Department of Health Care Policy and Financing

# Colorado Department of Health Care Policy and Financing

**Presentation to the Joint Budget Committee**

**December 21, 2009**



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# HCPF Presenters

- Joan Henneberry, *Executive Director*
- Sandeep Wadhwa, MD, *Medical & CHP+ Program Administration Office Director*
- Sue Williamson, *Client & Community Relations Office Director*
- Phil Kalin, *CIVHC Director*
- John Bartholomew, *Budget & Finance Office Director*

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- Federally designated agency to receive federal funds for Medicaid and CHP+
- Administers the following programs:

  - Medicaid
  - Child Health Plan *Plus* (CHP+)
  - Colorado Indigent Care Program
  - Old Age Pension State Medical Program
  - Comprehensive Primary and Preventive Care Grant Program
  - Primary Care Fund
  - Home and Community Based Services Medicaid Waivers

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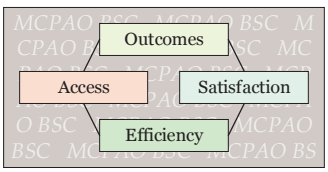
# Internal Performance Improvement Initiatives

- Balanced scorecards for all offices with key performance metrics for outcomes, satisfaction, efficiency, access
- Internal audit function
- Contract management improvement
- Financial management system
- Project management tracking tool
- Risk management
- Legislative implementation status

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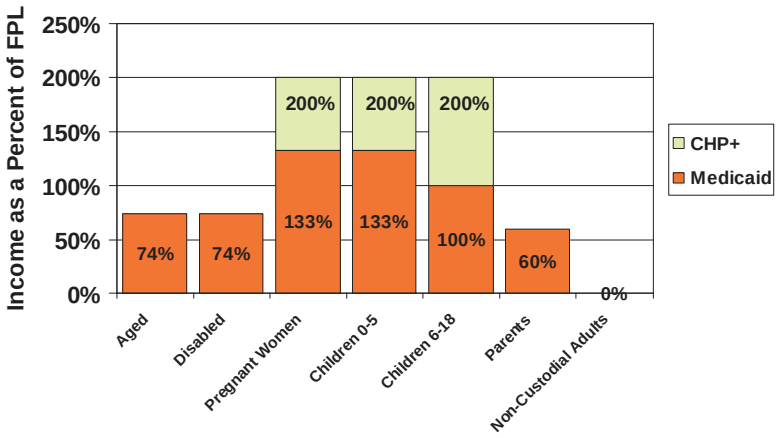
# Eligibility for Colorado Medicaid and CHP+




** For CHP+ a 2.5% income disregard is applied that equates to 205% of the FPL*

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# Program Eligibility

| Program | Income Eligibility | Other Requirements |
|---|---|---|
| Family Medicaid | Less than 60% - 133% FPL | Children age 0-18 and for parents with dependent children |
| Persons Who are Blind or Persons with Disabilities Who are Under Age 64 | Blind or disabled<br>Eligible for Supplemental Security Income (SSI) | Under the age of 64 and do not have dependant children |
| Persons 65 and Older | SSI and/or Old Age Pension (OAP) state supplemental payments<br><br>Income limit is $674 | Age 65 or older<br><br>Eligible for SSI and/or OAP state supplemental payments |
| Long-Term Care | Income limit is $2,022 a month | Under age 65 must meet the Social Security disability criteria either through SSI eligibility or Social Security Disability Income (SSDI) eligibility<br>Meet nursing facility level of care |

# Program Eligibility

| Program | Income Eligibility | Other Requirements |
|---|---|---|
| Child Health Plan *Plus* (CHP+) | 200% FPL and below | Low income children (18 years of age and younger) and pregnant women (19 years of age and older)<br>Not eligible for Medicaid<br>Do not have other health insurance |
| Breast and Cervical Cancer Program | Less than 250% FPL | Diagnosed through a Women's Wellness Connection site<br>Between 40 and 64 years old<br>No mammogram or Pap smear test in the last year<br>No health insurance or it does not cover breast or cervical cancer treatment<br>Not currently enrolled in Medicaid and are not eligible for Medicare |
| Colorado Indigent Care Program (CICP) | Less than 250% FPL | Cannot be eligible for Medicaid or CHP+<br>Must exhaust other insurance before CICP reimburses the health care provider |

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# 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*

**"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

*Medicaid programs must provide assurance of transportation.

**Only covered as HCBS waiver service

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# Colorado Medicaid Waiver Programs

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

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# Colorado Medicaid Waiver Programs

**Waiver participants must be:**

- medically qualified,
- certified for the waiver's institutional level of care,
- choose to enroll in the waiver as an alternative to institutionalization,
- 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.

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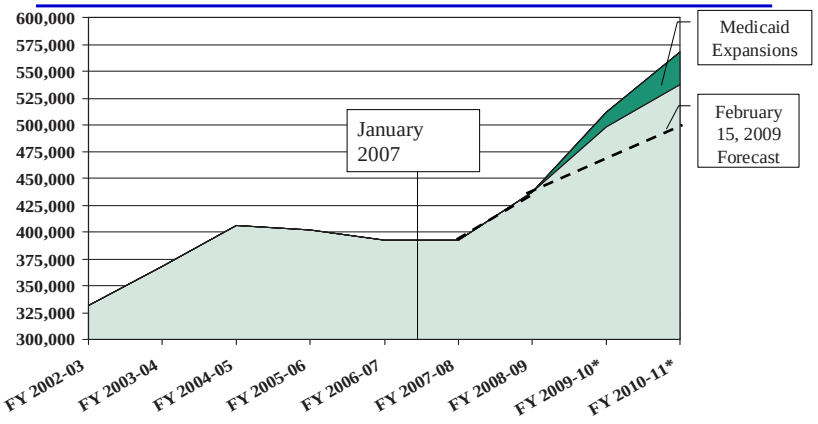
# Medicaid Caseload




* FY 2009-10 and FY 2010-11 projections from the Department's November 6, 2009 Budget Request.

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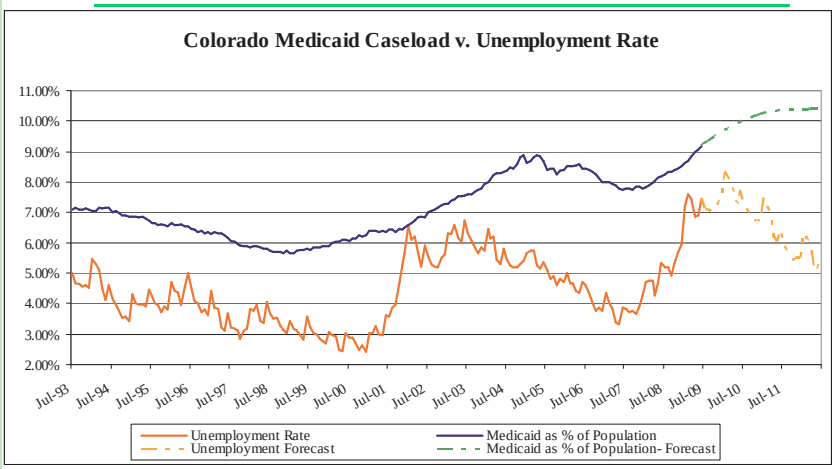
# Medicaid Caseload



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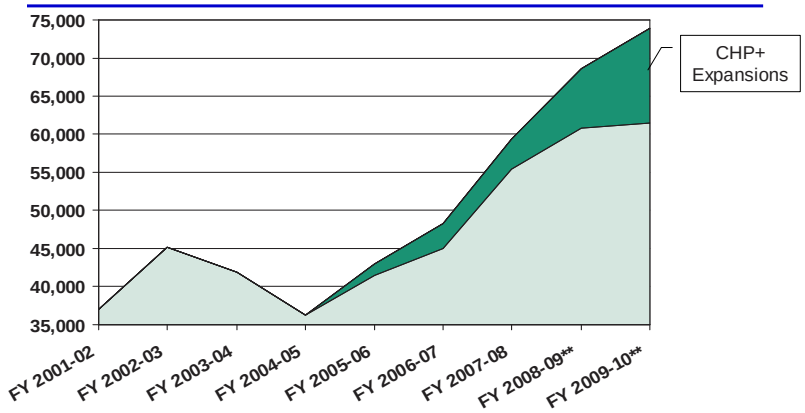
## Child Health Plan *Plus** Caseload




* Includes children and prenatal.
** FY 2008-09 and FY 2009-10 projections from the Department's November 3, 2008 Budget Request.

