Streamlining the Health Care System: Options for Colorado

A Briefing Paper

December 2003

by
Nellie Hester
Dann Milne
Yondorf & Associates

prepared for
Colorado Coalition for the Medically Underserved

Funding provided by Caring for Colorado Foundation, The Colorado Trust, COPIC, Exempla Healthcare, HealthONE, Colorado Association of Health Plans, and Carol K. Gossard in memory of Dr. Abe Kauvar

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Introduction

Purpose and Background

The Colorado Coalition for the Medically Underserved (CCMU) is committed to ensuring health care coverage for all Coloradans through a variety of public and private mechanisms. Out of a growing concern about the need to improve the efficiency and effectiveness of Colorado's health care system, CCMU has recognized that streamlining the Colorado health care system could free up more dollars for coverage of Colorado's uninsured and underinsured. To that end, CCMU decided to sponsor a conference and summit in November 2003 and another summit in December 2003 to address opportunities to improve the efficiency of all aspects of health care in Colorado. Prior to each summit, participants received a draft copy of this report, which examines 20 options to streamline the Colorado health care system. Summit participants were informally polled to ask for the options they liked best and would like to see CCMU address.[1]

The options fall under one of three main categories: streamlining the delivery and organization of health care, streamlining health care financing and payment systems, and streamlining benefits, eligibility and enrollment. The analysis of each option includes the following information:

- A description of the option and how it works;
- The problem at which each streamlining option is targeted;
- Other states' and/or private sector experience with the option;
- How implementation of the option may free up dollars;
- Notable advantages and disadvantages of the option; and
- What the state can do to implement or further the option.

It should be noted that the purpose of this report is to stimulate discussion on options for streamlining the Colorado health care system. No decision has been made by CCMU on whether or how to pursue any of the options presented in this paper.

Selection of Streamlining Options Examined in this Report

This report does not cover every possible option for streamlining Colorado's health system. In choosing streamlining options to examine for the summit and this report, the following criteria were used:

- Broad interest and appeal of option;
- Concrete findings to support validity of option or option recognized as an emerging best practice innovation;
- Feasibility of option; and
- Timely and topical option.

[1] Please refer to the November 3, 2003 CCMU Conference and Summit Meeting Summary and the December 4, 2003 CCMU Summit Summary and Action Priorities report for further details on the conference, summit activities and voting on options.

In addition to the above selection criteria, the option must have the potential to free up dollars or improve the efficiency of health care in Colorado. CCMU would like to see these savings or efficiencies directed toward expanded access to care. As such, the options included also meet at least one of these criteria:

- Reduce administrative costs so that savings can be applied to increased coverage;
- Improve efficiencies by treating more people with the same level of resources; and
- Increase quality of care in order to provide more efficient, effective care and keep people healthier and more productive.

In a few instances, as noted in the report, specific options were recommended for inclusion by invitees to the November 3, 2003, "CCMU Summit on Streamlining the Health Care System: Options for Colorado."

Some Caveats

The scope of this report is limited to those options that meet the above selection criteria and address health care in Colorado. The options presented here are intended to cover a wide variety of possibilities but still meet the inclusion criteria. Exclusion of streamlining options that are outside of the selection criteria or are more applicable on a national level is not intended to diminish the importance of those options.

Accuracy of the information. Every effort has been made to provide accurate information. We welcome comments or suggestions on the options presented or for considering other options. Please send comments or suggestions to Yondorf & Associates, consultants to the Colorado Coalition for the Medically Underserved, at yondorf@usa.net.

Acknowledgments

This report would not have been possible without the cooperation and assistance of the following organizations and individuals:

Holly Batal, MD, Denver Health
Aggie Berens, Colorado Department of Health Care Policy and Financing
Lynn Dierker, health policy consultant
Mark Earnest, MD, PhD, University of Colorado Health Sciences Center
Susan Gambrill, Colorado Division of Insurance
Pete Gutierrez, Community Health Services, Denver Health
Jonathan Harner, Colorado Department of Health Care Policy and Financing
Ally Kempe, MD, MPH, The Children's Hospital
C.T. Lin, MD, University of Colorado Hospital
Lori Stephenson, RN, Rocky Mountain HMO
John Scott, MD, University of Colorado Health Sciences Center
Cory Sevin, RN, MSN, Clinica Campesina
Sandy Simmons, Indigent Care Coalition, Austin TX
Bill West, Colorado Department of Health Care Policy and Financing

CCMU appreciates the financial support received for this project from **The Colorado Trust** and **Caring for Colorado Foundation**.

STREAMLINING OPTIONS

A. Streamlining the Delivery and Organization of Care

Of the amount spent on health care each year, estimates are that up to one-third is wasted through fragmented, inefficient care that, in some cases, actually causes harm. Research by the Institute of Medicine confirms that the health care system is outmoded in its processes and structures. For example, data show that evidence-based care is delivered only 70% of the time; appropriate preventive care is provided only 50% of the time. Fortunately, there is considerable momentum to redesign health care delivery. A model for streamlining the delivery and organization of care is presented for consideration. In addition, several individual components and options for streamlining are also discussed.

1. Chronic Care Model[2]

What is the Option?

