Colorado Access Overview

10/19/09

Colorado Access

- Established 1994
  - Colorado, non-profit
  - Public sector health plan
  - Founding/corporate members
    - Colorado Community Managed Care Networks (CCMCN)
      - Majority of FQHCs in the state
    - The Children's Hospital (TCH)
    - University of Colorado Hospital (UCH)/University Physicians (UPI)
    - Denver Health and Hospitals (split off 4 years ago)

Colorado Access Mission

COLORADO ACCESS IS DEDICATED TO THE OPERATION OF A COMPETITIVE HEALTH PLAN DESIGNED TO IMPROVE ACCESS TO NEEDED HEALTHCARE DIRECTLY FOR ENROLLED MEMBERS, AND INDIRECTLY THROUGH ITS PARTNERS, TO ALL UNDERSERVED COLORADANS WITH AN EMPHASIS ON PRIMARY CARE AND THE MAINTENANCE OF THE CONTINUUM OF CARE.

Colorado Access Product Lines

- Current Product Lines
  - CHP+ HMO (Risk)
  - CHP+ State Managed Care Network (ASO)
  - Medicaid Physical Health
    - CRICC (Risk)
  - Medicaid Behavioral Health
    - ABC-Denver (Risk)
    - BHI (ASO)
  - Medicare Advantage (Risk)
    - Dual Eligible Special Needs Plan
    - Behavioral Health Special Needs Plan
    - Chronic Condition Special Needs Plan
    - 2 MA-PD plans
      - Low premium
      - No premium

Colorado Regional Integrated Care Collaborative (CRICC)

5

Colorado Access CRICC Overview

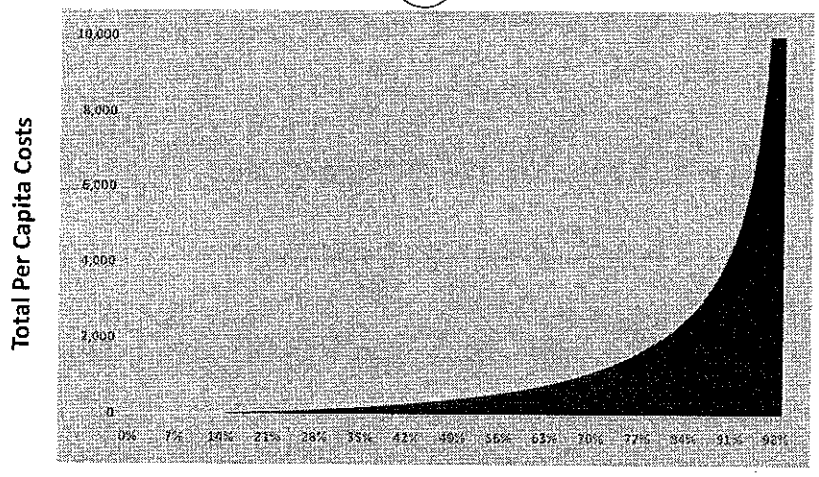
Center for Health Care Strategies Rethinking Care

- **Goal**: Improve quality and reduce expenditures for complex patients in Medicaid who have the greatest potential to benefit from improved care management and integration.
- **Objectives:**
  - Identify, stratify and prioritize "high opportunity" patients;
  - Develop and implement tailored care management interventions;
  - Evaluate the effectiveness of interventions on quality, utilization, patient/provider satisfaction, return on investment, etc., and
  - Realign financing to reward stakeholders

*Colorado Access CRICC- joint project with HCPF and CHCS
**1st in Nation- Rethinking Care now in 8 states

6

Per Capita Medicaid Spending



Source: Sommers A. and Cohen M. *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006

Stated Goals (1)

8

- Improve the quality of care received by Colorado Medicaid's highest-need, highest-cost clients
  - Improve patient linkage with PCP medical home
  - Increase care coordination across systems
  - Provide supports around transitions of care
  - Assist members with self management, system navigation, and psycho-social barriers to care
  - Support patient, family, and PCP in the development of better functioning patient-centered medical homes