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## Current Medicaid Caseload

- Highest enrollment in history – 487,000
- 25% caseload growth
- 70,000 children and women in CHP+
- 45% caseload growth
- 40% served by safety net
- 70% - 90% physician participation
- 236,000 children in medical homes

# Delivering on 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 all 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

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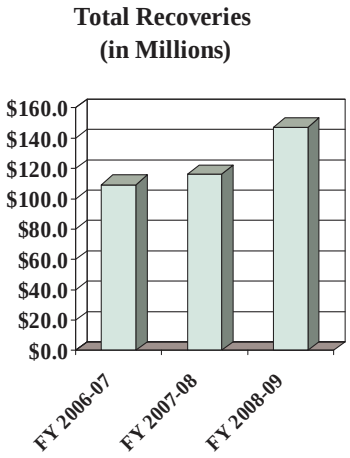
# Primary Care Participation in Medicaid

| | 10/08 | 03/09 | 11/09 |
|---|---|---|---|
| **Family Practice** | 70% | 72% | 75% |
| **OB/GYN** | 80% | 81% | 84% |
| **Pediatrics** | 87% | 88% | 89% |
| **Internal Medicine** | 76% | 78% | 79% |

Peregrine Management Corporation, 2009

# Department Recoveries

- In the last three years, the Department has recovered over $373 million in funds paid for fraud, waste, abuse and drug rebates.
- Governor Ritter's GEMS projects have greatly enhanced the Department's ability to identify these funds.








# Colorado Eligibility Modernization Project

- Goals of Eligibility Modernization
  - Increase enrollment and retention (and access to services)
  - Implement a variety of self-service options that make it easier for applicants to apply for health care programs
  - Ease workload burden on eligibility workers and increase worker satisfaction
  - Reduce application processing times and provide good customer service
  - Increase administrative efficiencies
  - Reduce administrative costs
  - Leverage existing technology (eliminate reliance on paper)
  - Design and implement effective policies

# Strands of Eligibility Modernization

- Systems (CBMS)
  - Phase I Colorado Program Eligibility and Application Kit (PEAK) (October 2009)
  - Phase II PEAK online application (April 2010)
  - Intelligent Data Entry – Fall 2010
  - Streamline Client Correspondence (ongoing)
  - Electronic interfaces with other state and federal databases
- Business Process
  - Eligibility and Enrollment for Medical Assistance Programs (EEMAP) RFP
    - Electronic Document Management System (scanning, imaging, OCR, document retrieval)
    - Interactive Voice Response
    - Workflow Management Process
  - Colorado Eligibility Process Improvement Collaborative (working with Medical Assistance sites to improve business processes)

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# 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
- 7 discrete projects

# CO-CHAMP 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)

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# Other Department Grants

- July 2007 – December 2009
  - Grant Funding
    - $51,390,805 awarded to Department
    - $14,415,961 received to date
  - Grant Funded Activities
    - Colorado Household Survey
    - Community Outreach Projects
    - Eligibility Modernization
    - Emergency Room Diversion
    - CIVHC
    - Medical Home Pay for Performance Pilot
  - Technical Assistance
    - Recipient of five grants (health care reform initiatives, leadership, medical homes, state scorecard measures)

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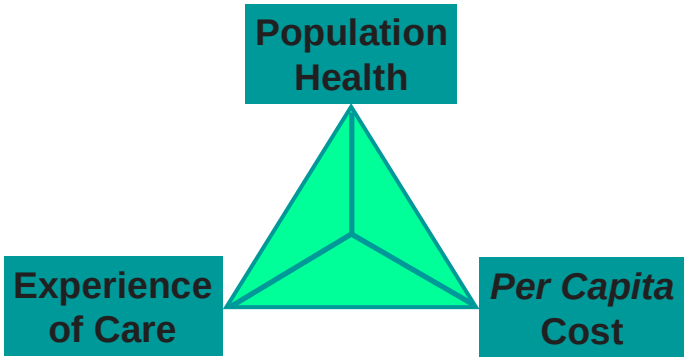
## Consensus Around the Triple Aim

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## What's the Problem?

*The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society on the other hand needs these three aims optimized simultaneously.*

***-Tom Nolan, PhD***

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## Evolution of CIVHC

- From the Blue Ribbon Commission for Healthcare Reform (208): "…creation of an inter-agency, multi-disciplinary group to facilitate and implement strategies to improve quality and contain costs."
- From Governor Ritter's Executive Order 005-08: "…develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care…"

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## Evolution of CIVHC (cont.)

CIVHC planning process included leaders from:

- Consumer groups
- Business groups
- Dept/Divisions of Public Health, Insurance, DPA
- Health care providers
- Health insurance carriers
- Health care organizations
- The Office of the Governor

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## Evolution of CIVHC (cont.)

Areas of research:

- Payment reform
- Data gathering, analysis, and distribution
- Consumer engagement and activation
- Health care delivery system improvements
- End of life care

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## The Result - CIVHC

The Center for Improving Value in Health Care (CIVHC) is a public/private coalition created to develop and implement statewide strategic initiatives that will improve the health of Coloradans, contain costs, and ensure better value for health care received.

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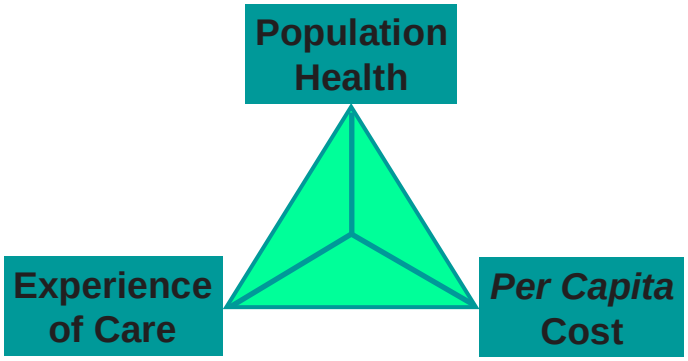
# Vision of CIVHC: Triple Aim

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# CIVHC Advisory /Task Forces Created

- Consumer Engagement
- Aligning Benefits and Financing
- Data Sharing for Performance Measurement

Task Forces:

- Improving Access to Palliative Care Services
- Decreasing Unnecessary Acute Care Utilization (Emergency Department/Hospital Admissions)
- Reducing Avoidable Hospital Readmissions

## Role of CIVHC

1. Establish Big and Audacious Goals/Objectives
   - Capture the imagination
   - Create sense of urgency (we do it or have it done to us)
   - Measureable and time bound
   - Look more through lens of businesses/consumers
   - Position Colorado to be a leader in health care outcomes and in supporting businesses/consumers

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## Role of CIVHC

2. Serve as the statewide entity for promoting health, and facilitating and tracking high quality, cost-effective health care
3. Identify gaps, barriers, successful practices and opportunities

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# Role of CIVHC

4. Set structure and actions to maximize multiple stakeholder involvement. Multi-pronged approach to issues:
   - Develop capacity to do big system change
   - Bring key leaders to the table
   - Engage multiple stakeholders at one time on key goals
   - Mobilize resources across state and country
   - Pilot across multiple payers, providers and populations
   - Leverage with capacity to bring CIVHC–related covered lives

