Design of a Streamlined Program

For CHP+ and Medicaid

Commissioned by the State of Colorado
Department of Health Care Policy and Financing

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Introduction

The State of Colorado's Department of Health Care Policy and Financing (The Department) is committed to improving the use of public dollars for the purchase of health care on behalf of low-income children and families while improving access, continuity and quality of care. The Department hopes to realize this goal by coordinating the efforts of Medicaid, Child Health Plan *Plus* (CHP+), and the Colorado Indigent Care Program (CICP) under a single, streamlined, health care program that provides comprehensive benefits. In order to accomplish this goal, the Department commissioned MDF Associates, a consulting firm located in Medford, Massachusetts, specializing in the development of health care programs for publicly funded beneficiaries for the public and private sector, to make recommendations around benefit design and delivery systems.

In designing this streamlined program, the Department seeks to increase the ease with which children receive appropriate and necessary benefits while decreasing the incidence of "bouncing" between the Medicaid and CHP+ programs, which causes disruptions in service delivery due to small changes in family finances. The Department further plans to improve appropriateness, efficiency and quality of, and access to care on a budget neutral basis.

The design of any health care system, including this streamlined program, is multi-faceted and complex, given the interdependencies within the system. In the case of a streamlined program, key interdependencies include benefits, delivery system configuration and management, risk arrangements and network management. Therefore, MDF Associates suggested a logical sequence in which decisions regarding the design of the streamlined program should be considered. In addition, the Department's assumptions, guiding principles and description of populations to be included, which were provided to MDF Associates, are paramount in the design process (included as Attachment 1).

The sequence, used in developing and compiling these recommendations is as follows:

1. What benefits will be provided to enrollees?
2. What delivery system model(s) will best meet the needs of enrollees?
3. What type(s) of risk arrangements create appropriate incentives for vendors and providers?
4. How should the delivery system be managed?

Responses to these questions appear below in the following format:

- Executive Summary of Recommendations and Rationale
- Environmental Assessment and Background
- Detailed Recommendations and Rationale

Executive Summary of Recommendations and Rationale

MDF Associates' recommendations are comprehensive in scope, addressing benefit design, delivery systems, risk, and network management for the majority of children in the proposed streamlined program, excluding Children With Special Health Care Needs, which is addressed in detail in a companion document[1]. Some of the recommendations relate to fundamental structural elements of the program, while others relate to implementation and operational issues.

This section includes only those recommendations that relate to those fundamental structural elements, specifically Benefits and Delivery Systems issues.

Benefits

Recommendation: Provide a common "Core" benefit package, with comprehensive, quality, cost-effective services that fully meet the needs of a majority of children.

Recommendation: Provide "Core Plus" wrap-around benefits to all children in the streamlined program who appropriately require such expanded services.

Rationale:

Core Benefits

At the center of the Department's strategy is a desire to provide health care services to all children – those who are eligible for CHP+ or Medicaid; those with routine needs and those with special needs – within a single integrated health care delivery system. Such a system would feature a single benefit package that is sufficiently comprehensive for all children and ensures access to appropriate care. The state further wishes to attract insurers who might not otherwise show interest in offering publicly funded health care. Blending the evidence-based strengths of a commercially oriented SCHIP model with the broader set of benefits available under Medicaid, and employing commercial practices where possible meets both objectives.

The vision of a streamlined program with a common set of Core benefits is based on a number of factors.

Evidence in the literature, and experience in other states, suggests that "mainstreaming" can improve access to, and satisfaction with, "core" child health services, especially, primary care and dental services. **Based on extensive data analysis, the current CHP+ benefit package is sufficiently comprehensive so as to meet the needs of the majority of children enrolled who currently receive either CHP+ or Medicaid benefits.**

The current Colorado CHP+ benefit package, based on the Small Group Market Standard plan, is very comprehensive relative to SCHIP programs nationally as well as commercial benefit packages. It is a suitable basis for the Core benefit package recommended for the streamlined program. The Small Group Standard plan is one which health plans have experience administering. Using this as the basis for the Core package is likely to make participating in the program more attractive to plans.

Core Plus Benefits

The creation of a "Core Plus" wrap-around structure, over-and-above a set of common "Core" benefits further enhances the Department's ability to ensure the delivery of appropriate, cost-effective care. Through a "wrap around" model, Core Plus benefits will be provided to consumers with special needs who are likely to require additional care management and coordination.

Segmenting benefits into Core and Core Plus packages permits multiple purchasing strategies – one for Core and one for Core Plus – that provide maximum flexibility for the Department to negotiate arrangements that encourage plan participation while ensuring efficiency and cost-effectiveness of care. This approach offers the ability, for example, for reimbursement and benefit management strategies to be tailored to Core and Core Plus populations and benefit packages, respectively.

The Core-Core Plus structure also eliminates the experience of children "bouncing" between Medicaid and SCHIP programs. An analysis of enrollment data over a thirty-month period showed that over 30,000 children bounced between Medicaid and CHP+. The Core-Core Plus structure will create a seamless system for families who are burdened by program complexities in the current system. A child will receive the same Core benefit package regardless of whether he is a Medicaid or SCHIP enrollee, and will receive additional Core Plus benefits as needed, without having to access services through different delivery system or health plan.

While Medicaid clients would be entitled to all medically necessary services, the recommended Core-Core Plus structure could provide access to appropriate services for all children. This includes access for CHP+ enrollees to all, some, or none of the Core Plus benefit package, depending on need and the State's ability to provide additional benefits paid for by savings, without spending additional funds.

Recommendation: Establish a clear delineation between Core and Core Plus benefits for the purpose of enhancing seamlessness, continuity and administrative simplicity.

Rationale: Because managing the boundaries between benefit packages is a known challenge in administering wrap-around models, seamlessness requires clear definitions of how Core and Core Plus benefits are divided. For consumers, a clear definition of benefits is important to managing expectations. For payers, disputes over payer responsibility can result in cost shifting as well as impediments to access where providers disagree with coverage decisions.

Clear delineation of Core and Core Plus benefits:

- Promotes efficiency and cost-effectiveness of care by ensuring that Core benefits are exhausted before Core Plus benefits are utilized;
- Promotes accuracy in rate-setting and reimbursement; and,
- Increases appropriateness and accountability by ensuring Core Plus benefits are covered only for those members who require them.

Delivery Systems

Recommendation: Promote seamlessness and continuity of care by utilizing the same provider network(s) for Core and Core Plus benefits, where feasible.

Rationale: Utilizing the same provider network to coordinate the different, but complementary, sets of services, promotes opportunities to:

- Maximize efficiency by limiting the number of providers and plans the Department must manage;
- Reduce the need for inter-plan coordination and referrals, promoting continuity of care, user-friendliness and administrative simplicity; and,
- Place the delivery of clinically appropriate care, and not bureaucratic or administrative hurdles, at the heart of the system.

This approach, as compared to maintaining separate delivery systems for Core and Core Plus benefits, also reduces the need for consumers (and to some extent, providers) to negotiate multiple systems.

Recommendation: Develop a series of value-based purchasing strategies to ensure and strengthen the delivery system for the streamlined program. Recommended best practices for value-based purchasing strategies include:

- Limited partnerships with vendors that are willing to provide (and will receive) outstanding service in exchange for volume;
- An enrollment design that supports volume with a limited number of strong partners;
- Use of reasonable, measurable performance-based structure, process and outcome measures; and,
- Inclusion of a self-insured product as an enrollment option for consumers.

Rationale: Value Purchasing includes those strategies and techniques employed to ensure the purchase of high-quality health care, tailored to the specific requirements of the purchaser, at a reasonable cost. In many states, Medicaid and SCHIP directors have already made the transition from payer to purchaser; Colorado should pursue such a strategy to maximize value per purchasing dollar. In order to do so, Colorado should consider:

- Offering a sufficiently large membership to obtain leverage with vendors;
- Developing a relatively sophisticated administrative and systems infrastructure to support data collection and analysis, rate development, clinical quality improvement program, etc.;
- Strategies to develop solid partnerships with stakeholders;
- Offering adequate reimbursement;
- Selective contracting with providers who are willing and able to agree to State requirements;

- Conducting quality improvement efforts including performance monitoring and feedback; and,
- Financial or other incentives or disincentives for providers.

Specific recommendations for implementing a value purchasing strategy follow:

Recommendation: Purchase health care from a limited number of plans, requiring outstanding service in exchange for volume. Offer a market potential of 30,000 to 35,000 wherever possible, while balancing access and choice. Provide an excellent level of service of contracted plans by Department staff.

Rationale: Successful value purchasing requires that the purchaser have sufficient leverage over contracted vendors. By aggregating purchasing activities among a limited number of vendors, the Department can build strong business relationships with key providers and both require and provide a high level of service. A volume of 30,000 enrollees may justify the creation of special systems and processes that would simply not be reasonable for 5,000 enrollees. The implementation details of this recommendation, such as guaranteed enrollment, warrant further discussion and will be discussed more fully outside the context of this paper.

By developing preferred relationships, the Department can maximize the opportunity for vendors to view State business as attractive, given the opportunity to spread financial risk over a large number of covered lives. Ultimately, the Department can better meet its fiduciary responsibility to taxpayers and simultaneously purchase better care for consumers by creating "win-win" partnerships with vendors, with volume as a central element of the relationship.

Recommendation: Structure enrollment in a manner that maximizes market potential for vendors while maintaining strong access. Require enrollees to select plans or providers within their geographic area, regardless of utilization or special needs. Allow variability in the number of vendors based on market conditions by geographic region.

Rationale: A geographically based system promotes the balance between access, choice and administrative simplicity, and supports the opportunity to offer a few strong partners a critical mass of volume in exchange for excellent service.

Geographically based enrollment (vs. population-based enrollment) allows the State to:

- Maximize access and network adequacy. Under such a system, the State can conduct analyses regarding the adequacy of providers in any given geographic area (e.g. zip code analysis) and match clients, based on specific needs, to plans and network providers;
- Promote equity across the system for consumers;
- Minimize "split families" that may be forced to enroll in different delivery systems under a population-based enrollment system;
- Maximize choice for consumers; and,
- Promote administrative simplicity and flexibility in program administration.

Recommendation: Develop and monitor reasonable, clearly defined structure, process and outcome standards that promote compliance and improvement, based on state of the art practices in the industry. Reinforce performance-based purchasing through incentives and disincentives, such as:

- Bonuses for exceeding quality standards;
- Enrollment volume (e.g. through an assignment process); and,
- Increased or decreased flexibility in plan management and benefit administration.

Rationale: As the agent responsible for financing health care in Colorado, the Department must ensure that vendors are capable of providing quality, cost-effective care to enrollees in the streamlined program. This responsibility is magnified when a plan accepts a large number of enrollees. Given the Department's desire to provide volume to a limited number of vendors, the selection, evaluation of readiness to serve enrollees, and ongoing performance is central to the programs' success. At the outset, the Department can procure services based on measurable standards of performance. Procurement activities should include review of documentation as well as a detailed and thorough on-site readiness review.

On an ongoing basis, a major focus of value purchasing relies upon monitoring plan performance to ensure compliance with, and continuous quality improvement in a vendors' ability to meet the Department's standards. Implementation of consistent network management strategies across all health plans and segments of the delivery system (i.e. self-insured and HMO plans) will ensure value for each purchasing dollar. Such strategies include:

- Provider profiling and performance measurement;
- Utilization management;
- Provider services;
- Provider credentialing; and,
- Provider and member education

Monitoring efforts are then strengthened by financial and non- financial incentives.

Recommendation: Maximize competition and leverage by maintaining a self-insured option as a choice for consumers to select among other health plans. Manage the self-insured network using value-based purchasing strategies.

