accountable national leadership and public/private collaboration
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EVOLUTION OF CIVHC

- Blue Ribbon (208) Commission for Health Care Reform
 - Governor Ritter's Executive Order
 - Create inter-agency multi-disciplinary group
 - Facilitate and implement strategies
 - Improve quality
 - Contain costs
 - Protect and engage consumers
 - CIVHC fits in the niche of public/private partnership
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CIVHC BOARD AND PARTNERS

- Consumer groups
 - Business groups
 - State and federal representatives
 - Health care providers
 - Health insurance carriers
 - Health care organizations
 - Office of the Governor
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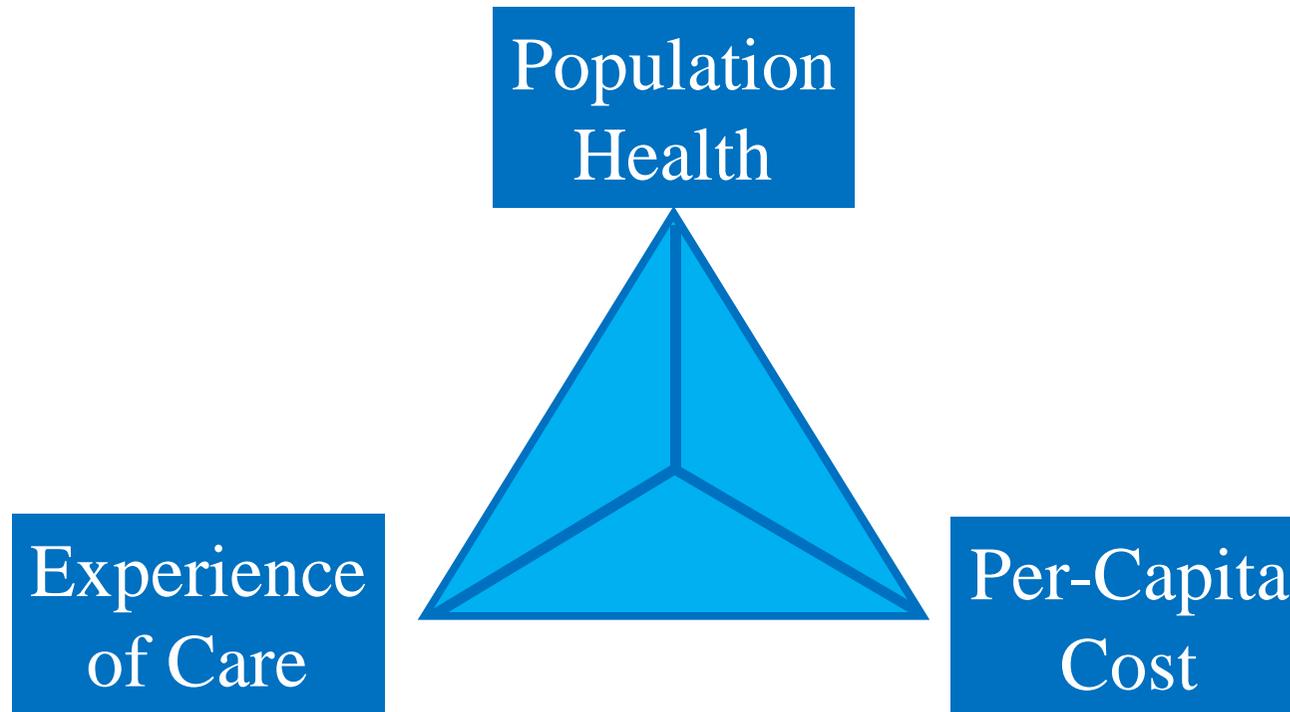


