Health Law and Policy Update: January 12, 2012

This week's updates

Headlines of the week

Governor addresses health reform victories and Medicaid challenges

In a State of the State address delivered Thursday, Gov. John Hickenlooper cited bipartisan efforts to create the Colorado Health Benefit Exchange and said the state "will be ready at the end of 2013 to support small businesses and provide health insurance for 300,000 Coloradans who presently do not have it." Hickenlooper said Colorado has established a model for other states to follow by passing Senate Bill 200 last year, which created the governing structure for the exchange.

Hickenlooper noted that the current economic downturn is resulting in more Coloradans enrolling in Medicaid and said "the costs of Medicaid are not sustainable for the state budget." "We are absolutely committed to bending the Medicaid cost curve", he continued "and pursing strategies that will cut Medicaid costs." Among the strategies he mentioned that would lead to controlling health care costs are moving "away from the expensive fee-for-service system to one that drives towards value and rewards healthier outcomes." He said the state has "started to make progress by focusing on preventive care, reducing obesity rates and improving the technology that links people to services." In addition, he said "we are tackling fraud, overpayments and eligibility."

Regarding the Colorado Benefits Management System (CBMS), the Governor said the state has been working with "local governments to bring the Colorado Benefits Management System in to the 21st century." CBMS is the computer system that manages public programs such as Medicaid and food stamps. Still, he said, more work remains and additional funding will be needed to "ensure that eligible Coloradans can access benefits in a timely manner."

The text of Hickenlooper's address is on the state's website.

Medicaid the top priority for CCLP's Health Care Program this year

While it's always fair to examine how a program is working and whether it can be improved, the Colorado Center on Law and Policy is troubled by the idea advanced by some lawmakers that Medicaid is in competition with other important programs, particularly education. Colorado kids need to be educated and they need to be healthy. And a lot of children in Colorado are healthy because of Medicaid.

During the next few weeks, CCLP will examine legislative proposals to change the Medicaid program and explain why funding the program through block grants doesn't make sense for Colorado. CCLP analysts will continue to follow the state budget, looking at what proposals might reduce costs and create efficiencies, and what proposed cuts would harm clients and raise health care costs.

CCLP products, including Health Law and Policy Update, will talk about why Medicaid is structured the way it is, what purpose it serves in the broader context of the health care system, and the critical role it plays in serving the needs of vulnerable children, seniors and people with disabilities.

Look for a piece next week setting out the history of Medicaid and discussing the role the program plays in serving the needs of the most vulnerable. Later, CCLP will explore Medicaid's role in supporting the health care system in Colorado and its effect on the state economy. Throughout the legislative session CCLP will analyze budget proposals and bills that affect the program. Please join us in learning about Medicaid and the contributions it makes to our state.

Lawmakers aim to cut Medicaid costs while improving care
Medical providers would work with the Department of Health Care Policy and Financing to test programs to restructure Medicaid payments under a proposed bill announced this week at the state Capitol.

The measure is sponsored by Rep. Dave Young (D-Greeley) and Rep. Mark Ferrandino (D-Denver) who described the proposal as an attempt to provide better care for Medicaid recipients while reducing costs. The test programs contemplated in the measure, they say, would move away from a fee-for-service model, where providers get paid for each medical procedure, to a "global payment" model.

"The 'fee for service' model is outdated," Young said, according to a report by Colorado News Agency. "Moving toward a global payment, integrated delivery system will ensure that physicians are getting incentives to provide quality of care rather than quantity of care."

CCLP will follow the bill and provide analysis after it's introduced.

Colorado organizations selected for new CMS programs
Physicians Health Partners (PHP) has been selected as an accountable care organization (ACO). An ACO is a group of providers and suppliers of services that have agreed to a system of shared governance and work together to coordinate care for patients. The Denver Post reported on the selection Monday.

The selection is important because it includes a Colorado organization in one of the demonstration projects under health reform designed to explore ways to contain costs in health care. PHP will be the accountable care organization and therefore manage care for Medicare beneficiaries and help hold down the costs of their care.

Thirty-two organizations across the United States have entered into contracts with the Centers for Medicare and Medicaid Services (CMS) as part of a new Medicare program designed to reduce costs and improve the quality of care for seniors. PHP will be eligible to receive from CMS a share of any savings. PHP is hiring nurses and social workers to serve as care coordinators for Medicare patients. The organization is also investing in software to track patient activities, including hospital discharges, tests and procedures and prescriptions. Those efforts are designed to prevent avoidable problems such as overmedication and hospital re-admissions.