Rationale: One of the strongest arguments for states to develop a strong self-insured program, as exists in Colorado, is to ensure access to members who live in a geographical area not served by an HMO. A secondary reason to maintain a self-insured option is as a hedge against declining HMO participation in publicly funded programs. **Nationally, states need to be more proactive about the following in order to maintain commercial managed care participation:**

- Appropriateness of capitation rates, particularly for members with disabilities;
- Plan solvency (independent of the Medicaid book of business) and market consolidation;
- Changes in insurance law;

- Attention to the Plan's "business as usual" practices in the commercial market, when designing programs, and;
- Support from states for commercial plans new to serving the Medicaid population.

Despite recommendations contained within this paper that address some of these factors, the relative instability of the Colorado marketplace makes the maintenance of a viable self-insured option an appropriate risk management strategy.

Environmental Assessment and Background

Much of the success of the existing CHP+ program stems from its orientation as a non-entitlement program, that is, one that expands access to and assistance for health insurance beyond those traditionally eligible for entitlement programs, and that provides states with sufficient flexibility to meet the needs of low-to-middle income working people. Because SCHIP enrollees are largely from working families and because of the program's specific requirements with respect to the commercial market[i] the program has, from the start in many states, been viewed as a bridge between public and private insurance for the unemployed or underemployed. A key result of this is that many states have adopted the use of a commercial plan as benchmark for their SCHIP program.

Given this commercial orientation, it is important that the design of any streamlined program be complementary to the existing the commercial marketplace; that is, that the program provide benefits to enrollees that are consistent with standard commercial offerings (to the extent possible given the unique needs of enrollees), and delivered in a manner that utilizes commercial provider and plan networks (again, to the extent possible).

As a result, MDF Associates undertook a review of best practices in the commercial marketplace nationally and of market conditions generally in Colorado. MDF specifically took a variety of factors into consideration in making recommendations to the Department. Key topics considered in developing recommendations include:

- Conditions in the Colorado marketplace;
- Innovations in commercial markets nationally; and,
- Potential applications of best practices in the streamlined program.

There is sufficient literature on innovations in employer-based health insurance market that point to clear emerging trends in delivery systems and benefit design. This is further supported by interviews with national experts. Although the state of Colorado's goal of creating a streamlined program without paring back benefits precludes the state from adopting some of these approaches, they may have an indirect impact on decisions regarding program design, and are therefore worth exploring.

Factors Influencing the Design of a Streamlined Program

Trends in Benefit Design

A review of literature and practices in innovative states regarding Medicaid, SCHIP benefits and commercial markets is broad in scope, but not deep on information about the particular practices within states or commercial markets. This is not surprising with regard to SCHIP in particular, given that the first evaluations on SCHIP performance were just recently completed for the federal government[2]. What little literature exists on benefits innovation in the commercial sector stems from purchasing coalitions, and is not directly relevant to the design of a streamlined

[i] Including provisions to limit crowd-out, as well as program design options that include modeling the program on commercial health insurance products

program Following is a brief review of literature and practices regarding benefit design in public and private markets.

Benefit Design in Medicaid and SCHIP

The Centers for Medicare and Medicaid Services (CMS) website identifies 18 states with combined Medicaid and SCHIP programs. Each of these programs differs in which aspects of the programs are jointly administered and how they are managed. The literature yielded virtually no information about innovative approaches to joint administration of Medicaid and SCHIP benefits. However, there is a substantial amount of literature on how to purchase health care services more effectively, which is discussed later in this paper. That said, benefit package determinations were largely driven by finances and challenges associated with budget neutrality.

Under Title XIX, Medicaid recipients are legally entitled to coverage for which "exceptionally broad preventive standards to determine coverage of children" exist[3]. States must offer all mandated Medicaid benefits but may choose from among optional benefits under Title XIX. For SCHIP, however, states have wide latitude to design their own benefit package (within broad federal guidelines). Although some states provide SCHIP enrollees with full (or near full) Medicaid benefits, there is no requirement to do so.

According to federal requirements, states must model their SCHIP benefits on a "benchmark" benefit plan, such as comprehensive state-based coverage (e.g. Medicaid), the Federal Employees Health Benefit Plan (FEHBP), or a commercially-oriented benchmark package (e.g. the Small Group Standard HMO Benefit package which is the benchmark in Colorado). In states, including Colorado, SCHIP coverage is viewed as a "bridge" to private insurance for children of unemployed parents who, temporarily, can't afford insurance; thus, a commercially oriented benchmark is more common than a Medicaid benchmark[4].

States that do utilize the Medicaid benefit package as a benchmark do so to provide exceptional *access* to care to SCHIP enrollees, and to streamline the administration of the programs. Importantly, some state administrators (e.g. Connecticut) believe that the offering of Medicaid benefits to SCHIP enrollees does not necessarily result in increased utilization of services among SCHIP enrollees.

While SCHIP program benefits vary greatly from state to state, all SCHIP and Medicaid programs, including Colorado, cover the following for children:

- Inpatient Services (IP)
- Outpatient Services (OP)
- Emergency Department (ED)
- Hospital services
- Physician services
- X-ray and lab
- Immunizations
- Well-baby visits and other preventive services
- Inpatient and Outpatient mental health treatment

- Vision screens
- Pharmacy benefits.
- Rehabilitative Therapies

Colorado's SCHIP benchmark benefit package is based on the Small Group Standard HMO Benefit package, but is modified somewhat to ensure access to preventive care and other services that are essential to a low-income population.

In addition to the benefit listed above, a comparison of SCHIP benefits nationally to Colorado's benefit package is provided in Table 1.

Table 1: Comparison of SCHIP Benefit Packages, US vs. Colorado

Most SCHIP Programs cover:[5]	**Colorado Covers:**
Hearing screens	YES
Preventive and restorative dental	Periodic cleanings, exams, x-rays, fillings, root canals and orthodontia covered. $500 maximum per year
Corrective lenses	Vision visits covered in full. $50.00 contribution toward corrective lenses per benefit period.
Inpatient and outpatient substance abuse	20 outpatient visits covered per benefit period. Inpatient and ancillaries for medical detoxification covered in full. Excludes residential rehab for substance abuse or alcohol
Durable Medical Equipment	Covered with a $2000 limit per benefit period
Physical therapy, occupational therapy, speech therapy	30 outpatient visits per benefit period
Home health	YES
Immunization and well baby visits	YES
Most SCHIP Programs do NOT cover:[6]	**Colorado Covers:**
Over the Counter Medications	NO*
Developmental Assessment	YES
Physical rehabilitation	Covered up to 30 visits. More covered with exceptions
Podiatry	YES
Chiropractic Services	By an osteopath only
Medical Transportation	NO
Nursing Facility Services	YES, for a defined period
Private Duty Nursing	NO
Personal Care Services	NO
Benefits that are typically included in Medicaid *but not* SCHIP include[7]**:**	**Colorado Covers:**
Family planning, midwifery	YES
Medical and Surgical Dental Services	YES, under Medical
Home health care (Skilled nursing, therapies, oxygen, IV Meds, Physician home visits)	YES
Rural health clinic services	YES
Nurse-midwife services	YES
Pediatric and family nurse practitioner services	YES

*Some Health Plans offer Over the Counter Prescriptions as a value-added benefit in CHP+

This table clearly illustrates that, relative to SCHIP programs nationally and to commercial benefit packages, the Colorado CHP+ benefit package is extensive enough to meet the needs of most children. The comprehensiveness the CHP+ benefit package is an important factor in the design of a streamlined program as it is MDF Associate's recommendation that it serve as the basis for a Core benefit package for the streamlined population.

Benefit Design in the Commercial Market

Benefit design strategies in the commercial market are different in important ways, compared to benefit design strategies used in government programs. According to a review of the literature and interviews with representatives from the private sector, employers are increasingly providing a fixed contribution toward the cost of care for employees rather than providing a specific health benefit (purchase of coverage with a well-specified and contractually-mandated set of health benefits). This contribution is frequently in the form of Flexible Spending Arrangements (FSA), in which the employer reimburses the employee for the cost of care up to a pre-determined limit. A secondary form of employee contribution is the Archer Medical Savings Account (MSAs) – available to self-employed individuals and those employed by firms with 50 or fewer employees to pay for covered medical expenses on a pre-tax basis.

In addition, many employee benefits managers and corporate medical departments report that employee health, wellness, and disease management are their primary focus. The tactics employers plan to implement include: data analysis to identify the employers' healthcare cost drivers; employee education, wellness, and support programs; disease management programs; incentives to encourage employee health, and drug therapy management protocols[8].

Medical Necessity

The definition of Medical Necessity has historically been considered a core issue in benefit design. This has been especially controversial, given a significant difference between Medicaid-oriented definitions of Medical Necessity, and those definitions used in commercial models (potentially applicable to SCHIP programs).

Numerous definitions of Medical Necessity can be found in the research literature and are largely represented by definitions that are set, individually, by governments (state and federal), purchasers of health care, and insurers. No federal regulatory definition of medical necessity exists for the commercial sector, and only one-third of all states have any regulatory definition of medical necessity. Colorado does not have a regulatory definition of medical necessity for the commercial sector. Not surprisingly, coverage design and related definitions of Medical Necessity vary widely in states with streamlined and stand-alone SCHIP and Medicaid programs nationally.

Medicaid, SCHIP and Commercial Approaches to Medical Necessity

Exploration of issues related to establishing a definition for a streamlined Medicaid and SCHIP program requires a review of:

- Medicaid, SCHIP and Commercial approaches to defining Medical Necessity nationally
- Components of a Medical Necessity Definition
- Key Issues in Developing a Medical Necessity Definition for a Streamlined Program and Policy Questions for Consideration by Colorado

Medicaid

Under Federal law, Title XIX requires the provision of broad, preventive care for children under EPSDT regulations. The Medical Necessity definition under Medicaid requires states to cover all treatments, regardless of whether such treatments are needed to restore normal functioning following an illness or injury (a commercially-oriented definition). Further, federal law requires that Medically Necessary care is that which lessens the effects of a chronic physical or mental health condition, promotes growth and development, or maintains function (e.g. EPSDT requirements). In other words, the Medicaid standard of Medical Necessity for children is a *preventive* standard of care, and is applied on a case-by-case basis for children.

Further, for covered benefits, federal law prohibits:

- Use of arbitrary limits and exclusions on required treatments,
- Across-the-board limits and exclusions based on standards other than medical necessity, and
- Use of irrefutable, condition-specific treatment guidelines that eliminate individualized decision-making and measure treatment coverage in accordance with pre-fixed and standardized norms.[9]

SCHIP

The Medicaid definition of medical necessity applies to SCHIP programs that are implemented as Medicaid expansions. However, under separately administered SCHIP programs, federal law gives states significant discretion to define Medical Necessity. The Title XXI statute, under which standalone SCHIP programs operate, contains almost no federal standards related to coverage design, including the definition of Medical Necessity. Rather, the statute simply requires a design based on a "benchmark" plan that typically follows a commercial orientation.

Of course, states may opt, as a matter of policy, to apply Medicaid *principles* in their coverage design. For example, 13 of 19 states studied by Rosenbaum, et al[10], employed a Medical Necessity definition that parallels the preventive standard of care used by the Medicaid program in the respective states, thus ensuring coverage that promotes growth and development.

While Rosenbaum identified states with strong preventive coverage guidelines under SCHIP, she concludes that states lean toward commercially-oriented insurance norms in designing care for children under SCHIP overall.