This option offers the promise of streamlining health care delivery by more efficiently and effectively managing care for people with chronic conditions. Seventy-five percent of medical costs are attributable to chronic disease.[3] Of the 100 million people in the United States with chronic conditions, at least half have multiple illnesses, such as hypertension, diabetes, cardiac disease and asthma. Of these, 41 million have limitations on their activities of daily living and 12 million are unable to live independently because of the chronic conditions.[4] A large national employer-sponsored health plan found, "Over 45% of health care expenditures for non-elderly employees are for people with three or more chronic conditions."[5]

The Chronic Care Model (also known as the Planned Care Model) includes several interdependent components, several of which are described in more detail in other sections of this paper. (See section 2--"E-Health," Section 3-- "Appointment Scheduling," Section 4--"Disease Management," and Section 5--"Evidence-Based Medicine.")[6] The components of the Chronic Care Model are:

- Strengthening patient self-management through dedicated staff and resources, including tools to help patients set and monitor goals, patient education, and alternative types of visits and provider interactions (e.g., Internet, email, group visits, patient networking);

- Using decision supports to improve the timing and choices among health care interventions including evidence-based guidelines available at the point of care for both patients and providers;

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[2] This same or a similar model is sometimes also referred to as "planned care" or a "comprehensive care model."
[3] Richard Bringewatt, National Chronic Care Consortium, Web site. www.nccconline.org
[4] "Chronic Care in America: A 21st Century Challenge," Institute for Health and Aging: University of California, San Francisco, prepared for the Robert Wood Johnson Foundation, 1996, as cited on the Improving Chronic Illness Care Web site. www.improvingchroniccare.org
[5] Johns Hopkins, Unpublished Report on Analysis of Claims Data for Large National Employer-Sponsored Health Plan," 2003.
[6] For more information on the Chronic Care Model, please refer to the briefing paper, "Promoting the Planned Care Model: Action Options," prepared by Lynn Dierker, Yondorf & Associates, for the December 2003 CCMU Streamlining Summit.

- Implementing clinical information systems such as electronic patient records and disease based registries or databases to monitor clinical status, generate reminders and care-planning tools, and provide feedback to patients and providers;

- Redesigning the flow of clinical office services including alternative types of patient visits and interactions (such as case management, electronic interactions, group visits), and redefining provider roles for more effective interdisciplinary care teams;

- Realigning organizational goals and strategies and providing leadership to remove barriers to achieve and sustain reorganized delivery systems; and

- Establishing working links with community providers and resources for use by patients and providers, including community sponsored case management, community education and support programs, and resources for assistance with medication and treatment costs.

The Chronic Care Model has been piloted, evaluated and revised and is now being adopted by a variety of health care provider practices and health care systems.

At Which Streamlining Problem is the Option Targeted?

The Chronic Care Model is aimed at reducing inappropriate, fragmented and costly care for a large segment of the population. This approach to care delivery improves care by incorporating enhanced patient involvement and accountability, multidisciplinary care teams, alternative care methods and effective coordination of services.

Other States' and/or Private Sector Experience with Option

- This model and its components are being implemented in provider practices and public and private health care systems throughout the United States and internationally, as well as in Colorado specifically.

- The federal government is supporting implementation of the Chronic Care Model through Medicare Quality Improvement Organizations and an initiative by the Bureau of Primary Health Care.

- Under the California Statewide Collaborative for Achieving Better Care for Asthma, 15 health plans will work with Medi-Cal, providers, and consumers to create pilot programs intended to improve the quality and delivery of care for asthma.

- The Colorado Foundation for Medical Care, the Colorado Department of Public Health and Environment, and the Colorado Clinical Guidelines Collaborative have joined together to offer a diabetes collaborative for interested providers in Colorado. The collaborative provides technical assistance to help providers implement a chronic care model for diabetes care management.[7]

How Implementation of Option May Free Up Dollars

Improving systems of chronic illness care can reduce short-term costs by: reducing symptoms, increasing client functioning, reducing exacerbations, increasing patient ability to manage their own condition, and reducing fragmented, redundant and unnecessary care. Costs can also be reduced by decreasing utilization of emergency departments and hospitalization through more effective health maintenance, and by substituting different types of visits and provider interactions for physician visits.

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[7] For more information, refer to: http://www.cfmc.org/professionals/pro_cdcdc.htm.

Notable Advantages and Disadvantages of Option

+ Research documents that implementation of the Chronic Care Model and enhanced chronic care management reduces health care costs and improves health care outcomes. [8]

+ The Chronic Care Model is not an abstract theory but a concrete guide to improving practice. It can be implemented incrementally in a variety of health care settings. The benefits of the model may be realized within a relatively short period of time (several months to two years).

– To be sustained, changing the approach to and culture of health care delivery requires commitment at all levels of a health care system to redefining roles, relationships and incentives and is a long-term process.

– Current financing and payment structures create barriers to achieving and sustaining new models of services delivery. Higher quality care is not linked to higher payments or increased market share.

What Can be Done to Implement or Further This Option

- The State could develop incentives for Medicaid and state employee health benefits plan providers to develop and use the Chronic Care Model, including revised payment structures that support alternative delivery methods and reward results.

- The State could support a public-private collaboration to provide providers with technical assistance and systems to implement the Chronic Care Model.

- The State could collaborate with providers, plans and the business community to promote the dissemination of education and information on the Chronic Care Model to patients and providers.

- Employers could tie payment for health care to quality performance by the health plans from which the purchase services.

- Professional associations can aid providers in implementing the Chronic Care Model by publicizing the availability of technical assistance and facilitating peer support to change delivery of care.

2. E-Health

What is the Option?