# CIVHC
# Long Term Goals (Draft)

| Consumer-Centered Experience | Improved Population Health | Bending the Cost Curve | Increased Transparency |
|---|---|---|---|
| By 2015, Colorado is in nation's top quartile in measures related to patient-centeredness including:<br>•Timely access<br>•Communication<br>•Participation in health decisions<br>•Customer service | By 2015, Colorado is in nation's top quartile of measures related to:<br>•Access<br>•Quality of services<br>•Healthy behaviors and personal accountability | By 2015,: premium increases track at same rate as CPI (without shifting costs).<br>Additionally:<br>•Reduce variability of cost across Colorado<br>•Improve statewide ranking on cost | By 2014, cost, quality, and safety data for all providers is publicly available statewide. |
| Example of Measures: Consumer Assessment of Healthcare Providers and Systems (CAHPS) | Example of Measures: Commonwealth Fund, Colorado Health Report Card, HEDIS | Example of Measures:<br>•Measures of regional cost variability<br>•Rankings nationally (e.g. Dartmouth Atlas) | Example of Measures:<br>•Regional cost variability<br>•National rankings (e.g. Dartmouth Atlas) |

# CIVHC

## Draft of Key Strategic Initiatives

| Strategic Initiatives | Interim Objectives | Role of CIVHC | Long Term Goals | | | |
|---|---|---|---|---|---|---|
| | | | Consumer-Centered Experience | Improved Population Health | Cost Containment | Accountability & Transparency |
| **DATA**<br>Create an All Payer Claims Database | • APCD Legislation for 2010 Session<br>• Implement APCD by July, 2011 | Lead effort; make business case; secure funding; engage stakeholders; define org. structures and goals; complete implementation | Provides access to info that helps consumers make informed decisions about cost and quality of their care | Assess disparities, identify cost-effective, quality care; Allows for targeted population health initiatives | Allows patients to find best value for care; Provides providers and businesses data for peer comparison; Gives businesses data to design benefits based on price and quality | Provides the info needed for individuals and businesses to make appropriate, informed decisions |
| **PAYMENT REFORM**<br>Lead the transformation for the way health care is paid for in CO | • All payer initiatives (by the slice)<br>• Maximize provider participation<br>• Comprehensive payment system in place by 2016 | Identify initiatives; bring to scale; integrate with initiatives already in place | Providers are incentivized to provide decision support and coaching for their patients | Provider incentives aligned with improving health status of their patients | Reduction in overutilization of services; Move from a fee for service system | Encourages collaboration and shared responsibility among providers; Focuses on evidence-based medicine |
| **HEALTH CARE DELIVERY SYSTEM**<br>• Integrate care coordination initiatives<br>• Develop structures to support integration<br>• Tie initiatives to payment reform | • Increase in access to palliative care<br>• Reduction of avoidable readmission rate within 30 days of discharge<br>• Reduction in unnecessary ED/hospital inpatient rate | Bring focus; identify measures; engage partners; bring to scale; integrate with other initiatives | Consumers receive appropriate level of care in the best setting at the right time | Initiatives lead to improved access to primary care/ preventive care | Reduction of ED use, avoidable readmissions, and increased access to palliative care proven to reduce HC costs | Provides clear accountability and more integration; Ability to track cost and quality of accountable entities |
| **HEALTHY BEHAVIORS**<br>• Engagement<br>• Activation<br>• Outcome Measures | • Engage and activate consumers and employers<br>• Integration of community and public health initiatives | Bring focus; engage partners; identify measures; develop action plans; integrate with other initiatives | Consumers are activated to demand patient-centered care, learn to take responsibility for their health | Improved health status as a result of increased health literacy; Access and incentives for care coordination and prevention | Improved health behaviors can lead savings of 20% of health care costs | Ability to provide data and info leading to increased access to services and activation of consumers |



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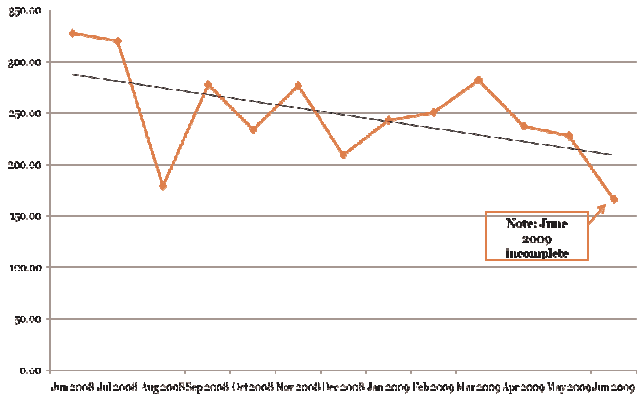
# Colorado Regional Integrated Care Collaborative (CRICC)

## Hospital Admissions per 1,000



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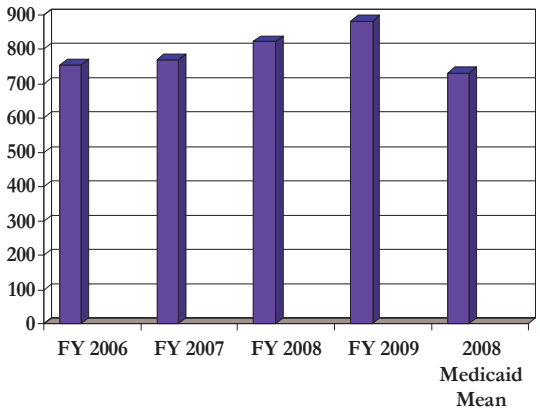
# Emergency Room Utilization Visits per 1000 FTE clients

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# Most Frequent ER Diagnoses by Age Group

**<1 year**

- Acute upper respiratory infection
- Fever
- Acute bronchiolitis
- Vomiting alone
- Otitis media

**1-9 years**

- Fever
- Acute upper respiratory infection
- Otitis Media
- Vomiting alone
- Croup

**10-19 years**

- Acute pharyngitis
- Abdominal pain
- Headache
- Ankle sprain
- Acute upper respiratory infection

**20-44 years**

- Abdominal pain
- Headache
- Migraine
- Chest pain
- Urinary tract infection

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## FY 08-09 ER visits per 1,000 FTE clients

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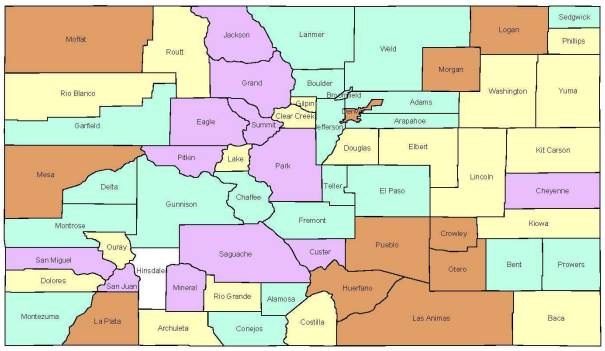
Range: 1,182 - 343
Median: 731




**Legend**

**Colorado Counties**
**Category**

- under 343
- 343 - 536
- 537 - 731
- 732 - 955
- 956 - 1182

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## ER Workgroup to Decrease Utilization

- Formed a multi-disciplinary team to advise on ways to decrease utilization
- Sent letters to high ER use clients encouraging them to use primary care providers and nurse advice line
- Adding nurse advice line prominently to eligibility card

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# Readmissions

- Rate of Hospital Readmission within 30 Days: 12.6%
- Over $30 million per year
- The Department is working to identify those areas with the greatest potential to be significantly lowered.
- Successes:
  - Enforcement of 24-hour readmissions payment policy
  - BHO & Rocky Mtn. Health Plan: Contracts contain performance standards for readmission rates.
  - Stakeholder committee working to establish hospital performance payments has consensus on incentive payments for readmission rate reduction.
  - Dr. Judy Zerzan is co-chairing a national workgroup of state Medicaid agencies working on lowering rates of readmission.

