Health Law and Policy Update: January 6, 2012

Join us for Budget Works on Jan. 13, including a panel discussion of federal health care funding issues
Time is short to register for Budget Works on Jan. 13, an annual training presented by the Colorado Fiscal Policy Institute, a project of the Colorado Center on Law and Policy. The event should be of high interest to people concerned about federal health care policy, particularly an afternoon session examining federal health care funding issues.

The session will include Melissa Hansen (National Conference of State Legislatures), Mark Wallace (North Colorado Health Alliance and Weld County Department of Public Health), Andrea Autobee-Trujillo (Office of U.S. Rep. Diana DeGette) and Tracy Johnson (special assistant to the CEO for health reform at Denver Health). Panelists will discuss current conversations and decisions on health care funding at the national level, what other states are doing with their Medicaid programs in the face of federal budget decisions, the potential and real effects in Colorado and the delivery of health care services here, and how to influence the federal decision making process.

The cost is $40. Visit the event website to register today.

This week's updates

Headlines of the week

HCPF budget proposal presents opportunities and challenges
The Colorado Department of Health Care Policy and Financing spent a day this week in front of the Joint Budget Committee presentingresponses to questions raised at last month's budget briefing . The proposed budget contains good ideas, but certain proposals could hurt Medicaid recipients. An examination of some of the issues follows.

CHP+ for state employees: CCLP supports the idea of expanding Child Health Plan Plus (CHP+) eligibility to children of state employees. The federal government made that option available to states for the first time in the Patient Protection and Affordable Care Act, but only a handful of states have taken advantage of the opportunity. While state fiscal impact calculations are not yet available, the option appears to provide an opportunity to save state general fund dollars while offering state employees a robust health insurance option for their children. The Children's Health Insurance Program gives states a two-to-one match for every state dollar spent on the program, although there is a requirement that states taking up the option not reduce their spending on health insurance for state employees below 1997 levels, adjusted for inflation. Find coverage on the federal law offering offering coverage for children of stateworkers from Stateline.

Old Age Pensioners in Medicaid: CCLP is intrigued by the idea of using Old Age Pension Medical Care Funds, which currently support a state-run medical program, to draw down federal matching funds that can be used to make Old Age Pensioners eligible for Medicaid. The Old Age Pension Program is established in the Colorado Constitution and ensures Coloradans older than 60 have a minimum (albeit very low) income, comparable to Supplemental Security Income. There is a medical program associated with the state Old Age Pension program, but it is not well funded, not matched by federal dollars, has limited benefits and typically pays providers a fraction of what Medicaid pays. Using some of the funding for the state-run program to draw down federal matching funds and shifting beneficiaries to Medicaid has potential to improve service for recipients.

Cost containment and reform: Medicaid ought to be focusing attention on cost containment and quality improvement, and the budget submission includes a range of options to do that. CCLP's concern is the department is proposing a large number of projects to realize savings, but it is not clear how state officials intend to integrate the proposals, whether the proposals are consistent with each other, what the effect is on providers and clients, and whether there is sufficient time or staff built in to correct for error and/or accomplish a thoughtful roll out. The briefing documentpoints out the department has not established baseline performance measures for multiple goals outlined in the document.

In addition, the department is very lean and manages a more than $5 billion dollar annual budget with a staff of just 313 full-time equivalent employees (FTE). When asked how many additional FTE it would take for the department to achieve an ideal staffing level, the director said 30 percent. The budget request includes only two additional FTE.

This is a constant dilemma; the budget process looks at a one-year budget cycle and the imperative to balance the budget, however there are any number of large initiatives where it makes sense to move slowly and retool based on the evidence accumulated during a project, but savings may not be realized for several years.

ACC Program: The Department of Health Care Policy and Financing continues to move quickly to implement the Accountable Care Collaborative (ACC) Program and proposes to reduce the cost of medical services for clients enrolled in ACCs by 7 percent compared to those not enrolled in ACCs. Last year, as a result of discussions with the Joint Budget Committee, including staff, the savings projections were reduced by half.

In addition, the department is moving to enroll people who are enrolled in Medicare and Medicaid into the ACC program during the 2012-13 fiscal year. Advocates have questions about potential cost savings estimates that are based on moving a highly vulnerable population into a new ACC program.

As part of its budget proposal for the program, the department introduced two programs designed to move Medicaid in Colorado away from the fee-for-service reimbursement system. The department noted the fee-for-service model rewards providers for the volume of services they provide, and presented the ACC program as an opportunity to move toward a system that promotes quality of care.

The first proposed program would provide "gainsharing" incentive payments to providers. Clients will be assigned to providers, based on where they have previously received care, and assigned a risk score. The department will calculate expected baseline expenditures for those clients, based on historical cost data for similar patients. If the actual expenditure for the patient is less than the expected baseline, the assigned provider will receive a share of the savings.