E-Health refers to a wide range of applications of electronic information technology to health care delivery. Examples include comprehensive electronic patient medical records, patient “registries” (databases that track patient records related to specific health conditions), and electronic prescribing systems or computerized medical order entry systems. These options streamline health care by reducing administrative management of paper records, decreasing redundant testing, providing practitioners with complete patient information, improving patient safety by helping to prevent adverse events, and improving quality through analysis of care patterns and outcomes.

The use and importance of e-health technologies is gaining national attention.[9] Properly applied, electronic medical records can improve quality of care and ultimately reduce health care costs. For example, a 1998 study showed that, during a three-month period, 8.6% of selected diagnostic tests at Brigham and Women’s Hospital in Boston performed on a cohort of 6,007 adults appeared to be

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[8] Thomas Bodemheimer, Edward H. Wagner, Kevin Grumbach, “Improving Primary Care for Patients with Chronic Illness,” *Journal of the American Medical Association*, 2002; 288: 1909-1914.

[9] See “Remarks by Tommy Thompson, Secretary of Health and Human Services at the National Health Information Infrastructure Conference,” July 1, 2003, Washington, DC.

redundant. It also showed that not performing the tests would result in an estimated $930,000 charge reduction (actual cost savings would be less). The authors of the study suggest that using a computerized tracking system could reduce the level of redundant testing.[10]

Electronic medical record systems can also create efficiencies in a clinical setting. A cost-benefit analysis of implementing an electronic medical record system in a primary care setting showed an estimated net saving of $86,400 per provider over a total of five years.[11] The new system included online patient charts, electronic prescribing, laboratory order entry, radiology order entry, and electronic charge capture. The prescribing, lab and radiology order entry systems included a decision support function that alerted and reminded providers of potential adverse drug events, alternatives to expensive medications, and appropriate testing guidance. The analysis showed that implementation costs were offset by savings created from reduced chart pull and transcription, reminders generated in the decision support feature, increased billing capture, and decreased billing errors.

At Which Streamlining Problem Is the Option Targeted?

Paper medical records can often be incomplete, illegible, or unavailable when a patient is seeking care, forcing a provider to make decisions with incomplete knowledge of a patient's history. This situation creates inefficiencies within medical care that hinder patient safety and the quality of care, particularly for those with chronic conditions. Increased use of e-health and its application to the medical record can streamline the information available to a provider and thus streamline the care and quality of care delivered to the patient.

Other States' and/or Private Sector Experience with Option

- **Rocky Mountain HMO** has dedicated plan resources to working with primary care practices in their region to implement an electronic patient care registry to track certain conditions, such as diabetes, asthma, coronary heart disease and depression. RMHMO has helped practices integrate the tracking system into their everyday practice and aided practices in the start-up phase of using the registry. The practices are allowed and encouraged to add other patients who are covered by other insurance. RMHMO pays a case management fee to the practices for the RMHMO patients in the registry to compensate for the additional staff time involved with the registry. While the plan doesn't have cost information at this time, improvements in outcomes measures have been documented. It is anticipated that increases in per member per month pharmacy costs will be offset by a decrease in hospital and emergency room visits.[12]

- The **Indigent Care Coalition (ICC) in Austin, Texas**, is a coalition of 12 safety net providers across three counties. With the goal of finding an efficient way to track and document the uninsured going to multiple safety-net clinics, the ICC developed an Internet based Master Patient Index/Clinical Data Repository (MPI/CDR). The MPI allows safety net providers to use a reasonably accurate unduplicated count of the uninsured seeking services for budgeting and planning purposes. The database currently shows approximately 200,000 patients with 240,000 encounters. Patients are asked, but not required, to sign a common authorization form for their medical information to be shared between the safety net providers. The MPI is not a complete electronic medical record but is a "medical snapshot" that allows providers to see patient data, diagnoses, pharmacy data (written but not dispensed), and inpatient, outpatient and emergency room visits. The ICC believes the system will improve the health of the uninsured by improving efficiencies, maintaining or reducing costs, and streamlining the system through reduction in redundant testing and procedures.[13]

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[10] DW Bates et al., "What Proportion of Common Diagnostic Tests Appear to be Redundant?" *American Journal of Medicine* 1998; 104: 361-368.
[11] SJ Wang et al., "A Cost-Benefit Analysis of Electronic Medical Records in Primary Care," *American Journal of Medicine* 2003; 114: 397-403.
[12] Phone conversation, Lori Stephenson, RN, Director of Quality Improvement, Rocky Mountain HMO, September 9, 2003.
[13] Phone conversation, Sandy Simmons, Director of Research and Evaluation, ICC, Austin, TX, September 18, 2003.

- The **University of Colorado Hospital** uses a common electronic medical record for all primary care and specialty clinics and makes the record available in the emergency room and inpatient units. The records include lab, radiology, pathology, and discharge reports. Beginning in the fall of 2003, several clinics will pilot a program that includes a decision support program featuring drug interaction checking and medical necessity checking for labs and radiology orders, among other functions.[14] The University has also used the electronic medical record tool to test a program, System Providing Patients Access to Records Online (SPARRO), allowing patients access to their medical records. Using a secure electronic messaging system, a group of patients with heart failure had access to their physician notes, including laboratory results, and a patient guide for heart failure. While there was no difference detected in utilization rates, there was a trend toward increased patient satisfaction and providers and patients agreed to continue with the program at the conclusion of the study.[15]

- **Denver Health** has an electronic medical records system that links all components of its health care system, including its community health clinics, specialty clinics, school-based health centers, hospital, ambulance paramedics, public health section, and even the jail. Providers throughout the Denver Health system have direct, on-line access not only to patient records but also to clinical literature that can aid in making a diagnosis or identifying best practices.