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# Department Progress
# FY 2009-10 Medicaid Program Efficiencies

- Serious Reportable Events
  - Implemented October 1, 2009
  - Improvement in quality expected
  - All CO hospitals cooperating with program
- Fluoride Varnish
  - Implemented July 1, 2009
  - Treated 14,300 children
- Benefit Collaborative
  - Women's health services, pediatric dental, echocardiogram, therapies (speech, OT, PT)

# Department Progress

- Provider Volumes and Rate Reductions
  - Updated provider codes to below 100% of Medicare rate after Medicare rate reductions
- Enroll eligible Veterans in VA health care system
  - Identified 3,100 potential clients
  - Working with VA outreach





# Colorado Accomplishments in Long Term Care

- Enactment of HB 09-1103 authorizing the pursuit of presumptive eligibility for long term care clients.
  - Working with CMS on implementation options
- Initiated a work group with Colorado Division of Housing, Colorado Housing Finance Authority, and advocates to address housing issues for LTC eligible clients.
  - identify and solve barriers in accessing housing
  - expand housing options

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## Colorado Accomplishments in Long Term Care

- Executive Order Directing Development of Olmstead Plan signed in June 2009
  - Workgroup to deliver plan to build community capacity and promote health, functioning and self-sufficiency by July 1, 2010.
- Expand Care Transition Services to clients in MI waiver in FY2009-10

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## Colorado Health Care Affordability Act

- Authorizes Department to assess and collect hospital provider fees
  - Creates a sustainable funding source
  - Increase Medicaid hospital rates and CICP payments
  - Reduce cost-shift to private payers
  - Quality incentive payments
  - Increase Expand Medicaid and CHP+ eligibility, expand health coverage to the uninsured
  - Pay Department's administrative costs
- Creates Oversight and Advisory Board

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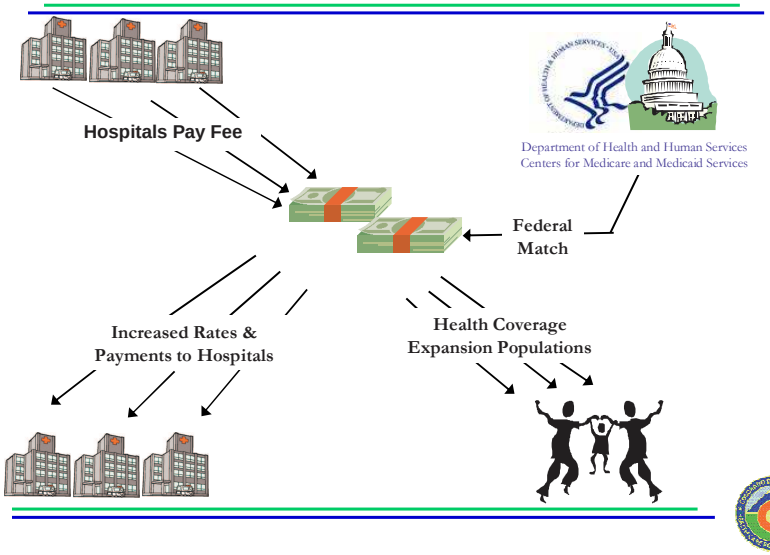
# Provider Fee Overview

## Provider Fee Model



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# Where Do the Funds Go?

Hospital Reimbursement

- Medicaid inpatient rates up to 100% of Medicare rates and Quality Incentive Payments
- Medicaid outpatient rates up to 100% of costs
- CICP rates up to 100% of costs

Upon CMS Approval in Spring 2010

# Where Do the Funds Go?

Expansion of Public Health Care Programs

- Medicaid parents up to 100% FPL
- CHP+ children up to 250% FPL
- CHP+ prenatal up to 250% FPL

} Spring 2010

- Disabled Buy-In up to 450% FPL } Summer 2011
- Adults without dependent children up to 100% FPL } Early 2012
- Continuous eligibility for Medicaid children } Spring 2012





# Reduction to Cost Shift

- The implementation of the hospital provider fee will reduce the need for hospital providers to shift uncompensated care costs to private payers, and ultimately employers, in the following ways:
  - Higher rates for public insurance clients.
  - Reducing the number of uninsured.
- Measurement of cost to payment ratio by payer
  - Report the difference between costs and payments for each of Medicare, Medicaid, and private insurance

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# Current Model

- Submitted to CMS in September 2009
- Questions received in December 2009
- Approval Expected in April 2010

- FY 2009-10 Model
  - Hospital Provider Fee Model is expected to generate $210 million in new federal funds
  - Approximately $87 million in new direct reimbursements for serving Medicaid and uninsured clients

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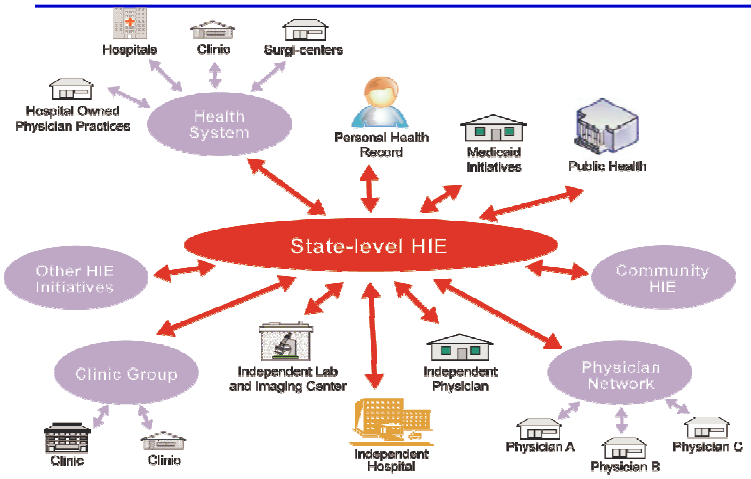
# CORHIO: State-level Convener/Coordinator and Solutions Provider/Broker (HIE Services)




# ARRA... A Massive Stimulus for Health IT Adoption & HIE Expansion

**Appropriations for Health IT**

**$2 billion for loans, grants & technical assistance for:**

- National Resource Center and Regional Extension Centers
- EHR State Loan Fund
- Workforce Training
- Research and Demonstrations

**Appropriations for HIE**

**At least $300 million of the total at HHS Secretary's discretion for HIE development**

- Funneled largely through States or qualified State-designated entities
- For planning and/or implementation

**New Incentives for Adoption**

**New Medicare and Medicaid payment incentives for HIT adoption**

- $20 billion in expected payments through Medicare to hospitals & physicians
- $14 billion in expected payments through Medicaid
- ~$34 billion expected outlays, 2011-2016

**Community Health Centers**

**$1.5 billion in grants through HRSA for construction, renovation and equipment, including acquisition of HIT systems**

**Broadband and Telehealth**

**$4.3 billion for broadband & $2.5 billion for distance learning/ telehealth grants**

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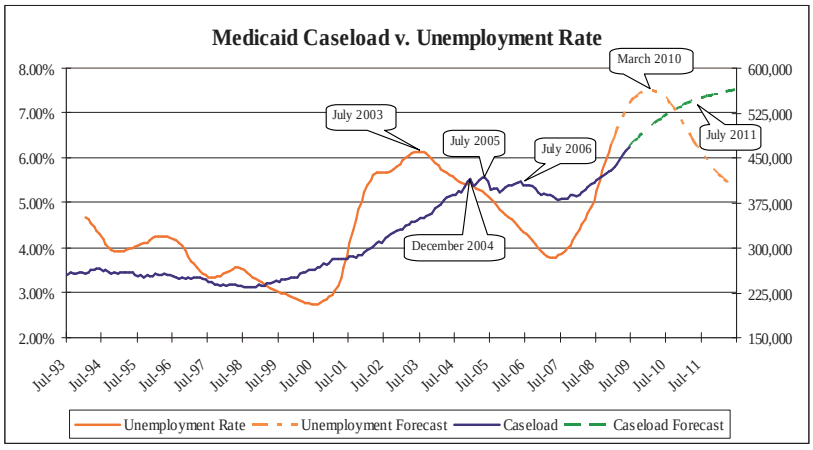
# Medicaid Caseload