Stated Goals (2)

9

- Decrease cost of care
  - Decrease inappropriate ER use
  - Decreased unnecessary specialty care
  - Decreased admissions for Ambulatory Care Sensitive Conditions
  - Decrease hospital readmissions

Pilot Parameters

10

- Non-dual disabled and elderly in certain counties
- Passive (voluntary) enrollment process
- Provider and patient fears of "managed care"
- Provider fears of increasing Medicaid case load
- Member fears of losing existing providers
- Almost any willing provider
- Provider clinic heterogeneity re: internal care management capacity
- Evaluation design (control group)
- Compressed time frame

Clinical/Financial Model

11

- Clinical Model
  - Colorado Access Intensive Care Management
  - Clinic-based medical home with clinic hired case managers/care managers
- Financial Model
  - Capitated risk contract with HCPF
  - Initial enhanced care management funding
    - 3-year Colorado Health Foundation Grant ($1.8 million)
  - PCP medical home contracting
    - Medicaid FFS
    - Plus $8 pmpm for clinic-based care management
    - Plus opportunity for gain share
  - Demonstrate cost-savings and ROI over 3 years

General Population Attributes

12

- 2,357 Members enrolled
- Average age 45
- 57% Female; 43% Male
- Top 5 chronic Conditions:*
  - Diabetes
  - Hypertension
  - Chronic Obstructive Pulmonary Disease
  - Osteoarthritis
  - Asthma
- Patients are expected to cost approximately 3.3 times as much as the average adult Medicaid recipient

*Mental Health Conditions not included (in the BHO data sets)

Utilization Profile

13

Average member:

- 1.2 External Ancillary Services providers
- 0.5 Internal Primary Care providers
- 1.0 Outpatient Hospital provider
- 2.3 Specialty Care providers.

High Utilizers:

10+ Diagnoses	18.6%
10+ Providers	23.5%
10+ Medications	31.4%

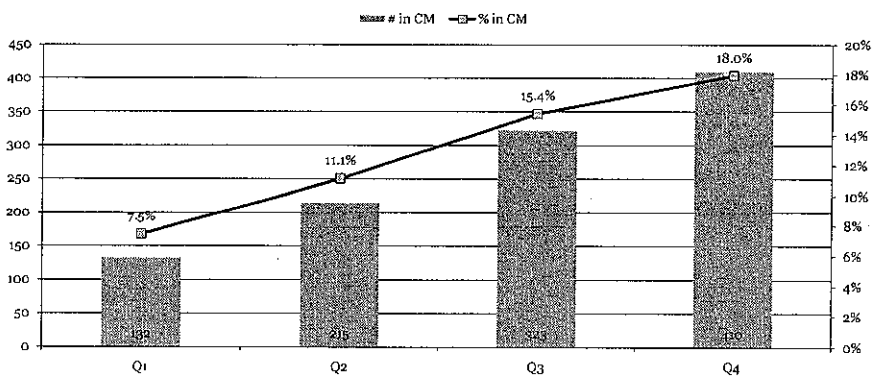
Other Member Attributes

14

- Based on FFS data 50% of population showed no evidence of accessing PCPs prior to enrollment
- Based on FFS/Medicaid technician data, ~30% have no phone numbers and ~50% have phone/addresses that do not generate member response

Care Management Enrollment
Colorado Access Care Manager

15



As of August 2009, 59.1% (107) of the members in the top 20% and 24.4% (576) of the total population are enrolled in Care Management.