How Implementation of Option May Free Up Dollars

E-health technologies can free up dollars by reducing spending on administrative costs associated with paper records, decreasing redundant testing, providing practitioners with complete patient information, improving patient safety, and improving opportunities for analysis of care patterns against proven best practices.

Notable Advantages and Disadvantages of Option

\+ E-health systems can improve quality of care, patient safety and patient satisfaction by giving providers a complete medical record at all points of care. Additionally, electronic tracking of laboratory and radiology tests can reduce redundant testing.

\+ Electronic medical records can improve clinic workflow and continuity of care, especially for patients with complex and multiple conditions.

– Some e-health technologies require significant up-front investment of time and money.

– In order to be effective, patient registries must be user-friendly and efficiently integrated into the workflow of a practice. If staff and providers do not find registries useful, the registry will be incomplete and overlooked.

What Can be Done to Implement or Further This Option

- To encourage the implementation of e-health measures, the State could provide resources and incentives for Medicaid providers to use electronic medical records with decision support features and patient registries for the management of chronic health conditions. For instance, the State could pay a case management fee to providers using registries for chronic conditions.

- The State could seek federal or grant funds and/or vendors to provide community health clinics with registry software. An investment in registries to track patients and chronic conditions could re-pay the state through better management and clinical outcomes for patients.

- The State could offer incentives to insurers and providers using e-health technologies through the State employee health benefits plan.

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[14] Email correspondence, from C.T. Lin, MD, Senior Medical Director, Informatics, University of Colorado Hospital, to Nellie Hester, September 9, 2003.

[15] The SPARRO study was funded by a grant from the Commonwealth Fund of New York.

- The State could convene public and private entities to discuss community standards for connectivity for medical records and how best to advance implementation of health informatics.

- Private payers and providers could form a coalition to design secure data transfer standards and then pursue implementation of shared electronic medical records.

3. Appointment Scheduling

What is the Option?

There are several innovative ways to change the nature and process of scheduling medical appointments that result in greater patient and provider satisfaction and more efficient delivery of care. The first is open access appointments, where patients are able to make same-day appointments for an illness, follow-up care, or a physical exam.[16] A patient does not need to call days or weeks ahead of time to make an appointment; the appointment is scheduled for the same day. Typically, a practice needs to offer the vast majority of appointments as same-day access to be successful.[17] The motto for an open access practice is: "Do today's work today." [18]
The second way to improve the efficiency of medical appointments is through group medical appointments. There are three basic models for group medical appointments:

- The cooperative health care clinic (CHCC) group medical appointment, in which care is provided to patients in a group setting on a regular basis. This is well suited to geriatrics clinics, or practices with a large number of patients needing frequent care. The CHCC concept began at a Denver-area Kaiser Permanente geriatrics clinic, originating from a physician's desire to improve care and to help patients more actively participate in their care. Since the inception of the clinic, the program has become a national program for Kaiser and has been used successfully for a wide variety of patient populations and conditions.

- The specialty care clinic group appointment is similar to a CHCC and focuses on specific needs such as well-baby visits, chronic conditions such as diabetes or congestive heart failure, or even a pre-operative clinic for certain procedures.

- The drop-in group medical appointment (DIGMA) clinic is intended for follow-up care and can be used for patients with the same disease or those needing follow-up care in general. The group visits generally include 15 to 20 patients and last up to 2½ hours.

In all cases, the group appointment model allows for individual, private consultations with a physician as well as a group component focusing on patient education.[19]

At Which Streamlining Problem Is the Option Targeted?

Open access appointments and group appointments are targeted at reducing the backlog of patients at clinics and allowing patients to be seen more quickly and efficiently.

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[16] For additional information on open access appointment scheduling, see the Institute for Health Care Improvement Web site. Click on Idealized Design topic under Idealized Design of Clinical Office Practices. http://www.ihi.org/idealized/idcop/index.asp

[17] In some instances, there may be appointments that practices want to schedule, such as procedure-related appointments.

[18] Minden, V. "Improvement Tip: Do Today's Work Today," *Continuous Improvement*, April 2003. http://www.ihi.org/resources/qi/qitips/ci0403tip.asp

[19] Phone conversation, John Scott, MD, University of Colorado Health Sciences Center, Department of Geriatrics, September 19, 2003.

Other States' and/or Private Sector Experience with Option

- The Community Health Services Division of **Denver Health** has systematically launched open access appointment scheduling throughout its clinic sites. To achieve successful intervention, Denver Health analyzed the care flows and processes at each clinic, reduced the patient backlog, redesigned phone access and the scheduling system, and redesigned clinic processes. Approximately 75-80% of appointments are open at the start of the day with the remainder of appointments filled in advance, compared to 75-85% of appointments being scheduled in advance under the prior scheduling system. As a result of the change, patient no-show rates and patient wait times have fallen significantly. The average no-show rate with traditional scheduling was 30-35%; it is now around 10%. The efficiencies gained by using an open access system have improved both patient and provider satisfaction rates. By smoothing the flow of patient visits, provider productivity has gained slightly. Denver Health has also measured a reduction in unnecessary visits as well as improved clinical outcomes.[20]

- A randomized trial of **HMO members in a CHCC** showed that the patients in the CHCC had fewer emergency room visits and fewer repeat hospitalizations and that patients and providers had higher levels of satisfaction with the CHCC visits over regular one-on-one patient visits. The study also demonstrated that per member per month costs dropped by $14.79 for those participating in the CHCC.[21]

- The family practice residency program at **Stanford University** requires residents to learn how to facilitate and manage group visit appointments.