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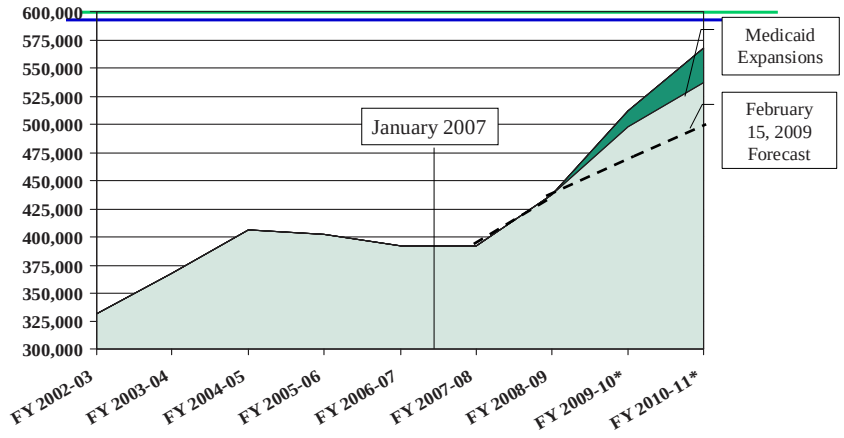
# Medicaid Caseload




* FY 2009-10 and FY 2010-11 projections from the Department's November 6, 2009 Budget Request.

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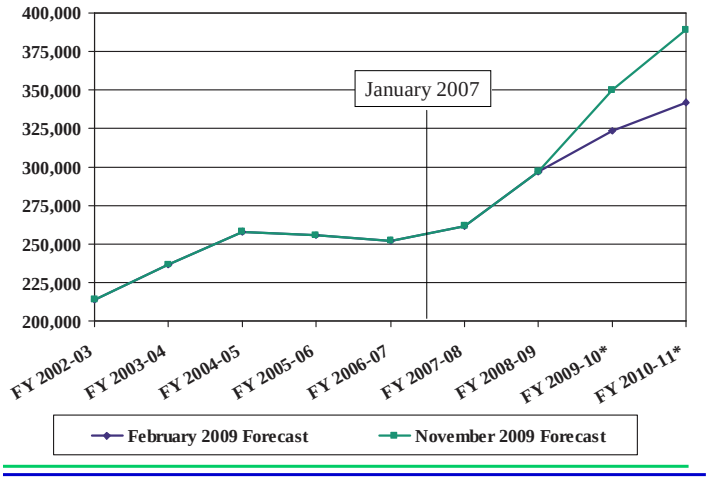
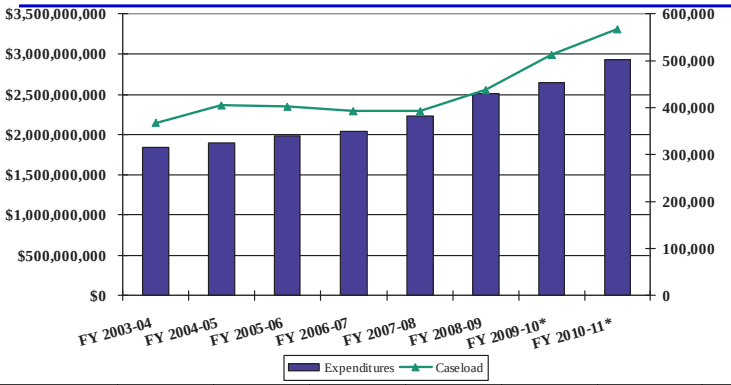
# Combined Children's Caseload



# Medicaid Expenditures*




| Medical Services Premiums | FY 2004-05 | FY 2005-06 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10* | FY 2010-11* |
|---|---|---|---|---|---|---|---|
| Expenditure Growth | 2.80% | 4.71% | 3.33% | 8.72% | 12.64% | 4.82% | 11.09% |
| Caseload Growth | 10.48% | -0.95% | -2.48% | -0.07% | 11.44% | 17.08% | 10.96% |
| Per Capita Growth | -6.95% | 5.71% | 5.96% | 8.79% | 1.07% | -10.03% | 0.12% |

* FY 2009-10 and FY 2010-11 projections from the Department's November 6, 2009 Budget Request.

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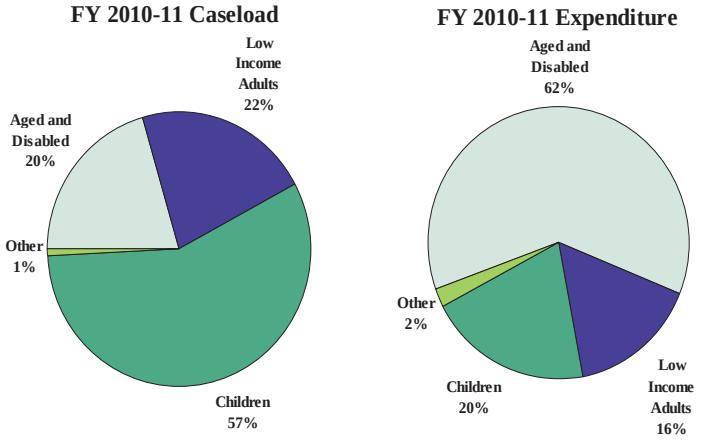
# Projected Expenditure and Caseload Shares



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# FY 2009-10 Budget Reductions July, September, and December 2009

- Reduced $299 million total funds, $218 million General Fund from the FY 2009-10 Budget
  - Medicaid Provider Rate and Volume Reductions
    - Almost 4.5% in rates, plus additional utilization controls
  - Safety Net Reductions
  - Elimination of State-Only Grant Programs
  - Used ARRA/Enhanced FMAP to refinance General Fund where possible
  - MMIS Payment delays to prevent further rate/program reductions
- Limited the amount of federal funds lost to cuts

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# FY 2009-10 Budget Reductions

| HCPF Reductions and Cuts (Totals in Millions) | Total Funds | State Funding |
|---|---|---|
| **Provider Reductions** | | |
| Provider Rate Reductions and Program Efficiencies | ($117.4) | ($46.2) |
| Indigent Care Program Reductions | ($41.6) | ($31.6) |
| Administrative Reductions | ($0.9) | ($2.2) |
| **Financing** | | |
| SB 09-264 ARRA/FMAP Reductions | $0.0 | ($31.6) |
| Hospital Fee Financing from ARRA | $0.0 | ($41.4) |
| **Payment Delays** | | |
| SB 09-265 MMIS Delays | ($94.7) | ($43.7) |
| Additional Payment Delay | ($44.8) | ($21.2) |
| **Total Reductions** | **($299.4)** | **($217.9)** |
| ARRA -- Enhanced FMAP | $0.0 | ($415.0) |
| **Grand Total Savings** | **($299.4)** | **($632.9)** |

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# FY 2010-11 Proposed Budget Reductions

- $194.4M Total Funds, $329.4M State Funds
  - Payment Reform (COPPR) - $2.5M TF, $0.7M State Funds
  - Medicaid Efficiencies - $10.1M TF, $4.5M GF
    - Home Health unit billing change
  - Delay MMIS Payments - $143.3M TF, $72.6M State Funds
  - Medicaid Reductions - $38.5M TF, $28.3M State Funds
    - 1.0% Provider Rate Cuts - $29.1M TF, $12.0M State Funds
    - Restrictions to Optional DME - $2.3M TF, $1.2M State Funds
    - Nursing Facility Per Diem GF Cap Reduction - $3M TF, $13.7M GF
    - Reduce BHO Capitation Rates 2.0% - $4.1M TF, $1.6M State Funds
  - ARRA Enhanced FMAP - $223.3M State Funds

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# Future Medicaid Growth

- Despite more than double the amount of cuts in the previous recession, Medicaid will continue to grow at a high rate in the future because of economic conditions and increasing health care costs.
- In order to permanently control costs, there must be a strong focus on measures that maximize the value received for each dollar spent.