The second proposed program, based on the Medicare Prometheus model, would use bundled prospective payments to pay for physician, specialty and laboratory care. Providers would receive incentive payments if actual costs were less than projected. The model will not be implemented in Fiscal Year 2012-13, but it will be shadowed throughout the year, to give an estimate of the savings it could provide.

Both programs have the potential to provide cost savings for Medicaid. However, both programs could also create incentives for physicians to limit the use of necessary services to qualify for incentive payments. It will be important for the department to ensure quality is not sacrificed to achieve cost savings in the ACC program.

Medicaid cost-sharing increases: The Department of Health Care Policy and Financing is proposing to increase or add copayments for certain services, including services that are not typically one-time events such as substance abuse treatment, home health, therapies and private duty nursing. The department also proposes changes to the daily co-payment for in-patient hospital stays and for prescription drugs. As

examples, the daily rate for a hospital stay would increase 20 percent (from $10 to $12) and for generic prescription drugs by almost 30 percent, from $1 to $1.30.

For families at these income levels, any increase is likely to be burdensome, especially where the care provided is repetitive in nature. The department also proposes to increase copayments for non-emergency use of the emergency room, but to do that the state must get permission from the federal government, which requires the state to demonstrate people have access to non-emergency services. In addition, the state proposes to charge co-payments to populations that have traditionally been exempt from co-pay requirements, including children. The co-payment discussion raises a number of issues.

First, as background: In Colorado parents of Medicaid-eligible children are eligible for Medicaid if their family income is less than 100 percent of the Federal Poverty Level (FPL), $22,350 annual income for a family of four, and children and pregnant women up to 133 percent, 29,726. Certain groups (such as children) and certain services (such as preventive care) have been exempt from cost-sharing requirements. People with incomes of less than 100 percent of FPL have typically been entitled to receive services regardless of whether they present at a provider's office without a co-payment.

CCLP's concerns:

1. There is a significant body of research establishing that increasing co-pays for very low income populations reduces the appropriate use of care.
2. The proposal is very likely a back-door rate cut for providers. Medicaid cost sharing is effectively accomplished by reducing payments to providers, who are put in the position of collecting cost-sharing amounts to be paid in full for services provided.
3. People with severe needs should not be at risk of losing access to critical services. Medicaid should not charge co-payments for daily or weekly services such as speech therapy or private duty nursing.
4. It is very troubling that Colorado is proposing to charge children for non-emergency use of the emergency room, since children have historically been exempt from co-payment requirements. CCLP appreciates that the federal government will require the state to demonstrate Medicaid recipients have access to alternative care before imposing the requirement and doubts Colorado can meet that standard statewide.

Medicaid service reductions: This proposal which, the department notes has already been implemented, is to cap skilled home health services at eight hours a day for a General Fund savings of $2,011,640. It might be the most significant reduction in terms of direct effects on clients.

At issue: If people need more than eight hours of skilled home health services, what happens to them when they don't get it? The kind of care includes helping people with things like eating if they have a gastrointestinal tube or have issues with choking, injections, bathing if they have skin break down, transferring from bed to wheelchair if they use a lift, medication when the client is unable to exercise adequate judgment, helping with some catheter needs or bowel programs. What alternatives exist for people who do not receive adequate care? How likely is lack of adequate care to result in hospitalization? How is the cut to home-based care consistent with the department's commitment to enabling people to live in the community?

There are many opportunities as the state examines how to deliver health care services in Medicaid more efficiently. It's imperative that stakeholders are part of the process so efficiency works hand-in-hand to support access, quality and self-determination.

Finally, a great consumer presentation on the importance of one Medicaid program that works for people with disabilities -- the Consumer Directed Attendant Supportive Services Program - is posted on the state's website.

What's new

Colorado Attorney general passes on review of Exempla deal

Colorado Attorney General John Suthers has rejected a call to review adeal transferring control of the Exempla hospital system, saying the matter isn't yet ripe for review. The deal includes Sisters of Charity of Leavenworth Health Systems and the Community First Foundation. It calls for the foundation to receive some $285 million from Sisters of Charity some time in 2014 in connection with arrangements between them allowing Sisters of Charity to take over management and control of Exempla Lutheran Hospital. Suthers' office said final arrangements were not in writing or committed to, and a review would be triggered if and when that happens.

Many hospital errors go unreported, report finds

Hospital staff members across the country regularly fail to report medical errors that harm Medicare beneficiaries, and when they do report the errors hospitals rarely change their practices to avoid harming someone else, a new report finds.

Some unreported problems include medication errors, severe bedsores, infections that patients acquire in hospitals, delirium resulting from overuse of painkillers and excessive bleeding linked to improper use of blood thinners, according to a news account on the report in The New York Times.

"To clear up confusion, Medicare officials said they would develop a list of 'reportable events' that hospitals and their employees could use. In addition, the Medicare agency said, hospitals should give employees 'detailed, unambiguous instructions on the types of events that should be reported,' the Times reported.

The investigation was issued Friday by the inspector general of the Department of Health and Human Services.