UNIQUE ROLE OF CIVHC

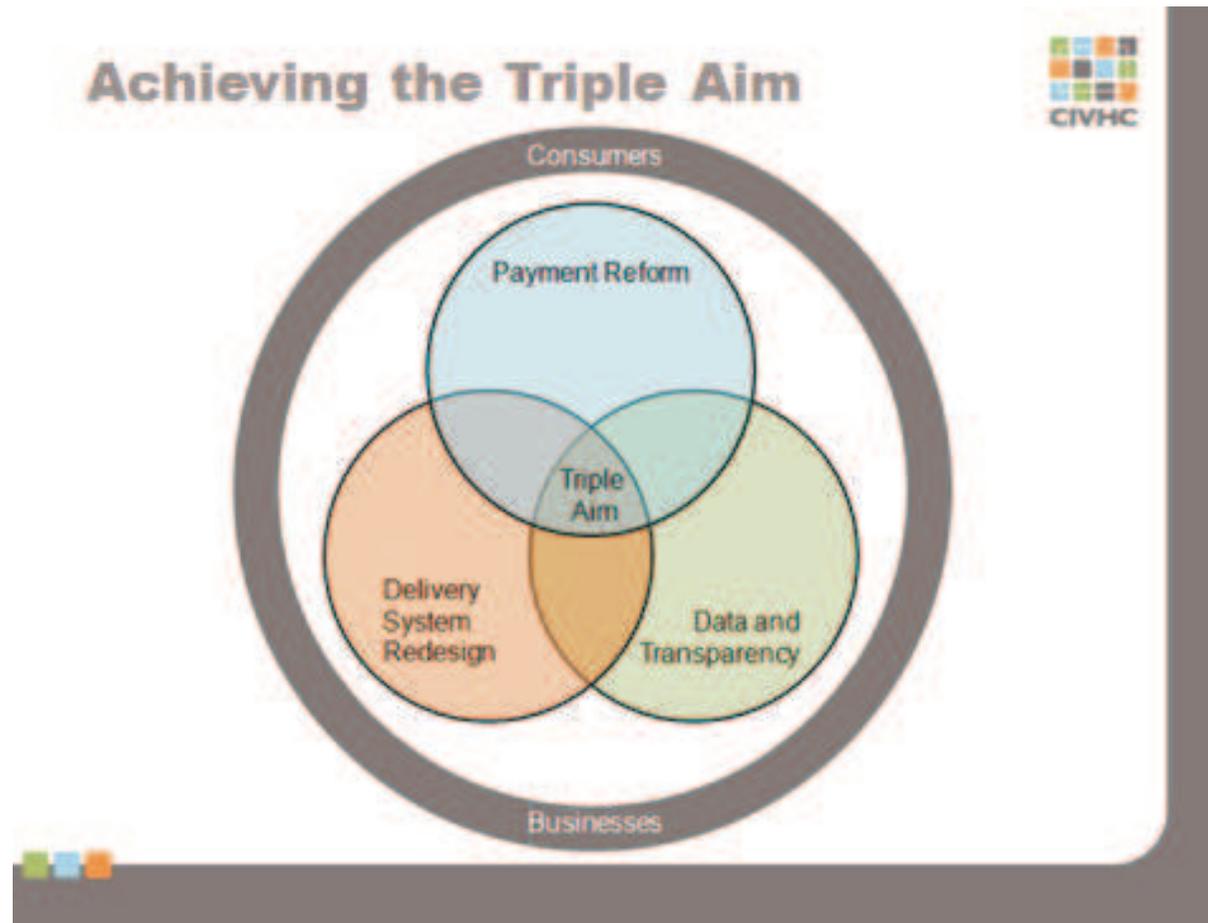
- Serve as “community” forum and integrator
- Convene advisory groups to identify best practices, break down silos, and scale up solutions
- Develop metrics and dashboard to measure progress towards Colorado goals
- Provide data that allows the market to measure value
- Integrate efforts with federal reform
- Promote integrated and multi-pronged statewide efforts



CIVHC: CONSENSUS AROUND THE TRIPLE AIM



CIVHC: ACHIEVING THE TRIPLE AIM



CIVHC: LONG-TERM GOALS

Consumer-Centered Experience

By 2015, Colorado is in nation's top quartile in measures related to patient-centeredness including:

- Timely access
- Communication
- Participation in health decisions
- Customer service

Example of Measures: Consumer Assmt of Healthcare Providers and Systems (CAHPS)

Improved Population Health

By 2015, Colorado is in nation's top quartile of measures related to:

- Access
- Quality of services
- Healthy behaviors and personal accountability

Example of Measures: Commonwealth Fund, Colorado Health Report Card, HEDIS

Bending the Cost Curve

By 2015, premium increases track at same rate as CPI (without shifting costs). Additionally:

- Reduce variability of cost across Colorado
- Improve statewide ranking on costs

Example of Measures:

- Measures of regional cost variability
- Rankings nationally (e.g. Dartmouth Atlas)

Increased Transparency

By 2014, cost, quality, and safety data for all providers and payers is publicly available statewide.