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## Maximizing Value

- Maximize health, functioning and self-sufficiency of all clients
- Optimize efficiency in the expenditure of taxpayers' money
- Balance these goals by maximizing value in Medicaid



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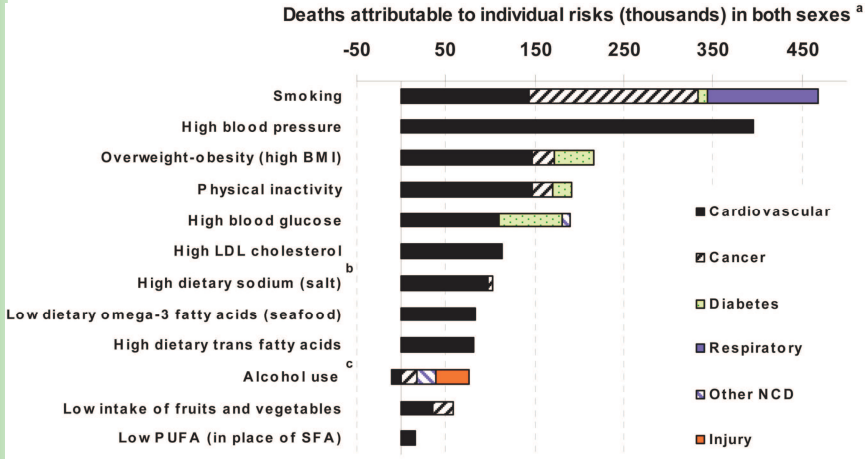
## Preventable Causes of Death




Danaei, The Preventable Causes of Death in the United States ..., PLoS Med 6(4), 2009.

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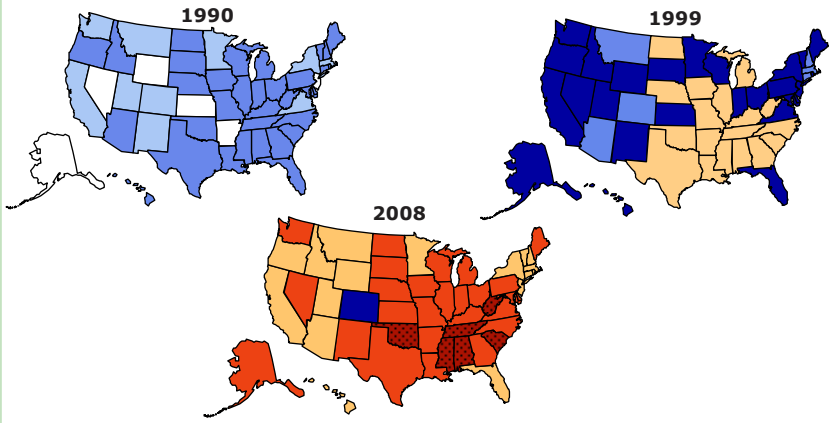
## Obesity Trends* Among U.S. Adults
### BRFSS, 1990, 1999, 2008
(*BMI ≥30, or about 30 lbs. overweight for 5'4" person)




Source: CDC Behavioral Risk Factor Surveillance System

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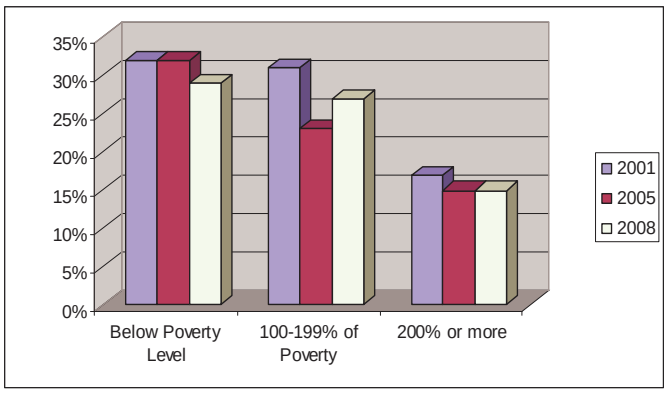
## Prevalence of Smoking in Colorado by Poverty Level and Time




100% of FPL is $21,000 for a family of four.

CDPHE, 2009

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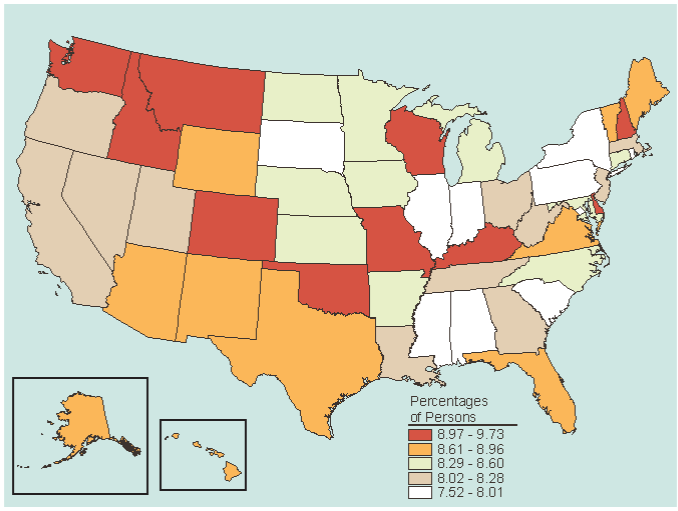
# Colorado has the highest rate of adolescent depression




Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004 and 2005

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# Maximizing Value

- Maximize health, functioning and self-sufficiency of all clients
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- Balance these goals by maximizing value in Medicaid

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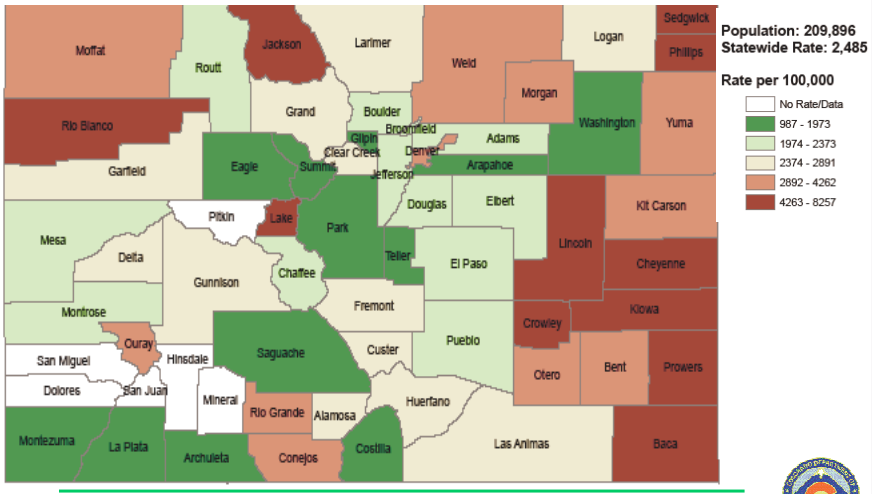
# Variation in Care: Overall Admission Rate for Acute and Chronic Indicators (FY2008-09)




* Dual Eligible clients not represented

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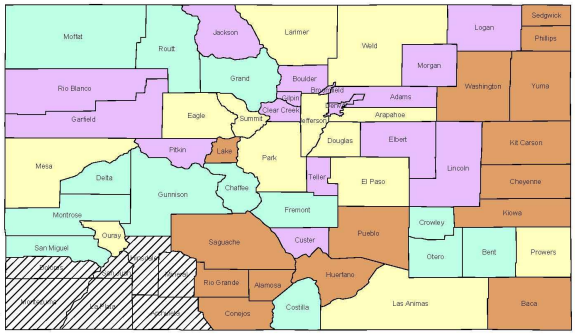
## FY 08-09 Office Visits per 1,000 FTE clients