Commercial

In commercial plans, the definition of Medical Necessity typically provides coverage to *diagnose and treat an illness or injury, specifically to restore a patient to normal functioning*. Under such a definition, for example, physical therapy would not be deemed Medically Necessary for a child with cerebral palsy simply because the child would not be capable of achieving "normal" functioning. Under Medicaid, that same child with cerebral palsy *would* be eligible for physical therapy, given Medicaid's definition, as described earlier. Hence, commercially oriented definitions of Medical Necessity historically have been more limiting than the Medicaid definition.

Limitations on coverage are mostly determined by benefit limits rather than medical necessity definition itself. Stand-alone SCHIP programs, like commercial insurers, can rely on those benefits that are covered rather than on decisions and conflicts that stem from variation in interpretation of a Medical Necessity definition.

Components of a Medical Necessity Definition

According to a seminal article by Rosenbaum, Kamoie, Mauery and Walitt, the prevailing definition of medical necessity is "broadly framed, multi-dimensional, and controlled by insurers" rather than treating professionals. Five different dimensions are typically included in the definition of medical necessity:

- *Standards of Practice* – whether the treatment accords with professional standards of practice.
- *Patient safety and setting* – whether the treatment will be delivered in the safest and least intrusive manner.
- *Cost* – whether the insurer considers the treatment cost-effective.
- *Contractual scope* – whether the contract provides any coverage for certain procedures and treatments, such as preventive and maintenance treatments, which are not necessary to restore a patient to "normal functioning." This dimension preempts any other coverage decision.
- *Medical service* – whether the treatment is considered medical as opposed to social or non-medical.

Analysis of Current Colorado Definitions of Medical Necessity

MDF Associates reviewed the current definitions of Medical Necessity for CHP+, Medicaid and the Small Group Market in Colorado. A comparison of the three definitions, parsed by the five dimensions identified in the literature, appears in Table 2.1. Key differences in the three current definitions of Medical Necessity used in Colorado, based on the dimensions studied, are shown in Table 2.2.

As the information included here indicates, states have the opportunity to significantly simplify benefit administration by *developing a clear, quality-driven, cost-effective benefit package, rather than continually managing a definition that is subject to swings in interpretation of Medical Necessity.*

Table 2.1: Comparison of Current Medical Necessity Definitions in Colorado

Components	CHP+	Medicaid	Small Group Market (as a Commercial Proxy)
Standards of Practice – Whether the treatment accords with professional standards of practice.	A covered service shall be deemed medically necessary if, in a manner consistent with accepted standards of medical practice, it is… Widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence	A covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it is found to be an equally effective treatment…	It must be within generally accepted standards of medical care in the community.
Patient safety and setting – whether the treatment will be delivered in the safest and least intrusive manner.	…The most appropriate level of care that can be safely provided to the Enrollee, and When applied to inpatient care, Medically Necessary further means that Covered Services cannot be safely provided in an ambulatory setting. [11]	Among other less conservative settings…	
Cost – whether the insurer considers the treatment cost-effective.		…or more costly treatment options AND	For medically necessary services, the Plan may compare the cost-effectiveness of alternative services or supplies when determining which will be covered
Contractual scope – Whether the contract provides any coverage for certain procedures and treatments, such as preventive and maintenance treatments, which are not necessary to restore a patient to "normal functioning." This dimension preempts any other coverage decision.	Consistent with the symptom, diagnosis and treatment of an Enrollee's medical condition Failure to provide the Covered Service would adversely affect the Enrollee's health.	Meets at least one of the following criteria: a. The service will, or is reasonably expected to • Prevent or diagnose the onset of an illness, condition, primary disability or secondary disability; • Cure, correct, reduce or ameliorate physical, mental cognitive or developmental effects of illness, injury or disability; • Reduce or ameliorate pain or suffering caused by an illness, injury or disability;	The service or supply must be provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury or disease. It must be necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms
	Not Experimental or Investigational; Not solely for cosmetic purposes	Not Experimental or Investigational	The service or supply must not be experimental, investigational or cosmetic in purpose.
Medical service – whether the treatment is considered medical as opposed to social or non-medical.		Assist the individual to achieve or maintain maximum functional capacity in performing activities of Daily Living. A course of treatment may include mere observation or, where appropriate no treatment at all [12,13]	

Table 2.2: Key Differences in Medical Necessity Definitions Currently Used in Colorado

Standards of Practice	The CHP+, Medicaid and Small Group Market definition of Medical Necessity all require that treatment be delivered in accordance with professional standards of practice.
Patient safety and setting	The CHP+ definition includes language regarding the delivery of care in the most appropriate setting in which care can be safely delivered. The CHP+ definition specifically states that, where inpatient care is concerned, care cannot be provided (safely) in an ambulatory setting. The Medicaid definition simply states that care must be provided in a setting that is equally effective among less conservative settings. The Small Group definition includes no reference to Patient safety and setting.
Cost	The CHP+ definition makes no reference to language regarding cost as it applies to the definition of medical necessity. The Medicaid definition states that care must be provided in a setting that is equally effective among less costly settings. In other words, if outcomes are equal, a higher cost setting is not "medically necessary" by definition. The Small Group definition states that the Plan may "compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered." Typically, commercially oriented definitions of Medical Necessity include language regarding cost-effectiveness.
Contractual Scope and Medical Service	The CHP+ definition states that medically necessary care must be consistent with the symptom, diagnosis and treatment of the Enrollee's condition and that failure to provide care would adversely affect the Enrollee's health. "Adversely affect" is not clearly defined in this definition and would be interpreted in light of professional standards of medical practice. The Medicaid definition regarding Contractual Scope and Medical Service is significantly broader than the definitions provided for CHP+ and the Small Group market. The language that most distinguishes the Medicaid definition of Medical Necessity from the CHP+ and Small Group definition lies in the contractual scope. Specifically, Medicaid considers care that assists the individual in achieving "maximum functional capacity in performing Activities of Daily Living" to be medically necessary. This is in contrast to the Small Group definition. The Small Group definition of Medical Necessity states that the service or supply must be provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury or disease. Care must be necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms. CHP+ and the Small Group definition explicitly exclude coverage for experimental or investigational care (or care which is for the personal convenience of the enrollee or provider) under the definition of Medically Necessary.

Innovation in Benefit Design

Innovation in Benefit Design: The Commercial Market

Despite the concern over the cost of health care and the growing body of knowledge regarding the importance of effective health benefits management and administration, there has been relatively little innovation in benefit design in commercial products documented in the literature or reported by private sector representatives. According to the Milbank Memorial Fund, which issued a study of value purchasing in September 2001[14] there are several reasons for this, the two most relevant being (1) a primary focus on cost-containment and consumer satisfaction rather than on clinical quality, and (2) that the business case for quality hasn't been made; that is, that there is a lack of proof that improved health outcomes yields to higher worker productivity. There are, however, pockets of innovation in disease management and care management, largely driven by large employers and purchasing coalitions, also described within this report under Value Purchasing. These tend to focus on specific populations or diseases/conditions, and are designed to help manage costs while improving health outcomes. Also, while many of the options available to commercial plans, such as increased co-payments, higher premiums and

larger provider networks are not available to Medicaid plans, the innovations discussed below could potentially work in public sector programs.

General Trends

According to another study completed by the Health Industries Research Co (HIRC)[15], the pressure of increasing health care costs is pushing more employers to proactively undertake initiatives to better manage the care of their employees. The study, conducted with employee benefits managers, corporate medical departments, employer healthcare coalitions, and employee benefits consultants, points to a "turning point" in health benefit design. HIRC's study suggests that some techniques that have come to be accepted (and in some instances adopted by Medicaid programs) are changing.

Health and Wellness

The study by HIRC indicates that employers' emphasis is shifting to employee health, wellness, and disease management in an effort to manage (rather than shift) costs. Employers will increasingly utilize: data analysis to identify healthcare cost drivers; employee education, wellness, and support programs; disease management programs; incentives to encourage employee health; and drug therapy management protocols."[16]

This trend toward emphasizing employee health and wellness is one that many states had, adopted for their Medicaid and SCHIP populations long before this became widespread in the commercial market. Its growing popularity in the commercial market now provides opportunities (e.g. through development of common purchasing specification and other joint purchasing strategies) to better manage costs and improve health outcomes across the health care system regardless of who the payer is. This is particularly important given the similarities in population characteristics of CHP+ and commercial enrollees.

Pharmacy Management

Employers are gradually moving away from the now-standard three-tier pharmacy co-payments, toward a percentage co-payment. In other words, consumers who desire a brand name (vs. a generic) drug must pay a percentage of the total cost of the drug, rather than a flat, pre-defined co-payment amount. In addition, employers are moving toward increased drug utilization management. HIRC expects to see an increase in employers' use of therapy management protocols and step therapy in several high cost areas (as identified by employers) such as drugs to treat musculoskeletal and Gastro Intestinal (GI) disorders, as their first targets for utilization management initiatives.

Though states and health plans have long managed pharmacy benefits under Case Management programs, this trend has seen an explosion in recent years. For example, twenty-one states have recently embarked on efforts to create or expand preferred drug lists. Nineteen states have enacted or enhanced pharmacy prior authorization rules under Medicaid.

Referral Systems and Prior Authorization:

Many commercial plans are reducing or eliminating advance approval requirements for treatments such as hospital admissions, outpatient tests and procedures, and for specialist referrals. Some plans have eliminated prior approvals for specialists altogether, while other

plans have eliminated the review of physicians' approvals. Other plans have made the approval process easier by replacing prior approval policies with prior notification policies. These changes in advance approvals are being done in an effort to become more "consumer friendly" and to reduce administrative and operational costs. The types of changes and the rate of change vary from market to market.[17]

Most of the plans that have eliminated certain advance approval requirements have instituted other utilization management policies in efforts to control costs. For example, one group of plans introduced new advance-approval requirements for the following: outpatient and office based surgical procedures, home health care, new diagnostic tests, and high-cost pharmaceutical and biological technologies such as injectable drugs and blood factor products. Other plans have utilization reviews conducted by their hospital-based employees in order to monitor lengths-of-stay and to arrange for lowest-cost discharge planning. Some plans have instituted length-of-stay approval processes that require physicians to justify hospital stays longer than an established minimum. Finally, other plans have enhanced their retroactive utilization review processes to provide physicians with detailed measures of quality of care and service use.[18] It is unclear if the commercial market's cost-saving measures will prove effective.

Evidence-Based Policy Making

A commercial plan's primary goal of medical management is to ensure that members receive care that is medically necessary, and to minimize clinical and arbitrary decision-making. In order to determine medical necessity, organizations are increasingly looking for clinical evidence to support decisions. Technology assessments, clinical practice guidelines, and medical review criteria are tools used in these "evidence-based medicine" decisions.[19] Medical management companies specialize in providing plans with these types of tools, and criteria developers provide updated data to the management companies.

Implications for Medicaid and SCHIP

While commercial markets are moving away from traditional managed-care products to products that allow for more choice and access, state Medicaid plans have largely accepted the limitations and restrictions associated with traditional managed care in favor of cost controls:

> Medicaid agencies have traditionally relied on mechanisms like prior authorization to impose utilization and cost controls on providers and beneficiaries. While they understand the dissatisfaction these have engendered, they also value their contribution to promoting appropriate service delivery and have not advocated for their modification as strongly as private purchasers. Medicaid agencies' perspectives toward primary care gate keeping is even more at variance with private sector buyers as enrolling beneficiaries with a primary care provider has made the concept of a medical home a reality (Hurley, Freund, and Paul, 1993). It also extends to beneficiaries the virtues of a designated care coordinator and a source of advice and consultation on a 24-hours-a-day and 7-days-per-week basis. Many States that have enrolled chronically ill and disabled beneficiaries in managed care have maintained the gatekeeper model, but have commonly permitted specialty physicians to play this role. Consequently, discontinuation of primary care gate keeping as a core element in managed care plans is not a welcome development in the eyes of many Medicaid purchasers.[20]

Innovations in Benefit Design: States and Commercial Markets

Case Management: States, rather than commercial health plans, have led the way in implementing case management programs for Medicaid and SCHIP enrollees. While Case Management is not a covered benefit per se, it is a value-added service made available to SCHIP and Medicaid consumers in some states and can be integral to the delivery of care for low-income populations.