Success Story A

16

- 50 year-old female on oxygen, legally blind, diabetes, fibromyalgia, and arthritis.
- History of hospitalization for COPD and high blood sugar.
- Member's care is inconsistent with different PCP each visit; scheduled every two days for blood sugar testing (600).
- After Care Management Interventions:
  - Member no longer on oxygen
  - Blood sugars improved but still high 100s to low 200s.
  - Member's affect is brighter and appears more hopeful
  - Member reporting consistency in PCP care
  - No emergency room or inpatient visits since March 2009

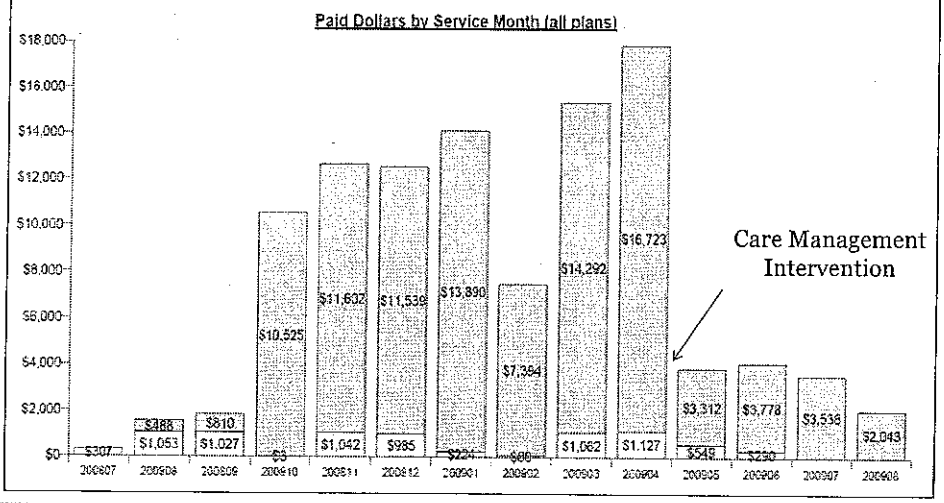
Success Story B

17

- 67 year old woman from Africa, does not speak English, has history of Hypertension, ESRD with 3 times per week dialysis, diabetes, asthma. Limited vision causes challenges in taking medication correctly.
- Assigned to Care Manager in February 2009
- CM intervention: Collaboration with community resources to assist member with medication management and supporting the member in her home environment.
- Results:
  - Member has had zero hospital admissions since enrolled into CM and is receiving additional support
  - Expenses decreased from Oct 2008 thru April 2009 ~$75,000; from May 2009 thru August 2009, ~$12,000.
  - Member reports feeling much better and although still receives dialysis which she will always need, her quality of life is much improved and expenses have been decreased substantially.

Case B Cost Impact

18



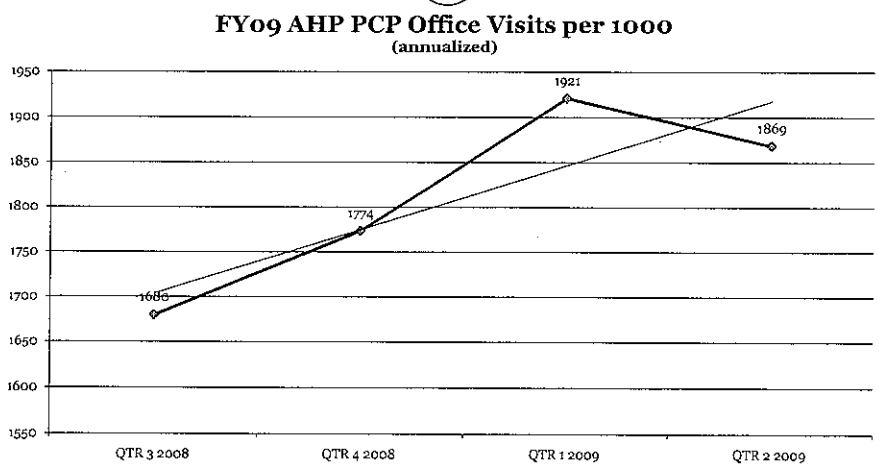
CRICC Preliminary Outcomes

19

- Increased PCP Utilization
  - Overall positive trend experienced to-date as indicated by an increase in PMPM costs
- Increased Pharmacy Compliance
  - Overall positive trend experienced to-date as indicated by an increase in PMPM costs
- Decreased ER Utilization
  - Overall positive trend experienced to-date as indicated by a decrease in ER visits per 1,000
- Decreased Admissions
  - Overall positive trend experienced to-date as indicated by a decrease in admits per 1,000