How Implementation of Option May Free Up Dollars

This option frees up dollars through better allocation of provider and clinical practice resources. As the randomized control trial of CHCC patients demonstrated, tangible cost savings can be realized from group appointments. Likewise, open access appointments reduce wait times for patients and optimize resources by reducing missed appointments and better allocating providers and resources to demand. An important but more difficult to measure cost benefit is an increase in provider satisfaction. A more content provider workforce means less staffing turnover and saves an organization in hiring expenses.

Notable Advantages and Disadvantages of Option

+ Open access appointments and group appointments improve office workflow, streamline the system for patients by increasing immediate access to care, and raise patient and provider satisfaction rates.

+ Open access appointments more effectively address acute illness and reduce the number of missed appointments and clinic wait times.

– Instituting an open access appointment system takes considerable planning and staff dedication for it to be successful. Resources must be dedicated to the re-design of the patient flow process. In order to reduce patient backlog, providers and clinic staff must be willing to do more work over several months prior to implementing the new scheduling system.

– Colorado Medicaid does not have a procedure code for a group medical visit and would not pay for care given in a group setting.[22] Fee-for-service Medicare will only reimburse providers for one-on-one time with the patient in the exam room and will not pay for the other services provided in a group setting. Therefore, providers may have difficulty billing for those patients at a group visit who do not need a private visit with their provider.

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[20] Interview, Pete Gutierrez, Operations Coordinator, Community Health Services, Denver Health, September 23, 2003.

[21] Beck A, Scott J, Williams P, Robertson B, Jackson D, Gade G, Cowan P, "A Randomized Trial of Group Outpatient Visits for Chronically Ill Older HMO Members: The Cooperative Health Care Clinic." *Journal of the American Geriatrics Society* 1997 May: 45(5): 543-9.

[22] Colorado Medicaid does pay for some group care such as group psychiatric therapy or group speech therapy.

What Can be Done to Implement or Further This Option

- The University of Colorado Health Sciences Center could implement curriculum requirements in the medical school and primary care residencies to train students and residents in management of group visits.

- The State Medicaid program should review Medicaid reimbursement practices as they relate to group visits. If the reimbursement practices discourage group visits, reimbursement should be modified to reflect private sector reimbursement of group visits with application for a waiver as necessary.

- The state could assist community health centers in implementing open access or group appointments through short-term funding for clinic re-design assistance. The streamlining of access to care that results would provide the state with better use of current funds.

4. Disease Management

What is the Option?

Disease management programs seek to provide streamlined access to more appropriate, preventive services in order to improve the health and control the cost of care for people with chronic conditions. This is accomplished by: identifying and proactively monitoring high-risk populations, helping patients and providers adhere to treatment plans, promoting provider coordination, increasing patient education, and preventing avoidable medical complications. Disease management programs work directly with consumers to give them education, tools and support to manage their health through diet, exercise and medications. Disease management is one of the components of the Chronic Care Model described earlier in this paper (see Section 1).

Many health plans and several state Medicaid programs have recently adopted disease management programs to contain costs and provide better health outcomes. According to the Kaiser Commission on Medicaid and the Uninsured, 21 state Medicaid programs were operating disease management programs in FY 2003. These programs target diseases and conditions that are expensive to treat, affect a large segment of the enrolled population, or result in a large number of preventable emergency room visits. These conditions include: diabetes, depression, coronary artery disease, chronic heart failure, asthma, and hypertension.[23]

Medicaid programs can operate their programs in-house or contract with private disease management organizations. Most programs focus broadly on patient care management, including all medical services and relevant lifestyle counseling for specific conditions. Private vendors hire registered nurses as case managers, adding other professionals as needed, who collaborate with the client's primary care physician on care plans. Other programs use pharmacists to focus on managing pharmaceutical services.

In July 2002, the Colorado Department of Health Care Policy and Financing began implementing a series of disease management demonstration programs in 14 Colorado counties. The conditions targeted are asthma, diabetes, schizophrenia, breast and cervical cancer, and high-risk infants. The Department also has a care management organization program intended to coordinate all of the separate disease management programs. Clients are typically identified for the programs based on high service utilization or high Medicaid claims costs. All Medicaid clients in neonatal intensive care units and in the new Breast and Cervical Cancer Program are targeted for disease management services. Funding for the pilot programs comes from Abbott, Astra Zeneca, GlaxoSmithKline, and

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[23] "State of the States--Bridging the Health Coverage Gap," Academy Health, State Coverage Initiatives, January 2003, p.12.

Pfizer pharmaceutical companies.[24] If these pilot projects prove to be effective, the model could be considered for expansion to other program populations and medical conditions.

At Which Streamlining Problem is the Option Targeted?

Many individuals with chronic illnesses can benefit from streamlined access to services, monitoring, and coordination of care. Disease management programs are designed to contain costs by improving the health of the chronically ill, who account for a disproportionate share of health plan expenditures. The elderly and people with disabilities in the Colorado Medicaid program constitute 28% of the Medicaid population but consume 67% of expenditures.