There is much debate over the distinction between case management, care coordination and disease management in theory and in practice. In this paper, disease management is defined as a form of case management, directed at specific conditions and health issues. This paper focuses attention on success in case management programs for individuals with multiple chronic diseases (rather than a single health problem such as asthma or diabetes).

Most plans have added disease management programs for conditions such as diabetes, congestive heart failure, asthma, and pregnancy or high-risk pregnancy. Other plans have programs that address cardiac care, oncology, lower back pain, depression, and chronic obstructive pulmonary disease. Most disease management programs assist members directly, without using the plan as an intermediary.[21]

From a policy perspective, these care management changes shift management from a larger group of insured to a smaller, select group of "sicker" plan members. As such, these management techniques are increasingly being viewed as tools for identifying members who need more intensive interventions, rather than a one-time encounter with members.[22]

In order to offset increased costs in commercial plans, most plans have sharply raised premiums and plans and employers have further instituted more consumer cost sharing, such as higher co-payments.

Athena Health Communications, a communications firm that maintains a "best practice" database for disease management and models of care management, describes several initiatives undertaken by employer or joint purchasing coalitions that reflect a growing interest in more effectively managing care. The database contains the results of interviews with 60 entities across the country, and details care and disease management programs that contracted plans and providers (as well as the employer or coalition itself) have in place for the following areas:

- Cardiovascular disease (CAD and CHF)
- Breast and cervical cancer screening
- Prevention, wellness, screening
- Diabetes
- Asthma

Although there are variations among them, interventions:

- Remind and inform physicians of guidelines and standards of care;
- Expand the role of non-physicians to allow them to work more closely and proactively with patients; and,
- Empower patients to take on responsibility for their own care more effectively.

One case management model successfully employed to serve a Medicaid population, comes from a behavioral health management company based in Virginia that provides primary preventive and behavioral health care management of clients served by the Massachusetts Executive Office of Health and Human Services. This system assumes that consumers needs exist along a continuum.

Some consumers simply have routine needs and require no additional care coordination or case management. Other consumers have some additional needs for coordination or extra-contractual benefits. This "middle" population also may be at-risk for becoming high need and is an important population to manage to avoid deterioration in health and related need for excessive amounts of services. Other consumers have special needs and require full-scale, intensive case management. All three populations may have varying needs for coordination of benefits and services. One of the most appealing aspects of this model is the ability to coordinate and integrate physical and behavioral health care for individuals in the streamlined program.

The objectives of this tiered Care Management system are to:

- Ensure the integration of primary, preventive and behavioral health care for the target population by developing systems to coordinate care at the local provider level;
- Enhance the cost-effectiveness of care delivery by managing the needs of consumers in the least-restrictive, most appropriate setting; and,
- Improve outcomes of care related to access, satisfaction and quality of care through integration and care management efforts.

The approach that the vendor has taken to achieving this goal is to design, implement and manage a system that features a flexible continuum of care management services designed to appropriately meet the needs of consumers. This system includes three key components:

- Targeted Outreach for consumers with minimal or episodic needs;
- Care Coordination for individuals that are at risk for high utilization of services or health care dollars; and,
- Intensive Clinical Management for individuals that require intensive care coordination, likely to include enrollees with special health care needs.

This system is a logical adjunct to the streamlined program in that it supports appropriate, cost-effective care delivered within a streamlined program, as described in the Detailed Recommendations section of this paper.

Child Development Services

While the literature cites child development services as a newer interest among states (not among commercial plans), there is no universal agreement as to what constitutes "child development services." There is, however, general agreement that these services relate to children's needs in the first two years of life, and include: 1) screening and developmental assessment; 2) health promotion; 3) developmental interventions; and 4) care coordination. Rosenbaum recommends purchasing specifications on child development services despite the realization that some services may not qualify for Medicaid reimbursement.[23] Given the SCHIP focus on children, child development screening and referral for clients who appropriately can benefit may merit consideration for Title XXI as well.

One example of an effort to provide enhanced child development services stems from an initiative of the North Carolina Division of Medical Assistance, in collaboration with the North Carolina Office of Research, Demonstrations and Rural Health. This initiative resulted in the development and implementation of child development services provided within a new health care delivery model. This initiative, known as the "ABCD Project," calls for the integration of developmental screening and surveillance into well-child visits in pediatric and family practice offices. Children with developmental issues are then provided with case management, specifically if the parents express concerns about their child's development. While the Department believes that providers generally screen for developmental delays, this program suggests a rigorous screening process with detailed assessments and referrals when required.[24]

The North Carolina effort cost the state $2.50 per member per month, paid to providers to offer child development services as described above. These funds are available to providers specifically to develop staffs and programs needed to improve the management of care provided to children. The program is in its early stages of development but offers positive preliminary results regard cost-effectiveness. The percentage increase in hospital and emergency room services is 50% lower for a group of children that received child development services, as compared to children who did not.[25]

According to the Center for Health Informatics and Statistics, the net-savings generated from reducing hospital admissions for individuals under age 21 was $2.5 million annually.[26] The program also reports improvements in documentation of asthma staging and action plans to address the needs of asthmatics.

Trends in Delivery System Design

Numerous trends in health care delivery system design contributed to the recommended design of the streamlined program. Following is a review of key trends that emerged as a result of literature reviews and interviews with industry experts and opinion leaders nationally.

Health Care Purchasing Coalitions

Health care purchasing coalitions have grown out of a desire by purchasers (e.g. employers or business associations), to leverage a combined membership to improve their purchasing power with health care providers. Because health care providers offer price discounts and administrative efficiencies to large purchasers in exchange for patient volume, coalitions can

purchase health care services for less money than individual employers could on their own and, at the same time, work to improve the delivery of health care services through value purchasing techniques.[27]

The roles of purchasing coalitions vary. Some simply collect information for coalition members to monitor costs and services. Others share information and jointly purchase services. Some coalitions go as far as developing PPO networks, prescription drug care programs, and mental health and substance abuse networks.

The common thread among coalitions nationally appears to be a general push for systems that reduce long-term medical costs and improve standardization and quality measurement in plan design. For example, several years ago coalitions began collecting consumer satisfaction and clinical outcomes data. Now with sufficient historical data, coalitions can negotiate performance guarantees with insurers and health care providers, thereby increasing their ability to obtain value for their purchasing dollar overall, and value for member organizations.

Although examples of truly innovative and successful initiatives led by purchasing coalitions are isolated, it is clear that the concept of purchasing coalitions (and increased leverage that is attainable by large purchasers) has taken root. In 1999, the National Health Care Purchasing Institute (NHCPI) was founded to "improve health care quality by advancing the purchasing practices of major corporations, government agencies, and public employers."[28] Housed at the Robert Wood Johnson Foundation's Academy Health, NHCPI was designed as a vehicle to promote results-driven health care by helping purchasers define and measure quality, communicate quality-related information to consumers, and reward and otherwise continuously support quality improvement activities. Among its success: NHCPI was instrumental in popularizing the need for incentives to reward providers for higher quality and for full public reporting of provider performance, initiatives which are now a key part of quality improvement efforts.

Some states have implemented a value-purchasing strategy, either for Medicaid or SCHIP enrollees, as part of a large employer-benefit purchasing coalition. One purpose of doing so is to take advantage of the benefits of a combined membership in the form of clout or leverage. For example, in 1999 Georgia created the Department of Community Health, which included purchasing for Medicaid and state employees, with the goal of bringing all of its health planning and purchasing operations under one roof, to consolidating its purchasing power, and to better coordinating health plan administration. The initiative resulted in the state's largest Preferred Provider Organization (similar to a Primary Care Case Management or self-insured model) for covered lives. The Department contracted out the management of the plan via a competitive procurement. This also resulted in a single Pharmacy Benefit Manager creating enough leverage to implement drug utilization review, a formulary, and drug rebate programs to rein in pharmaceutical spending.[29] Other states such as Illinois, California and Maine use such purchasing coalitions to improve their bargaining position but do not jointly purchase or administer programs within their coalitions.

Under the proposed streamlined Medicaid/CHP+ program, the Department will be able to leverage a consolidated membership of approximately 200,000 lives, with or without

participation in a purchasing coalition. Still, there may be potential value to the Department in establishing or joining a purchasing coalition. Joint purchasing initiatives for common functions and services can facilitate the progress toward achieving the necessary prerequisites to obtaining value for the Department's purchasing dollar, such as a sufficiently large membership to obtain leverage with vendors, and development of sophisticated administrative and systems infrastructure.

Direct Contracting

Another trend in the commercial marketplace is Direct contracting, where large purchasers (e.g. large employers or purchasing coalitions) contract directly with health care providers to create a self-insured PPO product. Under such an arrangement, employees may see any provider with whom the purchaser contracts.

Supporters of Direct Contracting believe that eliminating involvement of insurers can lower administrative costs and profits that are built into insurers' premiums. Supporters also believe that direct contracting gives more control to the health care providers, who are in the best position to lower costs and improve outcomes. This approach potentially frees providers from the restrictions of managed care. In most cases, providers work through a Third Party Administrator (TPA) to manage the administrative aspects of the contract with the purchaser.

A study conducted by the Johns Hopkins Bloomberg School of Public Health and published in Health Affairs demonstrated that one such arrangement by a coalition of Minnesota employers (Buyers Health Care Action Group on Health, BHCAG) lowers costs without sacrificing quality. As summarize in Managed Care Weekly,[30] this study demonstrated that, as a result of direct contracting efforts by the coalition:

- Overall, the coalition spent an average of $120 per month for each member, while the average Minnesota HMO spent $152 per month for each member.
- Hospital care, which is the most costly health care service purchased by the coalition, dropped over the 3-year period. Simultaneously, the cost of ambulatory care rose slightly and the cost of pharmaceutical care increased more sharply.
- The quality of treatment for depression, asthma, and diabetes remained stable or improved over the study period. Patients met or exceeded the standards for medical services for someone with one of these chronic conditions.
- Use of preventive care measures, (e.g. flu shots, cholesterol screening, and colorectal examinations) remained the same or increased over the study period.

Consistent with trends toward increased consumer participation in health care decision-making, BHCAG places an emphasis on consumer empowerment, believing that this is essential for quality improvement. Consumers select their care systems after receiving information from BHCAG on cost, provider choice, and overall customer satisfaction scores, ultimately deciding what aspects of a health care system are important to them. Consumers speak directly with their physicians as concerns arise regarding cost or health care delivery practices.[31]

The literature cites one interesting and important effect of Direct Contracting: the development of single-specialty and disease-oriented networks. These networks include "interdisciplinary

aggregations of providers that adopt a single-minded focus on specific markets, problems and diseases. They range from asthma to cancer to addressing the unique health problems of the homebound frail elderly."[32] Beyond a commitment to clinical excellence, these networks position themselves in narrow "layers" of integration combining best practices with efficiency and customer service.[33]

While Direct Contracting is not yet widespread in the commercial market (in Colorado or nationally), loosely defined, it is certainly widespread among state Medicaid programs, albeit less so among SCHIP programs. In fact, it is the model that states used prior to contracting with health plans to manage and deliver care to members. (MDF Associates believes that any fee-for-service or primary care case management model using a Medicaid network, loosely defined, can be considered "direct contracting").