Range: 1,468 - 7,825
Median: 3,748



**Legend**

**Colorado Counties**

Volume too low to include*

**Category**

under 3300
3300-3748
3749-4499
4500-7825

*Refers to counties which either have too few clients or too few services for comparison

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# How we compare…

CO Medicaid utilization is higher than national averages – for ambulatory and acute care

| 2009 Healthcare Effectiveness Data and Information Set (HEDIS) Benchmarking | Colorado Medicaid FFS* | 2008 HEDIS Nat'l Medicaid Average |
|---|---|---|
| **Ambulatory Care Visits/1000 member months**** | | |
| Outpatient* | 368.9 | 317.8 |
| ED | 63.9 | 60.9 |
| Ambulatory surgery | 11.2 | 5.5 |
| Observation stays | 2.5 | 2.0 |
| **Inpatient Utilization** | | |
| Discharges/1000 mm | 11.8 | 8.3 |
| Days/1000 mm | 45.9 | 30.6 |
| Average Length of Stay | 3.9 | 3.6 |

* Includes Primary Care Provider Program.
** Does not include federally qualified health centers.



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# Maximizing Value

- Maximize health, functioning and self-sufficiency of all clients
- Optimize efficiency in the expenditure of taxpayers' money
- Balance these goals by maximizing value in Medicaid

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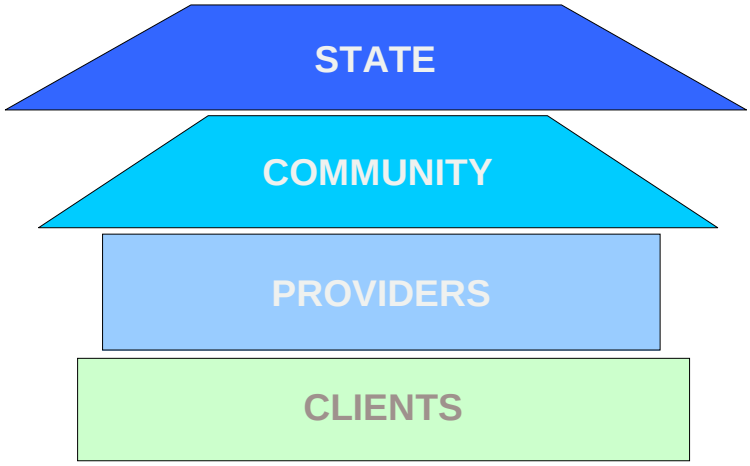
## Initiatives Occur At Varying Levels

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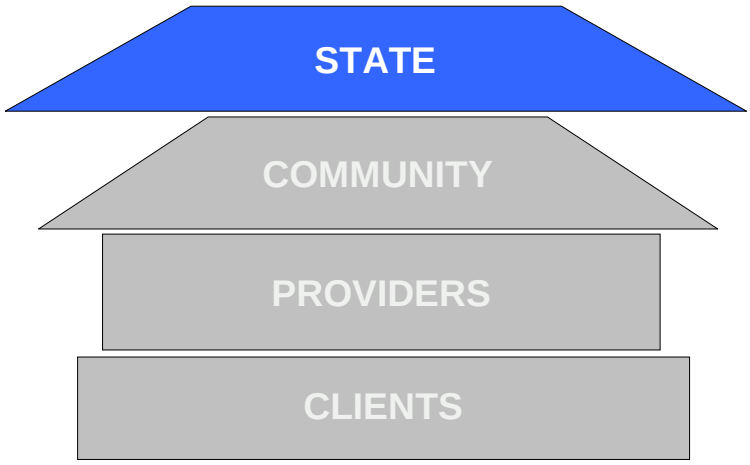
## Initiatives



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# Utilization Review Reform

- Department's UR systems are outdated
- Proven and rapid means of safely controlling medical spend
  - UR = 3.5 ROI *
  - New radiology review yielding 11% reduction in claims
  - Next hospital outpatient, outliers, specialty, additional therapies
- An increase of $118,359 total funds, with a reduction of $11,201 General Fund in FY 2010-11

* The Society of Actuaries: 2004

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# Evidence Guided Utilization Review (EGUR) Strategy

- Re-procurement of QIO July 1, 2010, including vendor consolidation
- Implementation of systems and technologies that:
  - Lower Department costs for manual reviews
  - Lower provider administrative burden
  - Build evidence-based standards into work flows
- Stepwise approach with other initiatives
  - Pharmacy auto-PA as platform for additional PAR systems
  - Coordinated provider Web portal

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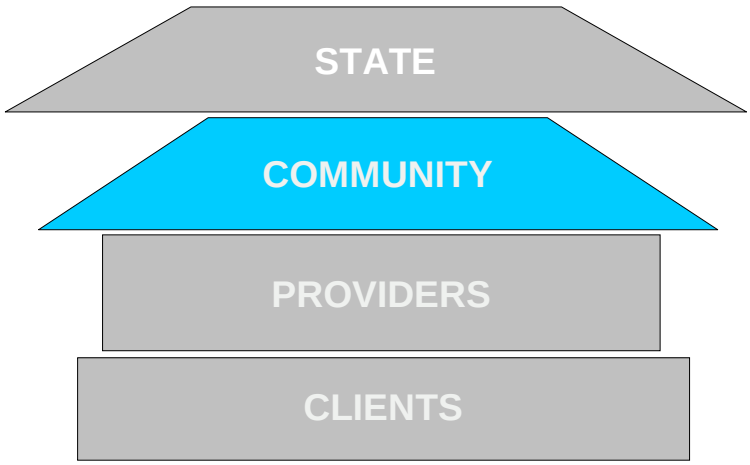
## Initiatives

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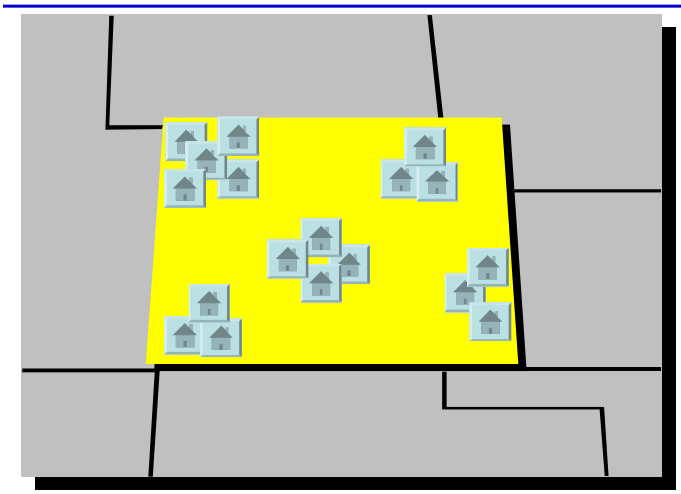
## Health Neighborhoods



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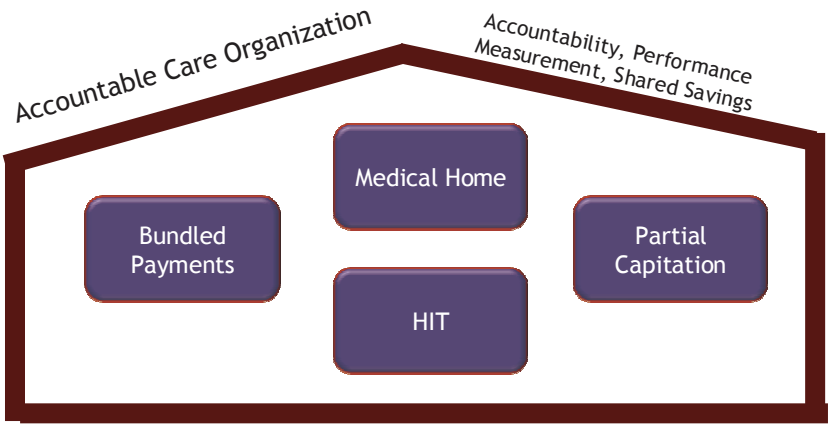
# The ACO is the overarching structure within which other reforms can thrive