In addition to participating in the Medicare ACO Program, PHP is a partner in the Colorado Community Health Alliance, which has been awarded a Regional Care Collaborative Organization (RCCO) contract, through the Accountable Care Collaborative (ACC) Program. The ACC Program is a payment-and-delivery-reform effort in the Colorado Medicaid program and is similar in many respects to the Medicare ACO Program. The inclusion of PHP in both programs could help align the payment-and-delivery-reform models being developed across the state. By creating common incentives and operating practices, it will become easier to gain the provider and consumer buy-in necessary to achieve effective systems reform.

Another Colorado organization, the Center for Improving Value in Health Care (CIVHC), has also been working toward payment and delivery reform, with a focus on moving private insurers away from the fee-for-service model of payment. Dr. Jay Want, chairman of the CIVHC board, was selected to be part of the CMS Innovation Advisors Program.

He is among 73 people from 27 states and the District of Columbia who will work with the CMS Innovation Center to test models of health care delivery in their own organizations and communities.

"The initiative will help health professionals deepen skills that will drive improvement to patient care and reduce costs," CIVHC said in a Jan. 4news release.

Other Coloradans selected for the program include Erin Denholm of Centura Health, Daniel Johnson of Kaiser Permanente and Candice Lagasse of the U.S. Air Force 460th Medical Group. Details about the Innovation Advisors Program are on the Centers for Medicare and Medicaid Services website.

The selection of Colorado organizations to participate in the programs gives the state an opportunity to be a national leader in payment and delivery reform. Successful reform could significantly lower health care costs and improve the quality of care delivered throughout the state. It will be important for the organizations to coordinate their work and create a unified payment-and-delivery-reform effort, which can gain the support of stakeholders throughout Colorado.

Premium increases in five states were 'unreasonable,' government review finds
The federal government has used authority granted under the Patient Protection and Affordable Care Act to find health premium rate increases in five states "unreasonable." The finding applies to proposed rate increases in Alabama, Arizona, Pennsylvania, Virginia and Wyoming, the Department of Health and Human Services announced Thursday.

"Before the Affordable Care Act, consumers were in the dark about their health insurance premiums because there was no nationwide transparency or accountability," HHS Secretary Kathleen Sebelius said in a news release. "Now, insurance companies are required to disclose rate increases over 10 percent and justify these increases."

Sebelius called on Trustmark Life Insurance Company, which had proposed the increases, to "rescind the rates, issue refunds to consumers or publicly explain their refusal to do so."

Since passage of the health care law in 2010, the number of states with authority to reject unreasonable premium increases increased from 30 to 37.

Advancing the debate

Brief examines 'Creating a Usable Measure of Actuarial Value'

Consumers' Union this week released an issue brief examining the policies needed to ensure requirements governing actuarial value in the Patient Protection and Affordable Care Act result in measures that are meaningful and usable by consumers. A summary from Consumers' Union:

The concept of actuarial value plays a large role in the implementation of the Patient Protection and Affordable Care Act. It is a key piece of information that consumers will use to navigate their coverage choices in the individual and small group markets. It is also used to establish minimum thresholds for coverage and to establish premium tax credit levels. In October 2011, Consumers Union convened a panel of experts to discuss several key issues: (1) how actuarial value will be employed under the health

reform law, (2) the definitional and measurement issues associated with its use, and (3) how to craft a measure that is usable by consumers. This brief distills this discussion and identifies the key challenges and issues that regulators must address if actuarial value is to be used effectively under the PPACA.

What's next

Colorado agencies will collect opinions on regulatory approach to creating essential health benefits package

Health care advocates can weigh in on the proposed regulatory approach to establishing an essential health benefits package (EHBP) at a meeting set for Jan. 18, convened by the Colorado Division of Insurance and the Colorado Health Benefit Exchange. The purpose of the meeting is to gather stakeholder input to inform joint comments from the two state agencies to the federal Department of Health and Human Services.

An essential health benefits package, under the Patient Protection and Affordable Care Act, will be required for health benefit plans offered in the individual and small-group markets.

An announcement of the meeting cautions: "This meeting will focus exclusively on the questions we have related to creating a Colorado EHBP, and will not discuss the content of the EHBP, including individual benefits, benefit levels, and cost-sharing structures, as these decisions are still far out on the horizon."

The meeting will be 10:30 a.m. to 12:30 p.m. Jan. 18 in the Mile High Room of COPIC, 7351 E. Lowry Blvd. Participants may also call in at 888-330-9939, PIN# 632148#.