These trends have important implications for the Department's self-insured CHP+ product, which may play a similar role for the State as self-insured products play in commercial markets. A self-insured product also potentially has an important role for people with special health care needs. By allowing the Department to contract directly with select specialty provider networks to serve (or augment the services provided to) special populations (e.g. children with a particular disease or condition not easily managed through a commercial health plan), the needs of these populations can be met more effectively and efficiently. Issues that require attention include the development of: appropriate provider networks; adequate data collection and analysis and management expertise, to effectively manage these networks; and, appropriate reimbursement strategies. However, there may be opportunities in the future for the Department to leverage this approach to improve health care delivery.

Consumer Driven Health Care (CDH)

Related to the shift toward defined contribution plans is a trend toward employee-customized benefits and provider networks. According to an article published in Health Affairs[34], so-called "Consumer Driven Health Plans" have become a critical component of major insurer's business plans and could comprise between 15 and 50% of the market in five years.

In consumer driven health plans, employees design their own benefit package and provider network. This is typically done through tiered plans, in which employees choose from among a set of options with respect to benefits, cost-sharing, networks, and utilization, Prior Authorization (PA) referral requirements), each of which is associated with a different price. Because employees are responsible for paying any costs above what their employer pays, and can elect to pay for richer benefits and levels of choice, these plans theoretically encourage more cost-conscious use of health care services.

According to a survey of employers conducted by Deloitte and Touche[35]:

- 11% of employers nationally offer a consumer-driven health plan (as of January 1, 2003).
- 8% expect to offer one by 2004 or 2005.
- 35% are currently reviewing Consumer Driven Health Plans and may offer one in the near future.

- 37% will consider the model if cost-savings and employee satisfaction can be demonstrated.
- Only 14% of survey respondents said they were not considering a consumer-driven option.

Most common with PPOs, CDH is becoming increasingly common among HMOs as well. A survey released in December 2003 by Milliman USA[36] finds that 46 of 79 HMOs operating in the commercial market that responded to questions about CDH plans either have a CDH product or plan to develop some type of CDH approach within the next year. Some HMOs are coupling high-deductible plans with health reimbursement arrangements (HRAs). According to Milliman, HMOs may be able to offer employers lower rates than employers could get through a PPO as a result of the HMOs' tighter networks.

Adapting consumer-driven initiatives for a streamlined program is difficult, largely because many recent incentives in consumer-directed care utilize financial strategies to incent consumers to utilize benefits, services and networks in a cost-effective manner. The fact that cost sharing cannot be applied to health care services for children that receive care under the Title XIX program limits the Department's options for designing and implementing consumer-directed initiatives.

Incorporating one of the more common aspects of consumer driven health care – that is creating financial incentives for making good health care choices – may be appropriate if and when the Department is in a position to evaluate cost-sharing strategies (e.g. increased co-payments for emergency department use). At the very least, however, the Department may want to consider offering extensive consumer and provider education to improve compliance with, and provide incentives for, healthy behaviors and appropriate utilization of services.

Examples of consumer-directed health care incorporated into Medicaid programs include those initiatives in Arkansas, New Jersey, and Florida. They are among the several states – Colorado is another – that have received an 1115 Research and Demonstration Waiver from CMS to participate in a "Cash and Counseling" program for consumers with disabilities.[ii]

The purpose of the demonstration is to assess how Medicaid members would fare in a system that empowers them to buy their own personal and community-based health-care services with defined cash contribution from the state Medicaid program. Unlike the typical private or commercial approach, Medicaid members have the assistance of a consultant to help them make appropriate decisions to purchase care with a cash allowance to buy services.

[ii] This discussion is limited to Arkansas, Florida and New Jersey because these states are participating in The Cash & Counseling Demonstration and Evaluation Program. The national program office for Cash & Counseling is housed at the University of Maryland Center on Aging and is sponsored by The Robert Wood Johnson Foundation and the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

In order to be eligible for the Cash and Counseling program, a Medicaid member must meet age and eligibility requirements, and must be in need of personal assistance services. Each enrollee receives a cash allowance based on the level of assistance needed. Since the program must be budget-neutral, the cash allowance is generally equivalent to the value of the services that would otherwise be purchased by the state on the individuals' behalf. The state also provides a fiscal intermediary to write checks, pay any necessary taxes, and handle related paperwork.

The Florida program is the most extensive, with cash allowances being provided for all of the covered under the state's Section 1915c waiver for home and community-based services. Populations eligible to participate in the program are:

- Frail elders (ages 60+);
- Adults (ages 18–64) with physical disabilities;
- Children (ages 3–17) with developmental disabilities; and,
- Adults (18–64) with developmental disabilities.[37]

According to an evaluation of Florida's program, performed by the Mathematica Policy Research, satisfaction rates among participating members are very high. An interim report based on a survey of 231 of Florida's 2820 initial Cash and Counseling participants found that 99 percent were "satisfied with their relationship with their caregivers" and that, of those, 96 percent were "very satisfied."[38] Studies of participant satisfaction rates in the Arkansas and New Jersey experiments found virtually identical results.[39]

More time and further study is necessary to assess the impact of "Cash and Counseling" on health outcomes and cost; such studies are currently underway. However, the interim evaluation of the Arkansas program conducted by Mathematica showed that participants indicated fewer unmet health care needs than did non-participants, as shown in Table 3, below. [40]

Table 3: Interim Results of Arkansas "Cash and Counseling" Program

	% of participants indicating unmet need (age 18-64)	% of non-participants indicating unmet need (age 18-64)
Personal Care	26%	41%
Household Activities	41%	56%
Transportation	27%	46%
Routine Health Care	27%	32%

The researchers concluded the following, using survey and Medicaid claims data for 2,008 adults randomly assigned to "treatment" (participating in the program) or "control" (not participating) groups:

- The program increased the receipt of paid care but reduced unpaid care.
- Those enrolled in the program (the "treatment" group) had higher Medicaid personal care expenditures than those who were not enrolled (the "control" group).
- By the second year after enrollment, lower spending for nursing home care and other Medicaid services offset higher personal care expenditures. [41]

According to the final report on the results of the Mathematica study of all three states, the "states that have experienced Cash and Counseling firsthand have already decided that they want to make the program available permanently to all eligible Medicaid beneficiaries."[42] Based on this, as well as Colorado's own experiences (which MDF did not study for this paper), the Department may want to consider incorporating some elements of Cash and Counseling for some or all of the populations covered by the streamlined program, specifically the populations that have cost sharing responsibilities.

Conditions in the Colorado Marketplace

Finally, the current structure and composition of the health insurance market in Colorado presents challenges and opportunities for the Department in designing a streamlined program. Therefore, it is important that market conditions are taken into consideration in the design of a streamlined program.

Among specific key characteristics and trends in Colorado (which other states are experiencing as well) are:

- A strong skew toward small groups, with an average group size of 10;
- Significant contraction in the marketplace.[43] For example:
  - The number of groups decreased 15% between December 2001 and December 2002, from 65,590 to 55,607, representing 43,308 lives;
  - A wave of mergers, consolidations and carriers exiting the state has left only ten carriers serving 92% of the market; and,
  - Five carriers dropped out of the small group market, reducing the number of carriers from 30 to 25 between year-end 2001 and 2002;
- Preferred provider plans (PPOs) and health maintenance organizations (HMOs) make up 45 percent and 53 percent of the market, respectively.[44] Enrollment in HMOs has fallen while enrollment in PPO products has increased;
- A move toward self-insuring among large groups;
- A decreased presence of the Small Group Market Basic and Standard health benefit plans from 2001 to 2002. A survey showed that 23 percent of small employers chose the basic or standard plans, while 77 percent selected other plan options.[45]

More significantly, the number of HMOs serving the state's Medicaid program has fallen, with only two remaining plans left – and only one of those on a full-risk basis. By contrast, as late as 2002 five health plans were serving Medicaid.

Given the overall state of the health care market in Colorado, and recent changes in the marketplace, a primary challenge will be attracting qualified plans to participate in the streamlined program. Interviews with health plan representatives in Colorado, and with purchasing coalitions and Medicaid staff nationally, yielded insight into concerns that may prevent plans from participating, and steps that can be taken to address these concerns: These include:

- Sufficient capitation rates that reflect actual utilization and case mix of the population with particular attention to enrollees with significant medical expenses that may not have a defined special health care need;
- A critical mass of members to allow plans to spread financial risk, diminishing the potentially problematic impact of financial outliers on the plans;
- Relatively stable member enrollment (e.g. a continuous enrollment guarantee);
- Collaborative, business-oriented relationships between with the State and plan;
- Efficient and plan focused administrative processes and procedures; and,
- Consistency between the streamlined program and commercial lines of business, to the extent possible.

These factors were all given serious consideration in the design of a streamlined program as described throughout the recommendations, below.

Detailed Program Design Recommendations

Benefits

The Department of Health Care Policy and Financing intends to provide benefits to enrollees in the streamlined program in an efficient, effective manner that both enhances cost-effectiveness and quality of care. Based on evidence in the literature, and the creation of successful program elements in other states, the Department intends to do so by streamlining, for CHP+ and Medicaid enrollees:

- The actual benefits provided (e.g. a common benefit package); and,
- The management of benefits to ensure appropriate utilization.

Specific recommendations with regard to benefits follow:

Recommendation 1: Provide a common "Core" benefit package, with comprehensive, quality, cost-effective services that fully meet the needs of a majority of children. The "Core" benefits will consist of the current CHP+ benefit package, based on findings described herein.

Recommendation 2: Provide "Core Plus" wrap-around benefits to all children in the streamlined program who appropriately require such services. The "Core Plus" benefit package will consist of full Medicaid benefits *less* full CHP+ benefits, based on findings described herein.

Rationale (Recommendations 1 and 2):

Core Benefits

At the center of the Department's strategy is a desire to provide health care services to all children – those with routine needs and those with special needs – within a single integrated health care delivery system. Such a system would feature a single benefit package that ensures access to appropriate and necessary services to all children in the streamlined program. Without question, the Department will continue to support legal entitlements to benefits under Title XIX.

The Department's vision of a streamlined program with a common set of Core benefits is based on a number of factors. From a purely operational standpoint, streamlining will improve continuity, access and ease of administration for families and children who "bounce" between the CHP+ and Medicaid programs.

The proposed streamlined model seeks to further offer a product that is both sufficiently comprehensive to meet the needs of the majority of children enrolled and attractive enough to insurers in the State who might not otherwise show interest in offering publicly funded health care. Blending the evidence-based strengths of a commercially-oriented SCHIP model with the broader set of benefits available under Title XIX, and employing commercial practices where possible is but one strategy to meet both objectives.

Evidence in the literature, and experience in other states, suggests that "mainstreaming" can improve access to, and satisfaction with, "core" child health services, especially, primary care and dental services.[46] For example, dental penetration rates in Colorado are higher for CHP+ clients than for Medicaid, [47] and a study done in North Carolina regarding Children with Special Health Care Needs, SCHIP, and privately insured programs found that SCHIP parents reported fewer unmet needs for primary care and most specialty care services, as compared to the parents of Medicaid enrollees.[48, iii]

This presumes that any such Core package is sufficiently comprehensive so as to meet the needs of the majority of children enrolled. Based on a careful analysis of Calendar Year (CY) 2001 data performed by JEN Associates of Cambridge, Massachusetts, under contract with MDF Associates, the sufficiency of the current CHP+ benefit package as the Core benefit package for the streamlined population is clear.[iv] Thus, the existing CHP+ benefit package is a suitable basis for the Core benefit package recommended for the streamlined program, as illustrated by the following analysis and data.