Example of Measures:

- Regional cost variability
- National rankings (e.g. Dartmouth Atlas)



ARRA HITECH ACT

- Medicare and Medicaid Electronic Health Record (EHR) Incentive Program
 - Eligible providers and hospitals receive incentive payments for “Meaningfully Using” EHRs
- Incentives encourage adoption of EHRs among the Medicaid provider community – where it otherwise might not happen
- Federal funding vs. State funding:
 - Incentive payments 100% Federal funds (no state funding required)
 - Development, implementation and administrative costs for Medicaid program 90% Federal funds (10% match required)

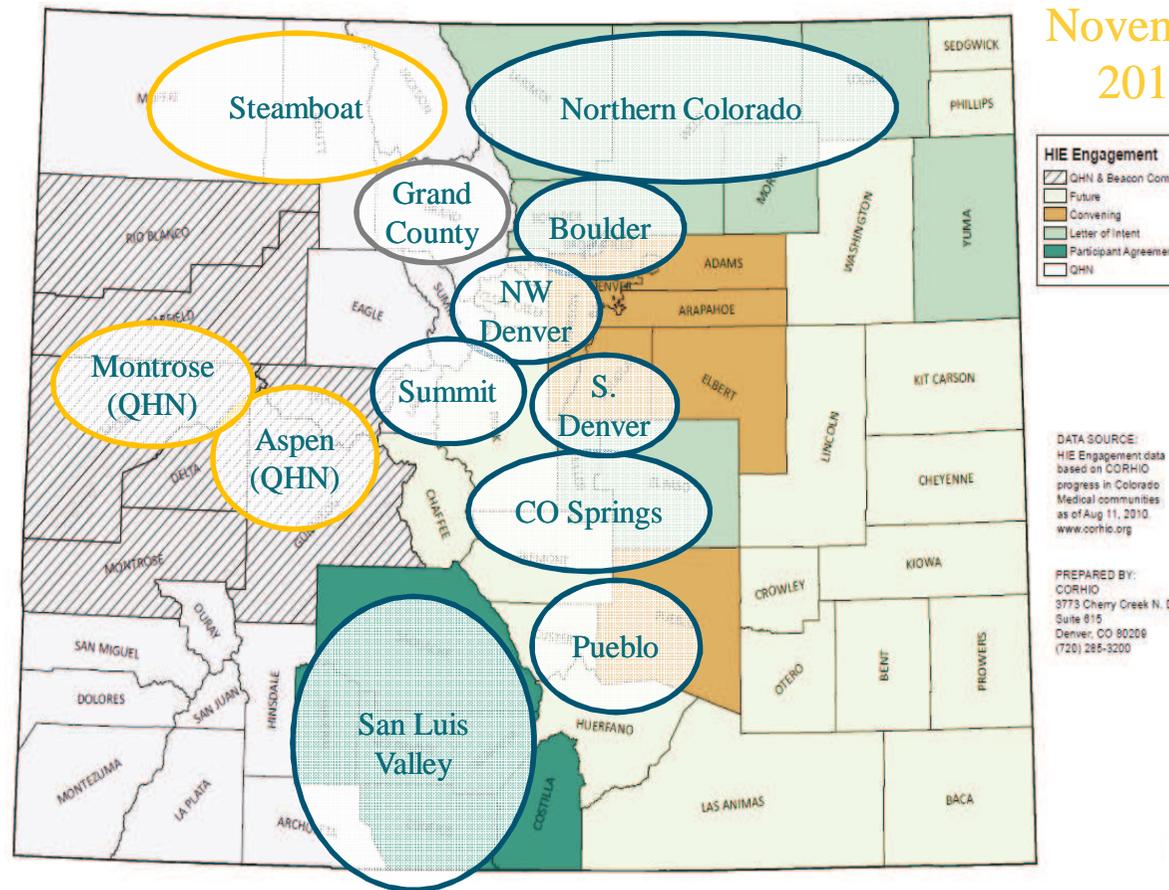


ARRA HITECH ACT

- Colorado Regional Extension Center (CO-REC)
 - Federally-funded Initiative of CORHIO, supports small primary care practices and specific hospitals to achieve Meaningful Use by providing these services at no charge:
 - Select, implement and meaningfully use an EHR
 - Standard contract language and negotiated pricing
 - Optimize practice workflow to ensure improvements in the quality of care
 - Protect privacy and security of patients' personal health information
 - Help meet qualifications for Medicaid or Medicare incentive payments
 - Improving Efficiencies in State Health IT
 - Partnership with OIT and CORHIO in implementation of HITECH Act to improve efficiency of underlying Medicaid technology infrastructure and more effectively implement impending health care reform efforts



HIE PROGRESS IN COLORADO



November 2010



HEALTH CARE REFORM

- Key Affordable Care Act (ACA) Components
 - Protects consumer, improves affordability, and holds insurers accountable
 - Contains costs for public and private programs to ensure fiscal sustainability
 - Cracks down on waste, fraud, and abuse in Medicare and Medicaid
 - Expands coverage to those who are currently uninsured



HEALTH CARE REFORM

- Immediate Benefits of ACA
 - Prohibits health plans from denying coverage to children with pre-existing conditions
 - Begins to close Medicare Part D “donut hole” through \$250 rebate to beneficiaries
 - Extends coverage to young adults (up to age 26) allowing them to remain on parents’ insurance plan
 - Bans lifetime limits on coverage
 - Holds insurance companies accountable for unreasonable rate hikes