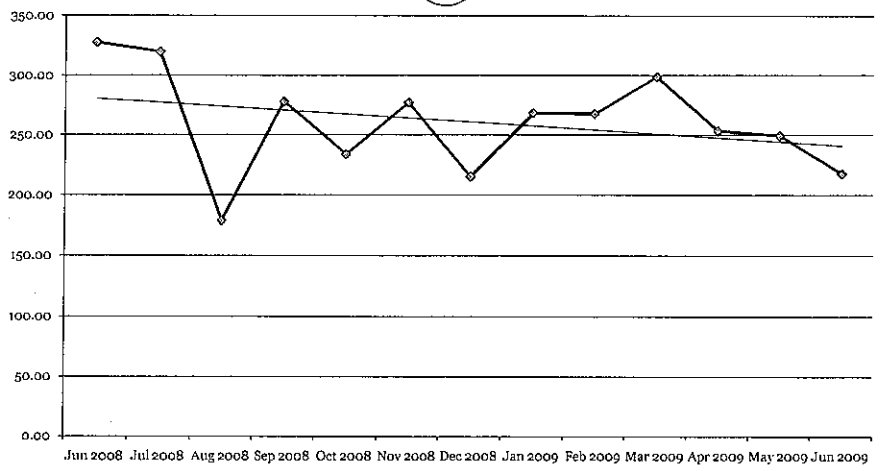
AHP-ECM PCP Visits per 1,000

20



AHP-ECM Admits per 1,000

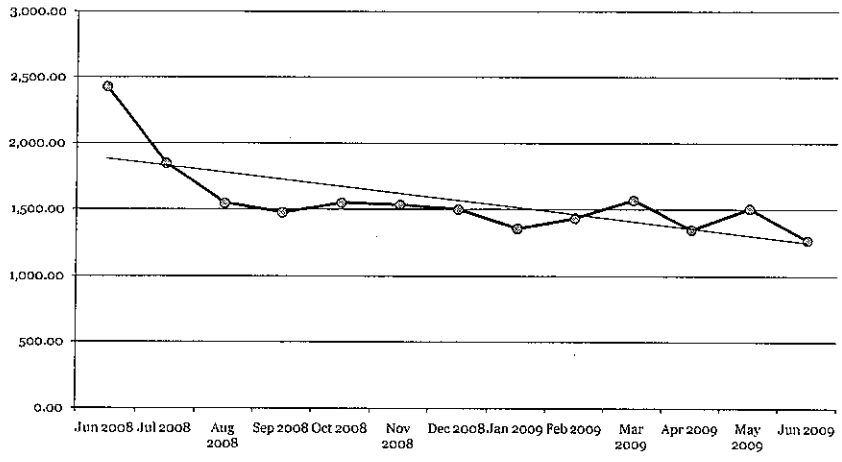
21



Source: MedStat run 10/16/09

AHP-ECM ER Visits per 1,000

22



Source: MedStat run 8/19/09

CRICC Challenges

23

- Contact information for members
  - invalid phone numbers, addresses
  - 10-20 calls per member to find and perform HRA
- Member willingness to engage in Care Management
  - Suspicious of the payer being involved
  - Takes time to develop relationship and affect behavior
- Provider engagement
  - Clinic by clinic
- Linking members without PCPs to medical home
  - Resistance to more coordinated care
- Compressed time frame
  - Initial increase in costs
    - Improved med compliance etc
  - ROI takes 18 months to 2 years to start

Future of CRICC

24

- Pilot started in June '08
- Rates (based on early risk scores) re-established after 3 months
  - Base rate for Medicaid X Risk Adjustment for severity of illness in CRICC population = CRICC rate
- Currently in "rate" negotiations with HCPF for Jan 2010 rates
- Given current financial situation at HCPF, unsure if funds will be available to sustain program