[iii] The same study found that SCHIP and privately insured children had more unmet needs than Medicaid beneficiaries for medical equipment, supplies, and therapy services. This latter finding likely reflects coverage limits and exclusions for these benefits under SCHIP and private-insurance.

[iv] A detailed description of the data analysis methodology and results is provided in a companion document, completed by JEN Associates.

The amount of utilization outside of the current CHP+ benefit limits ranges from non-existent to small for both the CHP+ and the Medicaid population, based on an analysis of utilization for both populations relative to the current CHP+ benefit limits. MDF and JEN Associates, who completed the data analysis for this project, will describe the complete study methodology in a companion document. Overall results from the analysis which support the recommendations herein indicate that:

- All children in the study sample utilized less than 20 Outpatient Mental Health visits;
- All children in the study sample utilized less than 20 Outpatient Substance Abuse visits;
- Only 21 children receiving Medicaid benefits in 2001 utilized 30 or more Rehabilitation Therapy Encounters, while only one CHP+ enrollee exceeded this limit;
- Two children receiving Medicaid benefits with psychiatry related hospitalizations required 40 or more inpatient days while three CHP+ children exceeded this benefit limit; and,
- Twenty-one children receiving Medicaid benefits exceeded the $2,000 cap on Durable Medical Equipment (DME), while four children in CHP+ required more than $2,000 in DME benefits.

In addition, the current Colorado CHP+ benefit package, based on the Small Group Market Standard plan, is very comprehensive relative to SCHIP and commercial benefit packages nationally. Moreover, as the current CHP+ benefit package is based on the Small Group Market standard plan, it is one with which health plans tend to have experience administering. Thus, using this as the basis for the Core package is likely to make participating in the program more attractive to plans.

Core Plus Benefits

The creation of a "Core Plus" wrap-around structure, over-and-above a set of common "Core" benefits, further enhances the Department's ability to ensure the delivery of appropriate, cost-effective care. Through a "wrap around" model, "Core Plus" benefits will be provided to consumers with special needs who are likely to require additional care management and coordination, including children enrolled in Medicaid and SCHIP. An analysis of CY 2001 data indicates that CHP+ and Medicaid children with special needs who would be eligible for Core Plus benefits have the following diagnoses:

- Sensory disabilities, including blindness and deafness;
- Cerebral Palsy, including muscular dystrophy and mental retardation;
- Chronic Mental Illness (CMI);
- Physical disabilities; and,
- Neurological disabilities including epilepsy and convulsion disorders.

As discussed in detail in a companion paper,[49] the rationale for implementing a Core Plus model for children with special needs, as defined above, includes purchasing, delivery system, access and benefit management considerations. Segmenting benefits into Core and Core Plus packages permits multiple purchasing strategies for – one for Core and one for Core Plus – that provide maximum flexibility for the Department to negotiate arrangements that encourage plan

participation while ensuring efficiency and cost-effectiveness of care. This approach offers the ability, for example, for reimbursement and benefit management strategies to be tailored to Core and Core Plus populations and benefit packages, respectively. Most importantly, it allows the Department to provide benefits appropriately to those individuals who need them.

Finally, designing the Core Plus package as a "wrap" to the Core package also eliminates the experience of children "bouncing" between Medicaid and SCHIP programs. In a study performed by JEN Associates, under this scope of work, MDF found that over 30,000 children "bounced" between the CHP+ and Medicaid program, resulting in service disruptions, based on small fluctuations in income. The ability to remain in the same program will create a seamless system for families who are burdened by program complexities in the current system. A child will receive the same Core benefit package regardless of whether s/he is a Medicaid or SCHIP enrollee, and will receive additional Core Plus benefits as needed, without having to access services through a different delivery system or health plan.

While Medicaid clients would be entitled to all medically necessary services under Title XIX, the recommended Core/Core Plus structure could provide CHP+ enrollees with access to all, some, or none of the Core Plus benefit package, depending on their special needs status and budget-neutrality considerations.

Recommendation 3: Establish a clear delineation between Core and Core Plus benefits for the purpose of enhancing seamlessness, continuity and administrative simplicity.

Rationale: Because managing the boundaries between benefit packages is a known challenge in administering wrap-around models, seamlessness requires clear definitions of how Core and Core Plus benefits are divided. For consumers, a clear definition of benefits is important to managing expectations. For payers, disputes over payer responsibility can result in cost shifting as well as impediments to access where providers disagree with coverage decisions.

Clear delineation of Core and Core Plus benefits:

- Promotes efficiency and cost-effectiveness of care by ensuring that Core benefits are exhausted before Core Plus benefits are utilized;
- Promotes accuracy in rate-setting and reimbursement; and,
- Increases appropriateness and accountability by ensuring Core Plus benefits are covered only for those members require them.

The rationale for this recommendation is further described under Delivery Systems below, but is included here to acknowledge the importance of *how* benefits are delivered within the streamlined program to the success of the overall effort.

Recommendation 4: Ensure the adequacy, appropriateness, and cost-effectiveness of the Core Benefit Package over time for the majority of children enrolled. Develop and implement a methodology to periodically assess the adequacy and appropriateness of the Core benefit package; develop and implement a methodology to cover additional benefits on an exception case-by-case basis; augment the existing CHP+ benefit package with certain

appropriate, cost-effective benefits that will have the effect of reducing long-term health care expenditures for children who require them, when necessary.

Rationale:

The Department must develop a rational process by which to periodically assess the adequacy and appropriateness of the Core benefit package overall to serve the needs of enrollees in the most cost-effective manner possible. Factors that the Department should include in such an assessment include trends in: health service needs among the population; advances in medical technology; coverage in Medicaid/SCHIP programs nationally; commercial benefit package design; and, the ability of health plans' to effectively deliver and manage specific services.

Under the proposed structure, both research and practical experience administering the CHP+ program indicates that a minority of children who do not qualify for Core Plus benefits may require additional services beyond the Core benefit package.[50] As stated above, based on an analysis of CY 2001 data, only 4 children exceeded the DME benefit limit of $2000. CHP+ and Medicaid children rarely exceeded the duration of benefits provided in the current CHP+ benefit package, recommended as the Core benefit package above.

In cases where individuals have clear needs that are in excess of those services provided in the Core benefit package, such as the need for a diabetic insulin pump which costs as much as $5,000, the Department can improve appropriateness, access and cost-effectiveness of care delivery by establishing a rational process by which to grant these extra benefits. The primary reasons for doing so are:

- Offering a non-covered service may be cost-effective relative to the alternative of denying care. For example, providing physical, speech, or occupational therapies in excess of the 30-visit limit may diminish or eliminate developmental delays and future health care service needs of children.
- Providing justified benefits on a rational basis is becoming more common in Consumer Driven Health Care plans in the commercial market. Such plans are increasingly allowing reimbursement for traditionally non-covered or alternative therapies that are determined to be more effective on the basis of cost or quality in the covered individual's specific circumstances.

Other examples of such services that merit consideration are providing two, rather than one, hearing aids for children with hearing loss in both ears; and, additional substance abuse coverage.[v]

Diabetic insulin pumps: Proper insulin dosing is shown to effectively manage diabetes in both children and adults, resulting in decreased emergency room and inpatient utilization and avoidance of other potentially complicated conditions. Currently, diabetic insulin pumps, which cost approximately $5,000, are not a specific covered benefit and are only covered up to $2,000.

Hearing Aids: Research on adults with hearing loss indicates that individuals who have a hearing loss in both ears and wear only one hearing aid progressively lose much of their ability to recognize speech in the other ear. This phenomenon, called "auditory deprivation," may be a physical deterioration, a psychological condition, or a combination of both. Likewise, studies have shown that the same loss of speech recognition occurs in children, for whom hearing assistance for both ears is crucial to the proper development of speech and language skills as they

Recommendation 5: Apply a single definition of Medical Necessity to all children in the streamlined program, including Children with Special Health Care Needs. Implementation of the definition should be managed through the provision of Core and Core Plus benefits.

The proposed definition, which MDF Associates believes complies with Title XIX requirements, is as follows:

A covered service shall be deemed medically necessary if it is provided in a manner consistent with accepted standards of medical practice, and it is:

- Widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence;
- The most appropriate level of care that can be safely provided to the Enrollee, (when applied to inpatient care, Medically Necessary further means that Covered Services cannot be safely provided in an ambulatory setting; [51])
- Among other less conservative settings or more costly treatment options; and,
- Meets at least one of the following criteria:
  - The service will, or is reasonably expected to
    - Prevent or diagnose the onset of an illness, condition, primary disability or secondary disability;
    - Cure correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability; or,
    - Reduce or ameliorate the pain or suffering caused by an illness, injury or disability;
  - Assists the individual to achieve or maintain maximum functional capacity in performing activities of Daily Living; and,
  - The service or supply must not be experimental, investigational or cosmetic in purpose. Failure to provide the Covered Service would adversely affect the Enrollee's health.

Rationale: The Department wishes to promote access, cost-effectiveness, seamlessness, administrative simplicity and consistency with the commercial market. The proposed definition, which MDF Associates believes is fully consistent with the federal Medicaid definition, supports

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grow and develop. In addition, the cost of cochlear implants (using non-discounted commercial rates which are exclusive of post-surgery therapy) is between $40,000 and $50,000, while the cost of a state-of-the-art hearing aid can range from a few hundred dollars up to $4,000.

Inpatient Substance Abuse Coverage or Eliminating Cap on Outpatient Therapies: There is little disagreement in the literature regarding the "cost offsets" resulting from effective substance abuse treatment; that is, that savings can result from reduced overall health care utilization relative to costs resulting from treatment. The duration of treatment is specifically related to cost-effectiveness; that is, studies have indicated that there may be an economic value of increased lengths of stay in *treatment*, as opposed to an inpatient or residential stay. Therefore, strictly limiting the number of outpatient visits may result in inflated costs, poor outcomes and poor quality overall. Currently, the CHP+ benefit package includes limited coverage for substance abuse. While such limits on benefits superficially limit the State's exposure on paying for substance abuse treatment, the limits may inflate utilization of other services over time.[v]

the Department's goals with regard to the overall streamlined program. In particular, this definition minimizes medical necessity conflicts as it relies on the benefit package to drive benefit decisions, paired with the various elements of the definition as described in the background section of this document.

Delivery Systems

Recommendation 6: Promote seamlessness and continuity of care by utilizing the same provider network(s) for Core and Core Plus benefits, where feasible.

Rationale: In the context of Core and Core Plus benefits, seamlessness and continuity of care are critically important but challenging to ensure. Based on experience in States that offer wrap-around benefits, continuity and seamlessness is a major problem for consumers and providers that must be addressed. Utilizing the same provider network to coordinate the different, but complimentary, sets of services, promotes opportunities to:

- Maximize efficiency by limiting the number of providers and plans the Department must manage;
- Eliminate disparities between members receiving Core and Core Plus benefits; and,
- Reduce the need for inter-plan coordination and referrals, promoting continuity of care, user-friendliness and administrative simplicity.

This approach, as compared to maintaining separate delivery systems for Core and Core Plus benefits, also reduces the need for consumers (and to some extent, providers) to negotiate multiple systems. Based on experience in Colorado and other states, use of a common provider network can ensure consistency of interpretation and implementation of policies and procedures (e.g. the application of a Medical Necessity definition). Ultimately, a common provider network places the delivery of clinically appropriate care, and not bureaucratic or administrative hurdles, at the heart of the system.