HEALTH CARE REFORM

- What ACA means for HCPF
 - Colorado is better positioned than most states to implement ACA due to passage of HB 09-1293
 - HRSA Grant Funding totaling \$42,773,029 over 5 years
 - Department is not requesting administrative funding to implement ACA for FY 2010-11 or 2011-12
 - \$200,000 Planning grant for Money Follows the Person Rebalancing Demonstration Program



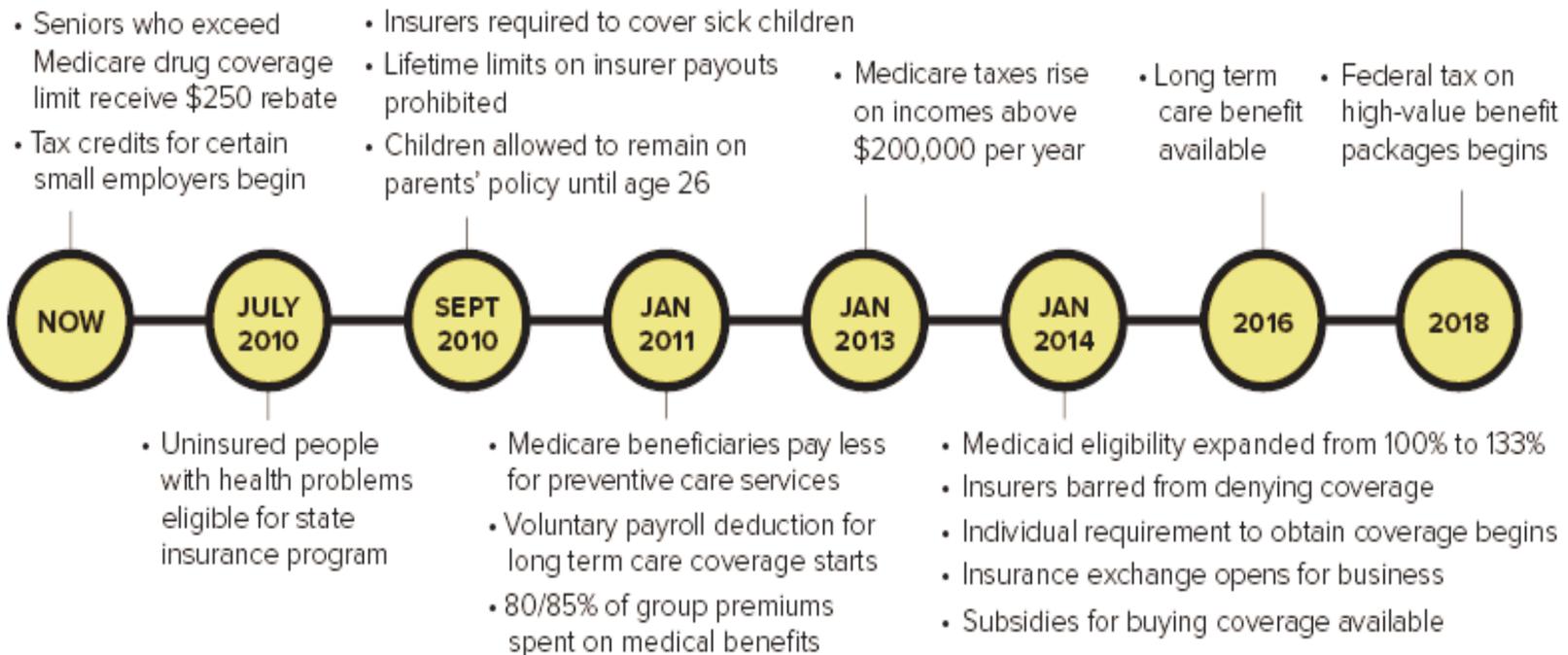
HEALTH CARE REFORM

- Interagency Implementation Board
 - Comprised of directors of state agencies and divisions impacted by reform: Director of Health Reform Implementation, OSPB, Governor's Chief Legal Counsel
 - Chaired by Joan Henneberry, Exec. Dir. HCPF
 - Director of board oversees and evaluates ACA implementation efforts, pursues grant and pilot opportunities, engages stakeholders, and ensures coordination of efforts among all state agencies



HEALTH CARE REFORM

Reform Timeline: When the Changes Happen



“Colorado is one of the states best-positioned to move forward with health care delivery system reforms and coverage expansion necessary to both increase access to care and help bend the cost curve.”

– Len Nichols, PhD

Director of Center for Health Policy Research, George Mason University



For more information
please visit our website:
Colorado.gov/hcpf