Other States' and/or Private Sector Experience with Option

- **Florida** operates the oldest and most extensive Medicaid disease management programs among the states. The programs, operated by disease management organization vendors, target asthma, diabetes, HIV/AIDS, hemophilia, congestive heart failure, end-stage renal disease, depression, and hypertension. The asthma program evaluation found that inpatient and outpatient hospital costs decreased by $200 per person. However these savings were offset by increased prescription drug costs averaging $125 per person and program administration costs. "In general, Florida officials believe that the programs have been successful in generating improvements in care quality and expenditure reduction (e.g., unnecessary emergency room visits), but the disease management program costs have generally offset these savings."[25]

- Most state programs "… have not been operational long enough to warrant a quantitative analysis of their financial benefits, ... Savings have not been as large as expected in the short term, but improvements in the quality of care have been seen. Alternatively, states with in-house disease management programs found some success at improving quality of care while reducing expenditures."[26]

- **Clinica Campesina in Lafayette, Colorado** uses patient registries for diabetes, asthma, chronic pain, depression, and prenatal care. The diabetes and depression registries are integrated while the others are independent. The registry allows the clinic to better manage patients' conditions on an individual as well as population based level. On a monthly basis, providers review their patients in each of the registries and determine if any follow-up action is needed, such as a phone call from a nurse or a follow-up visit. On a population basis, the registries allow Clinica Campesina to understand how the clinic as a whole is managing the various conditions and determine if an intervention, such as group visits for a specific need or a mailing campaign, would help patients.[27]

How Implementation of Option May Free Up Dollars

Access to health care services is improved through the focused efforts of disease management programs. The resulting improved health outcomes in patients with chronic illness decreases medical care utilization, especially emergency room, outpatient and inpatient visits.

Notable Advantages and Disadvantages of Option

+ Although Medicaid programs with experience in disease management "… have not found them to be an immediate panacea, they do believe that disease management does provide a longer term direction for state Medicaid programs and a potentially significant cost-saving strategy." [28]

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[24] Colorado Department of Health Care Policy and Financing, "Disease Management Demonstration Pilot--Report to the Joint Budget Committee," February 7, 2003.
[25] Ben Wheatly, "Disease Management Findings from Leading State Programs," State Coverage Initiatives Issue Brief, Academy Health, December 2002.
[26] "State of the States," op.cit., p. 12.
[27] Phone conversation, Cory Sevin, RN, MSN, Clinica Campesina, Lafayette, CO , September 23, 2003.
[28] Ben Wheatly, op cit., p.5.

+ Many health maintenance organizations have incorporated disease management programs for persons with chronic illnesses into their health care delivery systems, including those in Colorado. The Colorado efforts streamlined access to services for children with special health care needs and improved their quality of care.[29]

– Disease management programs have not clearly been shown to be cost-effective. They often require high-cost personnel to run them, who manage limited caseloads. A key to success is intervening at the right time in the disease with less expensive personnel.

– Most disease management programs are designed to focus on a single condition and are not integrated with other chronic conditions a person may have.

What Can be Done to Implement or Further This Option

- The State could carefully monitor and evaluate the existing pilot programs to determine if they are streamlining access to preventive services and providing cost-effective care and, if they are, consider expanding those programs.

- Private purchasers of health insurance, such as employers, could consider linking payment for insurance to disease management programs and the outcome of those programs.

5. Evidence-Based Medicine

What is the Option?

Evidence-based medicine is "…the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[30] Application of evidence-based medicine, determined by scientific evidence, can streamline health care by consistently using what is proven to be the best care for a patient's condition. Ideally, a provider's decisions about patient care are based on the application of current, scientifically proven best practices combined with a provider's evaluation of a patient's condition. However, the provision of medical care is often based on tradition, training or a provider's personal experience instead. Evidence-based medicine is not necessarily about saving money but about providing the most effective care interventions, which may or may not cost more money in the short-term. Evidence-based practices can be adopted on many levels, ranging from providers and clinics to health plan and state or business purchasers.

While evidence-based medicine has gained recognition and is expected to play an important role in health care, it has been slow to take hold in practices in a systematic way and on a widespread basis. On a provider and practice level, decision support tools founded on evidence-based research have the potential to improve patient care and safety and, depending on the intervention, reduce cost.[31] On a health plan and purchasing level, evidence-based medicine can be used as a tool for better management of certain patient populations or for purchasing strategies.

At Which Streamlining Problem Is the Option Targeted?

This option is targeted at the divide between what is considered best practices and what is actually practiced. This affects the quality of patient care and can also affect patient safety. Consistent application of best practices can improve patient care and could result in cost savings in the long term through better management of chronic disease.

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[29] Tracy Johnson, Dann Milne and Carol Rieder, "Improving Service Delivery and Care Coordination for Children with Special Needs in HMOs: The Safety Net Project," Colorado Department of Health Care Policy and Financing, October 2000.

[30] Sackett DL, Rosenberg WMC, Muir Gray JA, Haynes RB, Richardson WS, "Evidence Based Medicine: What It Is and What It Isn't," *British Medical Journal* 1996; 312: 71-72. http://bmj.bmjjournals.com/

[31] Bates DW, Kuperman GL, Wang S, Gandhi T, Kittler A, Volk L, Spurr C, Khorasana R, Tanasijevic M, Middleton B, "Ten Commandments for Effective Clinical Decision Support: Making the Practice of Evidence-Based Medicine a Reality," *Journal of the American Medical Informatics Association* 2003 August 4 (e-pub ahead of print).