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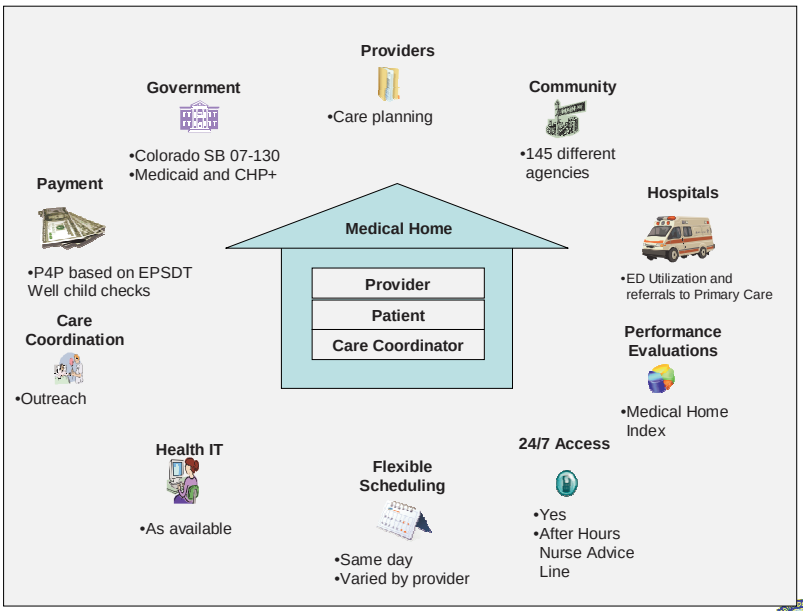

# Department Progress
# Accountable Care Collaborative

- Client
  - Establish a usual source of primary care for all Medicaid clients
  - Coordination across care settings, including social services
  - Emphasis on promoting health and functioning
- Providers
  - Financial support for caring for complex clients
  - Social and care management support for clients
  - Share in cost-savings
- State Benefits
  - Outcomes driven – reduce costs and improve population health
  - Allow regional entities to organize health neighborhoods
  - Regional pilots to benchmark success





# How does ACC reduce expenditures?

Through systematic efforts to improve outcomes and reduce costs across the community:

- Using appropriate workforce
- Improved care coordination
- Reduced waste (i.e. duplicate testing)
- Internal process improvement
- Informed patient choices
- Chronic disease management
- Point of care reminders and best practices
- Actionable, timely data
- Choices about capacity

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# Department Progress
# Accountable Care Collaborative

- Current Status
  - Initial outreach completed
  - RFI responses analyzed
  - Drafting RFP
- Timeline
  - 5 pilot programs sequentially, launching November 2010
  - Enrollment goal = 60,000
    - 40,000 adults & 20,000 children

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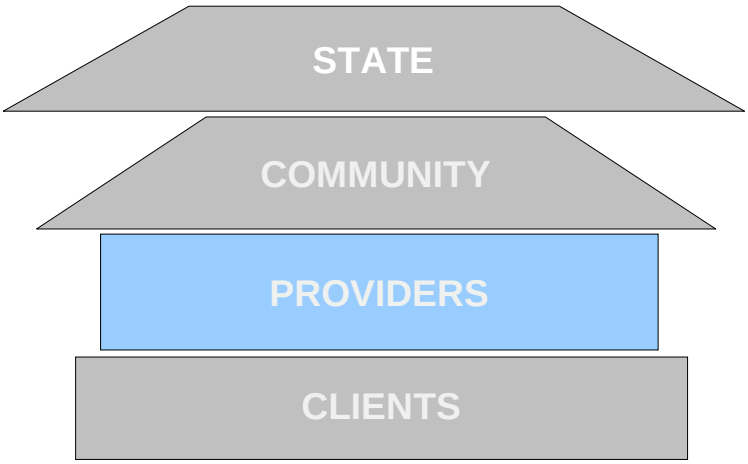
# Initiatives

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# Coordinated Payment and Payment Reform (COPPR)

- Two main features to COPPR:
  - Investment in Payment Reform
    - The Department intends to develop payment methodologies which reward outcomes, instead of just billing
    - Federally Qualified Health Centers, waiver services, physicians
  - Savings from Coordinated Billing and Payments
    - Ensuring clients who are eligible for Medicare get enrolled in Medicare
    - Ensuring that the right providers pay for the right services
- Systematic, sequential effort to move away from Fee For Service pricing
- Estimated savings of $2.5 million total funds, $500,000 General Fund in FY 2010-11

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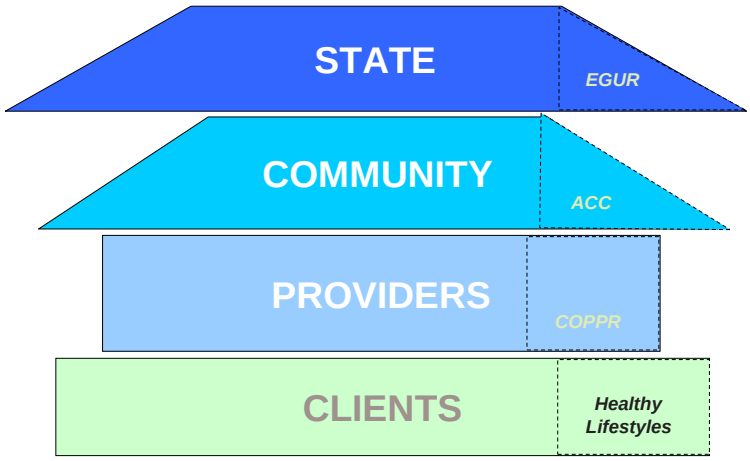
# Interventions



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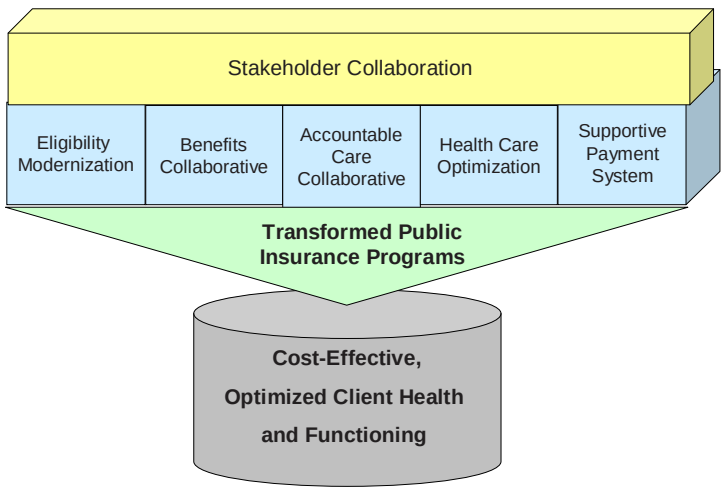
# Reform Vision

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# Connecting the Dots

- Household Survey
- CORHIO
- Eligibility Modernization
- Efficiencies and cost-containment
- Provider recruitment and retention
- Better care management
- CIVHC and Payment Reform
- Cost-effective, Optimized Client Health and Functioning

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## 2010 - 2015

- Medicaid Efficiencies Act
- All Payer Claims Data Base
- Preparation for National Reform
  - Analyze and score impact for CO
  - Insurance Regulations
  - Medicaid Expansions
  - Designing an Exchange
  - Pilot Programs
  - Service delivery & payment reform

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"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***

*Len Nichols, PhD, directs the health policy program at the non-partisan New America Foundation*

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For more information
please visit our Web site:

colorado.gov/hcpf