Recommendation 7: Develop a series of value-based purchasing strategies to ensure and strengthen the delivery system for the streamlined program. Recommended best practices for value-based purchasing strategies include:

> **7A.** Limited partnerships with vendors that are willing to provide (and will receive) outstanding service in exchange for volume;
> **7B.** An enrollment design that supports volume with limited partnerships;
> **7C.** Use of reasonable, measurable performance-based structure, process and outcome measures; and,
> **7D**. Inclusion of a self-insured product as an enrollment option for consumers;

Overall Rationale: Historically, public payers have asked little of vendors beyond rate negotiations and reporting requirements and comply only with state and federal requirements. In more progressive states, Medicaid and SCHIP directors have made the transition from payer to purchaser, focusing on value for the purchasing dollar. Value Purchasing includes those

strategies and techniques employed to ensure the purchase of high-quality health care, tailored to the specific requirements of the purchaser, at a reasonable cost.

There is general information in the literature about the characteristics of good value-based purchasing strategies. Some are more relevant to, or more easily achieved by, the Department via one delivery system versus another, and as a group they can serve as a checklist against which to evaluate current or proposed strategies. Detailed recommendations regarding key strategies that are relevant to the Department are described below.

The literature notes several factors that are necessary (though perhaps not sufficient) to ensure the viability of a value-based purchasing strategy, particularly by public entities. The most relevant for this discussion are:

- A sufficiently large membership to provide the needed leverage to facilitate change/improvement;
- A relatively sophisticated administrative and systems infrastructure to support data collection and analysis, rate development, clinical quality improvement program, etc.;
- Solid partnerships with stakeholders, including the plans themselves, providers, member advocates, and political leaders; and,
- Adequate reimbursement. [52]

Recommendation 7A: Purchase health care from a limited number of plans, requiring outstanding service in exchange for volume. Offer a market potential of 30,000 to 35,000 wherever possible, while balancing access and choice. Provide an excellent level of service to contracted plans by Department staff.

Rationale: Successful value purchasing requires that the purchaser (here, the Department) have sufficient leverage over contracted vendors. Member volume has been shown to be a key source of leverage that commands attention from vendors. By aggregating purchasing activities among a limited number of vendors, the Department can build strong business relationships with key providers and both require and provide a high level of service.

For example, a volume of 30,000 enrollees may justify the creation of special systems and processes that would simply not be reasonable for 5,000 enrollees. By developing preferred relationships, the Department can maximize the opportunity for vendors to view State business as attractive, given the opportunity to spread financial risk over a large number of covered lives. Ultimately, the Department can better meet its fiduciary responsibility to taxpayers and simultaneously purchase better care for consumers by creating "win-win" partnerships with vendors, with volume as a central element of the relationship.

It is crucial that the Department manage vendors effectively, particularly when a network of preferred high-volume vendors whose ability to function depends, in some part, on the Department's ability to offer a true business partnership – typically found in states that have evolved from the role of payer to purchaser. Based on discussions with plans in Colorado and nationally, vendors are significantly more likely to perform for purchasers if the relationship is

characterized by a business-oriented relationship where the purchaser, in this case the State, truly tries to:

- Listen to and understand the needs of the supplier;
- Share information honestly and openly;
- Discuss opportunities to improve performance, within the purchaser and the supplier organization, in an open-minded fashion;
- Be responsive to the needs and challenges of the supplier; and,
- Manage the relationship in a collaborative "win-win" fashion.

The Department can cultivate a business-oriented relationship, uncharacteristic of most government of operations, by simply working with internal staff to identify new ways of doing business with vendors.

Management strategies to ensure vendors can adequately handle a large volume of enrollees are described under Delivery System Recommendations, below.

Recommendation 7B: Structure enrollment in a manner that maximizes market potential for vendors while maintaining strong access. Require enrollees to select plans or providers within their geographic area, regardless of utilization or special needs. Allow variability in the number of vendors based on market conditions by geographic region.

Rationale: Establishing an effective enrollment system to support value-purchasing activities require careful thought regarding how to balance priorities – access, choice and administrative simplicity – while aggregating volume with committed partners. The literature notes that a purchaser (whether a state Medicaid program, a large purchaser, or a coalition of purchasers) must have alternative health plan options for maximum leverage. Still, an abundance of options precludes the ability to offer any one-plan volume in exchange for increased service and attention.

There is no consensus among experts as to which approach – population-based vs. geographically-based – is superior. MDF Associates believes that a geographically based system better promotes the all-important balance between access, choice and administrative simplicity than does population-based enrollment. Moreover, a population of 200,000 (under a streamlined program) is insufficient to support a population-based system, while a geographically-based approach provides an opportunity to offer a critical mass of membership volume to a few strong partners in exchange for excellent service – service to enrollees and to the Department.

Geographically based enrollment allows the State to:

- Maximize access and network adequacy. Under such a system, the State can conduct analyses regarding the adequacy of providers in any given geographic area (e.g. zip code analysis) and match clients, based on specific needs, to plans and network providers;
- Promote equity across the system for consumers;

- Minimize "split families" that may be forced to enroll in different delivery systems under a population-based enrollment system;
- Maximize choice for consumers, assuming that multiple vendors are available in any one region; and,
- Promote administrative simplicity and flexibility in program administration.

Recommendation 7C: Develop and monitor reasonable, clearly defined structure, process and outcome standards that promote compliance and improvement, based on state of the art practices in the industry. Reinforce performance-based purchasing through incentives and disincentives, such as:

- Bonuses for exceeding quality standards;
- Enrollment volume (e.g. through an assignment process); and,
- Increased or decreased flexibility in plan management/benefit administration.

Rationale: Over time, health care purchasers have become increasingly sophisticated in their efforts to maximize health care purchasing dollars[53]. Nationally, this has resulted in efforts by purchasers to develop measurable standards, and has been supported by the private and public sector alike. [54]

As the agent responsible for financing health care in Colorado, the Department must ensure at the outset, and on an ongoing basis, that vendors are capable of providing quality, cost-effective care to enrollees in the streamlined program. This responsibility is magnified when a plan accepts a large number of enrollees. Given the Department's desire to provide volume to a limited number of vendors, the selection, evaluation of readiness to serve enrollees, and ongoing performance is central to the programs' success.

At the outset, the Department can procure services based on measurable standards of performance. Procurement activities should include review of documentation as well as a detailed and thorough on-site readiness review to ensure that the vendor is truly prepared to serve the population.

On an ongoing basis, a major focus of value purchasing relies upon monitoring plan performance to ensure compliance with, and continuous quality improvement in a vendors' ability meet, the Department's standards. On-site reviews, performance data, and the use of quality improvement goals (in areas of particular concern for the Department) can support compliance and quality improvement efforts. Implementation of consistent network management strategies across all health plans and segments of the delivery system (i.e. self-insured and HMO plans) will ensure value for each purchasing dollar. Such strategies include:

- Provider profiling and performance measurement;
- Utilization management;
- Provider services;
- Provider credentialing; and,
- Provider and member education.

Monitoring efforts are then strengthened by financial and non- financial incentives. In the public sector, Massachusetts has demonstrated measurable improvement in service and quality as a result of managing to performance based standards in both physical and behavioral health, using a variety of performance-based contracting strategies for which vendors are financially rewarded.[55] With respect to physical health, health plans, responsible for meeting quality improvement goals that were designed to promote contract compliance, improved their ability to meet improvement goals by 101% in a one-year period. Plans were rewarded in rate negotiations for the year subsequent to strong performance and service.

Other states, such as New Jersey, are considering using performance incentives to improve Health Maintenance Organization performance and quality in state priority areas, such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) rates.

Recommendation 7D: Maximize competition and leverage by maintaining a self-insured option as a choice for consumers to select among other health plans.

Rationale: One of the strongest arguments for states to develop a strong self-insured program, as exists in Colorado, is to ensure access to members who live in a geographical area not served by an HMO. Some states (for example, Illinois) have in place the equivalent of a Primary Care Case Management (PCCM) program operating only in rural areas that lack HMO coverage, particularly for primary care.

Further, states are beginning to develop a self-insured option (again, largely in the form of Medicaid PCCMs) as a hedge against declining HMO participation in publicly funded programs. Nationally, states need to be more proactive about the following in order to maintain commercial managed care participation:

- Appropriateness of capitation rates paid to plans, particularly for members with disabilities;
- Plan solvency (independent of the Medicaid book of business) and market consolidation;
- Changes in insurance law;
- Attention to the Plan's "business as usual" practices in the commercial market, when designing programs; and,
- Support from states for commercial plans new to serving the Medicaid population.

Further, despite recommendations contained within this paper that address some of these factors, the relative instability of the Colorado marketplace makes the maintenance of a viable self-insured option an appropriate risk management strategy.

A study conducted by Dr. Vernon Smith[56] that examined PCCM arrangements in Medicaid programs around the country confirmed that many states operate Medicaid PCCMs as if they were well-managed HMOs; that is, they are tending to adopt program designs, policies, and procedures that are found in commercial health plans and in some of the better-managed Medicaid HMO programs.

While these factors place additional pressure on publicly funded programs to prepare for the loss of one or more health plans, it also provides an opportunity for greater partnerships and collaboration between the remaining HMOs and the state to innovate in purchasing and delivery system design. According to the Center for Health Care Strategies, many states are reacting to the declining HMO participation by developing value-purchasing strategies. States face a more complex purchasing structure than most private purchasers because they serve populations with more complicated needs and are held accountable to the public for their spending.[57]

Key value-purchasing strategies – necessary for developing and running successful self-insured programs, and resulting in better access, quality and cost-effectiveness – include:

- A sufficiently large provider network to ensure that members have choice and that the state is able to terminate providers that do not comply with requirements;
- The ability of the program to contract selectively with providers who agree to access, quality, referral and data submission requirements;
- Provider performance monitoring and feedback with an eye toward actually improving health care delivery; and,
- Financial or other incentives or disincentives for providers, based on their willingness and ability to comply with requirements.

Additional strategies that the Department may consider over time include:

- Developing new approaches to vendor procurement to stabilize HMO participation;
- Collaborating with other public/private purchasers;
- Developing a long-term vision through extended contracts with HMOs;
- Implementing risk-adjusted payment strategies;
- Financial incentives/disincentives for performance outcomes; and,
- Retaining the right to terminate contracts with plans or providers unable or unwilling to meet purchasing specifications.[58]

Recommendation 8: Offer a tiered case management benefit, provided to children that require services in excess of the Core benefit package. Employ appropriate levels of case management for all enrollees, based on individual need.

Rationale: States, rather than commercial health plans, have led the way in implementing case management programs for Medicaid and SCHIP enrollees. While Case Management is not a covered benefit per se, it is a value-added service made available to SCHIP and Medicaid consumers in some states and can be integral to the delivery of care for low-income populations. Some form of structured case management system is a logical adjunct to other recommendations outlined in this paper, as it supports appropriate, cost-effective care delivered within a streamlined program.

The objectives of the recommended tiered Care Management system are to:

- Ensure the integration of primary, preventive and behavioral health care for the target population by developing systems to coordinate care at the local provider level;
- Enhance the cost-effectiveness of care delivery by managing the needs of consumers in the least-restrictive, most appropriate setting; and,
- Improve outcomes of care related to access, satisfaction and quality of care through integration and care management efforts.

The recommended approach to achieving this goal is to design, implement and manage a system that features a flexible continuum of care management services designed to appropriately meet the needs of consumers. This system includes three key components:

- Targeted Outreach for consumers with minimal or episodic needs;
- Care Coordination for individuals that are at risk for high utilization of services or health care dollars; and,
- Intensive Clinical Management for individuals that require intensive care coordination, likely to include enrollees with special health care needs.