Other States' and/or Private Sector Experience with Option

- A bill (HB 1299) recently passed in **Washington** State instructs the state health care authority to adopt health care purchasing policies that are based on scientific and medical evidence. A goal of the legislation is to minimize the financial burden of health care purchased by the state. [32]

- As part of its patient registry quality program with selected providers, **Rocky Mountain HMO** gives providers decision support tools that are modeled on evidence-based guidelines. (For more on the registry program, see section 2, "E-Health"). Some of these guidelines are also summarized and provided to plan members in educational materials.[33]

- **Clinica Campesina in Lafayette, Colorado** is using evidence-based guidelines to develop flow sheets and algorithms for providers to better manage diabetes in their patients.[34] Additionally, the patient information items tracked in the Clinica Campesina registries are tests or measurements that, based on evidence, have been shown to be important indicators for a patient's condition. For example, the diabetes registry tracks a patient's hemoglobin A1C, blood pressure, and last eye and foot exams.[35] These indicators measure how well patients and providers are managing the patient's disease and help to prevent future complications of diabetes.

- **Denver Health** is making widespread use of evidence-based medicine in its electronic medical records system. For example, it has integrated information about the most common risk factors for tuberculosis into the system so that when a provider enters data about a patient that indicate that the patient should be tested for TB, the computer screen gives the provider an automatic prompt to do the check.

- As a company, **Kaiser Permanente** has made a financial and philosophical commitment to evidence-based medicine. As part of the recruitment package, physicians agree to practice by 12 principles or evidence-based guidelines and agree to allow Kaiser Permanente to measure outcomes against these principles. Registries are used to ensure that patients receive the best care based on evidence for conditions such as asthma, diabetes, and heart failure. The drug formulary is also evidence-based and the clinical pharmacology department has on-going initiatives to use medications that offer the best treatment based on evidence and cost.[36]

- The **Oregon** Health Resources Commission has implemented a drug formulary for the Oregon Health Plan created by evidence-based evaluation of selected classes of drugs.[37] (For more information on this program, see Section 11, "Targeting Prescription Drugs.").

How Implementation of Option May Free Up Dollars

Implementation of evidence-based guidelines can create an environment for better patient care and safety through the use of scientifically proven best practices. In some cases an upshot of this benefit is cost savings. A good example is evidence-based research being used to select an effective drug formulary that also contains pharmaceutical costs.

Notable Advantages and Disadvantages of Option

+ Evidence-based medicine guidelines can inform providers of the best practices for patient conditions resulting in better patient care and outcomes.

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[32] State of Washington, House Bill 1299, 2003-2004 Biennium. http://www.leg.wa.gov/wsladm/billinfo/dspBillSummary.cfm?billnumber=1299

[33] Stephenson, L. "Improving Care for People with Depression: Journal of Monthly Experiences," IHI Success Stories. http://www.ihi.org/resources/successstories/ci0301c3d.asp

[34] Curing the System: Stories of Change in Chronic Illness Care, prepared for The National Coalition on Health Care and The Institute for Healthcare Improvement, May 2002.

[35] Phone conversation, Cory Sevin, RN, MSN, Clinica Campesina, Lafayette, CO, September 23, 2003.

[36] Phone conversation, Paul Barrett, MD, Kaiser Permanente, October 14, 2003.

[37] Oregon's Practitioner-Managed Prescription Drug Plan. http://www.oregonrx.org/

– While many providers understand the concept of evidence-based care, it is difficult to achieve broad acceptance and use of these guidelines.

What Can be Done to Implement or Further This Option

- The state could use evidence-based criteria for the purchase of health care on behalf of the state. This would include Medicaid, the state employee health plan, correctional care, and any other health care purchases made by the state.

- The Colorado Medicaid program could assist providers in identifying and implementing appropriate decision support tools to integrate evidence-based guidelines into their practices.

- Colorado could pursue an evidence-based drug formulary similar to that of the Oregon Health Plan. Much of the research already done for the Oregon Health Plan is publicly available and could be applied to the formularies of other states' Medicaid pharmacy benefit programs.

- Private providers could implement evidence-based tools into decision support tools or patient registries.

- Private insurers could base benefit plan coverage and pharmaceutical coverage on research-based evidence and best practices. Purchasers of private insurance could seek out and demand policy coverage based on evidence-based research.

6. Management of Emergency Care Services

What is the Option?

Use of emergency care services for non-emergent situations is a costly and inefficient means for delivering care. The National Hospital Ambulatory Medical Care Survey indicates that there was a 16% increase in emergency room visits nationally between 1996-97 and 2000-01.[38] This increase was explained entirely by non-emergency visits resulting from the following factors:

> Capacity constraints experienced by office-based physicians, combined with a loosening of managed care restrictions, may be contributing to increases in nonurgent ED visits. Other research shows that more patients are having difficulty making appointments with their doctors and more people have long waits for appointment… For uninsured patients, EDs increasingly are one of the few remaining primary care options.[39]

Earlier access to health care and health care information could prevent some emergency room visits thus streamlining the delivery of services and reducing costs. Providers such as Denver Health have realized this and implemented a pediatric and adult walk-in clinic for urgent but non-emergent cases. Not only is the care at an urgent care center or walk-in clinic typically less expensive, but also it allows providers to arrange for follow-up care, such as care through the various Denver Health community clinics. Another option is to provide patients with better access to health care information through phone advice lines. This could be done through a health care information hotline to inform uninsured residents of their health care options based on age, income, and county of residence. Or, as the Denver Metro Chamber of Commerce has recommended, the State could implement a public access nurse advice line for Medicaid and CHP+ patients.[40]

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[38] Cunningham C, May J, "Insured Americans Drive Surge in Emergency Department Visits," Issue Brief No. 70, Center for Studying Health System Change, October 2003. http://www.hschange.org/CONTENT/613/

[39] IBID

[40] Denver Metro Chamber of Commerce. "Medicaid, the Uninsured, and the Impact on Your Business," 2001. http://www.denverchamber.org/chamber/paffairs/Whitepaper.pdf

At Which Streamlining Problem Is the Option Targeted?
Giving patients easier access to other less expensive forms of care could reduce the inappropriate use of emergency care services.