Targeted Outreach (TO) is *focused on short-term problem resolution to assist providers in serving difficult-to-reach consumers, including those with medical and behavioral health issues.* Key features of Targeted Outreach include systems that support the provider's ability to:

- Identify consumers who utilize the care delivery system sub-optimally. Systems to identify such consumers include a variety of data and referral intake and data distribution channels. For example, data is routinely used to inform providers of who requires preventive services and when;
- Triage requests for TO to regional and local agencies (equal to the Single Entry Points in Colorado) which conduct assessment of consumer needs and coordinate the delivery of care as indicated;
- Use established agencies who understand community-based services and strive to address cultural and language issues that act as barriers to care delivery;
- Manage and follow-up on all requests and outcomes of TO services; and,
- Increase the level from Targeted Outreach to Care Coordination (CC) should TO efforts prove unsuccessful.

Care Coordination (CC) features *periodic, intermittent support* provided to consumers and providers with needs outside of the normal benefit package or delivery system. CC efforts are specifically designed to improve the coordination and appropriateness of medical and behavioral health service utilization for consumers. CC support services are designed to prevent decreased function, exacerbation, crises or a need for higher levels of care and are provided *after* clear indication that TO is unsuccessful or upon meeting specific Care Coordination Criteria. CC is also provided to individuals that previously required Intensive Care Management or Care Coordination and are hospitalized (e.g. these factors, in combination, put the individual at-risk for intensive care or utilization of services).

Key features of the CC include systems support the provider's ability to:

- Identify consumers with medical and behavioral health diagnoses in need of periodic, intermittent support;
- Manage, track and follow-up on all CC services for members that meet criteria. CC services are managed by the provider and are delivered collaboratively by the insurer, clinicians and local agency staff, based on a care plan developed for each member;
- Increase the level of Care Management Services to Intensive Clinical Management (ICM), should CC efforts prove unsuccessful. CC provides support to consumers that are discharged from the ICM level of care or are hospitalized and previously received CC or ICM level of care; and,
- Focus on regional systems and service providers.

Intensive Clinical Management (ICM) features o*ngoing, intensive support provided over time* to consumers with a significant persistent behavioral health need. ICM services focus on individuals that require multi-agency involvement. ICM services ensure an emphasis on integration of medical and behavioral care. Coordination is provided on a regular basis, over time, by clinicians. Key features of the ICM system include:

- A regional multidisciplinary team approach including: member, caregivers, PCC, specialists, and an ICM Clinician;
- Management, tracking and follow-up on all ICM services for members that meet ICM Criteria. ICM services are aggressively managed by the provider and delivered collaboratively by the insurer, ICM Clinicians and local agency staff; and,
- Develop, implement and monitor an Individualized Care Plan (ICP) for each member with special needs.

Recommendation 9: Develop an enhanced screening system featuring child development services to CHP+ and Medicaid enrollees. The offering of child development services relates to how Colorado manages the actual delivery of care, as well as the benefits provided. NOTE: The actual "benefits" provided as part of this service, as well as what Medicaid would or would not cover, are unclear. This requires further investigation. Also, how this service delivery structure would differ from current developmental services provided in Medicaid and CHP+ requires further investigation.

Rationale: Child Development Services is a growing area of interest among states. Among the reasons for this interest is the potential for lowering costs while improving outcomes for children with a need for such services.

Where there is no general agreement as to what constitutes "Child Development Services," there is general agreement that such services relate to children's needs in the first two years of life, and include: 1) screening and developmental assessment; 2) health promotion; 3) developmental interventions; and 4) care coordination.

One particular Child Development Services program, North Carolina's "ABCD Project," calls for the integration of developmental screening and surveillance into well-child visits in pediatric and family practice offices. Children with developmental issues are then provided with case management, specifically if the parents express concerns about their child's development. While the Department believes that providers generally screen for developmental delays, this program suggests a rigorous screening process with detailed assessments and referrals when required.

The program is in its early stages of development but offers positive preliminary results regard cost-effectiveness. The percentage increase in hospital and emergency room services is 50% lower for a group of children that received child development services, as compared to children who did not. According to the Center for Health Informatics and Statistics, the net-savings generated from reducing hospital admissions for individuals under age 21 was $2.5 million annually.[59] The program also reports improvements in documentation of asthma staging and action plans to address the needs of asthmatics.

Given the success of this program, as well as the trend among other states toward providing Child Development Services, implementing such services to children enrolled in the streamlined program merits consideration.

Recommendation 10: Review prior authorization and referral requirements to ensure cost-effective, quality driven processes to manage service delivery.

Rationale: A review of trends in the commercial market indicates that prior authorization and referral processes are being eliminated nationally to support ease of administration; however, commercial plans have the benefit of using *different* types of controls, most notably cost sharing. Therefore, the Department may wish to periodically review where services are used excessively and require prior authorization procedures and where other services may merit the elimination of prior authorization.

Reimbursement

Recommendation 11: Employ full-risk capitation to compensate providers for services within the Core benefit package, to the extent feasible, given market conditions, in order to minimize risk and achieve predictability of health care expenditures. Maximizing full-risk capitation depends on the Department's ability to:

- Adopt commercial business practices, to the extent practical;
- Develop business-oriented relationships driven by value purchasing;
- Minimize incentives to cost-shift;
- Maximized incentives to provide an appropriate level of care; and,
- Pay adequate rates that clearly delineate responsibility for Core and Core Plus benefits.

In theory, Core Plus services can be paid for either on a fee for service basis, or through a separate capitation arrangement. Regardless, both instances call for payment of services through a mechanism that is separate from Core services. This is at the heart of the Core-Core Plus structure – enabling the department to blend the best features of a private and public sector

approach to health care delivery by piggybacking onto existing commercial health plans to the extent possible (through one benefit package and associated reimbursement structure) while ensuring that Medicaid members and members with special health care needs receive the service that they need.

According to a Rand study authored by Moira Inkelas, reimbursement arrangements that carve-out specific services from medical care contracts indicate that providers may change their behavior when "an individual receives care from more than one provider, institution, or payer, and when responsibilities for care are difficult to clearly define among providers. This may be particularly likely to occur for children with complex medical conditions, because of the inherent difficulty of dividing responsibility for their care."[60] However, the nature and magnitude of the behavior change is difficult to quantify.

While some states provide wrap services through a separate capitated program, in most cases, these are *categories* of services (e.g. behavioral health care, dental) as opposed to individual services. Creating viable programs for categories of services would be extremely challenging, in terms of developing appropriate rates, coordinating care and administering benefits within the system and the provider network.

The Rand study notes that a policy compromise that may achieve the best of fee-for-service and of prepaid health care involves a combination of these approaches. Such an arrangement places an organization at financial risk for some services but would handle other services sensitive to selection or underutilization problems under a different financial arrangement. However, this approach may create an incentive for the inappropriate (or premature) use of Core Plus services.

Recommendation 12: Reimburse Core Plus benefits in a manner that minimizes cost shifting and maximizes coordination and continuity of care. Additional research and analysis currently underway by MDF Associates needs to be completed before a definitive recommendation can be made with respect to how Core Plus services should be reimbursed. This recommendation will drive the selection of the method to minimize the State's exposure and ensure quality.

Network Management

Recommendation 13: Contract for an integrated Administrative Services Only (ASO) product for the self-insured network to administer the self-insured program as any other contracted managed care plan. Network management, risk-based reimbursement, management and limited quality bonuses should all be included in management efforts.

Rationale: Some states have chosen to contract out the management of their self-insured programs rather than manage them in house. Doing so makes sense when the state lacks the FTEs, or the technical infrastructure to adequately manage the plan, *as a plan*. At a minimum, the State should consider functions such as network management, risk-based reimbursement and limited quality bonuses. Still, there are attendant costs involved.

Consistent with this vision, Massachusetts uses many of the same value purchasing strategies for its self-insured product as it does for its Health Maintenance Organizations, striving to achieve a

level playing field between the two. The Primary Care Clinician Program (the state's self-administered PCCM program) has an extensive Performance Improvement Management Services (PIMS) program, including a Regional Network Management program that provides both concrete supports and incentives to providers to improve performance across a range of performance standards.[61] This network management function has been contracted out to a private vendor, while the state retains control over the administration and management of the program overall. The state and the vendor have developed a strong collaborative relationship, working closely together to develop and manage a wide variety of network management programs.

According to the vendor, the Massachusetts Behavioral Health Partnership, the result has been measurable improvements in both cost and quality.[62] For example:

- Providers with panels over 200 providers that were subject to network management activities within the PCCM performed better than unmanaged providers on HEDIS measures such as Well Child Care, Cervical Cancer Screening and Breast Cancer Screening.
- A majority of providers showed significant ability to accomplish data driven improvement plans, managed by the Partnership.

Network management, risk-based reimbursement and quality incentives can all serve to improve quality and cost-effectiveness of care delivery over time.

Attachment 1: Assumptions and Guiding Principles

Assumptions for the Development of a Streamlined Program

Key assumptions provided to MDF Associates by the Department are as follows:

- *HCPF wishes to write and submit a HIFA Waiver that supports an administratively streamlined CHP+ and Medicaid program.* The program will maintain separate financing for Title XIX and Title XXI for the Medicaid and CHP+ consumers respectively.
- *Underlying financing arrangements and federal match rates will remain unchanged in the streamlined program.* Medicaid and SCHIP clients will continue to have their care financed through Title XIX and Title XXI.
- *The streamlining project will include income-eligible Medicaid clients.* Medicaid clients who qualify for services on the basis of their disability (SSI children's waivers) and/or involvement with the foster care system (foster care, foster-adopt-4E adoption) will not be included in the streamlined program and will continue to receive services under Title XIX. The following low-income Medicaid aid categories were included in the study and are proposed to be included in the streamlined program: Transitional, AFDC - 4 month extended, Ribicoff, Needy Newborn - MA Mother, Qualified Pregnant - AFDC Need, 1931 Medicaid-only families, Prenatal State Only, AFDC Recipients in Work Programs, Poverty Level Pregnant (BCKC), Poverty Level <6 (BKCK), Qualified Child - AFDC Standard, 1931/TANF Families.
- *The Department intends to deliver appropriate, cost-effective services to all children in a streamlined program.*
- *Colorado does not intend to waive the definition of Medical Necessity for Medicaid consumers* and a definition for the streamlined program will be consistent with Title XIX requirements. The definition of Medical Necessity will only apply to those benefits covered under the streamlined program.
- *All streamlined program recommendations are pending budget neutrality and/or cost-effectiveness analysis*.

Guiding Principles

An undertaking as significant as the HIFA waiver generally, and the streamlining of the Medicaid and CHP+ populations specifically, requires considerable thought regarding principles to guide program development. The guiding principles, developed by HCPF leadership with input from key stakeholders are as follows:

1. The streamlined program will be:
    a. Efficient, effective and user-friendly
    b. Administratively simplicity for members, providers/plans and the State
    c. Accountable to Coloradoans
    d. Quality-driven
    e. Managed in a manner that is consistent with commercial practices
2. Integral components of the streamlined program include:
    a. Strong access to care for consumers through an adequate network of providers within a single program for CHP+ and Medicaid consumers
    b. Coordination with public programs and funding mechanisms
    c. Communication and training for members and providers
3. The benefits and related delivery systems under a streamlined program will be:
    a. Adequate (including both preventive and habilitative benefits)
    b. Evidence-Based
    c. Delivered in as "seamless" a fashion as possible
    d. Promote continuity, including a linkage between physical and mental health
    e. Cost-effective
4. The streamlined program will encourage participation by:
    a. Plans (locally and/or nationally)
    b. Providers

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