Other States' and/or Private Sector Experience with Option
- **Denver Health** offers a 24-hour a day, bilingual nurse-advice line to its patients. The advice given is protocol driven.[41] One of the major reasons for having such an advice line is to reduce the inappropriate use of the emergency room. Denver Health has found that people using its advice line frequently choose a lower level of health care than they would have without the advice line (e.g., go to a clinic instead of the emergency room). Advice lines also create a new avenue for access.

- **The Children's Hospital** of Denver provides an after hours nurse advice line for patients of the general pediatric clinic. Any Medicaid or CHP+ patients seeing providers at this clinic have access to the advice line. Additionally, many pediatric providers across the state use The Children's Hospital after-hours advice line, which also allows access by Medicaid and CHP+ patients of these pediatric providers.

  The Children's Hospital also offers a parent advice line to patients. The phone line has 250 pre-recorded messages on various subject areas, including prevention, acute illness, and behavior. Providers give their patients access codes to use this service.

How Implementation of Option May Free Up Dollars
Streamlining access to non-emergency services should reduce inappropriate use of emergency services, which in turn should lead to reduced emergency care services and costs.

Notable Advantages and Disadvantages of Option
\+ Nurse advice and pre-recorded advice lines already exist and are widely used in Colorado.

\+ Advice lines are easily accessible and often offer bilingual services making them convenient for most patients and providers.

– Advice lines can be costly to operate. For the most part, insurers do not reimburse for telephone advice.

– Unless advice lines are well-staffed and pick up quickly, a person worried that he needs emergency care will not be willing to be put on hold until someone is available to provide advise. The result may be that advice lines are not as effective as they could be in avoiding unnecessary use of the emergency room.

What Can be Done to Implement or Further This Option
- Colorado could pay for access by low-income uninsured patients who are eligible for the Colorado Indigent Care Program (CICP) to The Children's Hospital, Denver Health or some other existing nurse advice line.

- Colorado could use the existing nurse advice line offered through The Children's Hospital and advertise it to pediatric Medicaid and CHP+ clients who are already eligible to use it.

- Colorado could purchase access to a parent advice line for all Medicaid and CHP+ clients.

[41] Interview, Holly Batal, MD, Denver Health, September 12, 2003.

7. Consumer Directed Attendant Services (Cash and Counseling)

What is the Option?

This option would involve expanding the availability of consumer directed care for Medicaid recipients. Under consumer-directed attendant care (also known as cash and counseling), program participants select, train, manage, and dismiss their own personal care attendants. This program streamlines consumer access to personal care services by letting them decide what services to use, which workers to hire, and what time of day they will come. They may do this with another person or through an organization helping them. They can also hire their own family members, friends or neighbors to provide care at home. This means that they can receive help with personal acts like bathing or dressing from people with whom they are comfortable. They can schedule attendant care in the early morning, nights and weekends, when agency workers are hard to find. In some consumer-directed programs, consumers choose to pay the workers themselves. In others, an "Intermediary Services Organization" handles payments. Intermediary services organizations, also called employer agents or fiscal intermediaries, may perform the following tasks: provide training on worker management issues, assist in worker management, and assist consumers with the paperwork for paying workers (such as time sheets, tax forms and paying workers compensation and Social Security taxes).[42]

Colorado has a small Consumer Directed Attendant Support Program that was implemented in December 2002. The demonstration program is available to individuals with disabilities who are able to direct their own care and who have been receiving Medicaid-funded home health and/or personal care for 12 months. Participation is voluntary and each participant has a case manager to assist with planning and administering attendant support. An intermediary services organization under contract with the Colorado Department of Health Care Policy and Financing provides personnel and financial administration. It serves as the employer of record for attendants, and no cash payments are made to program participants. Each participant receives a monthly amount based on his history of use of

Medicaid-funded home health agency and personal care services. The major innovation in the Colorado program is the addition of home health agency services to personal care services as part of the service package. The unspent portion of a participant's allocation is divided between the state, as cost savings, and the individual participant. The participant may use this savings incentive to cover the costs of other services and equipment to promote the participant's independence.[43] As of September 2003, 57 participants were enrolled in the program. The average monthly allocation per participant was $4,279 (May 2003), with 12% being allocated to the intermediary services organization for personnel and financial management services.

The Department of Health Care Policy and Financing is developing two more consumer-directed programs. The In-Home Support Services program will add a consumer-directed personal care service option to the Home and Community Based Services (HCBS)-Elderly/Disabled waiver program. Based on legislation passed in 2002, the program streamlines access to personal care workers by allowing consumers to direct their own caregivers. This service option has the potential for reaching far more clients than the existing Consumer-Directed Attendant Support program, by giving a choice of service delivery to many of the 15,000 HCBS program clients.

The second program is the Consumer-Directed Care for the Elderly program. The Department recently submitted a federal HCBS waiver application to authorize the program. The program has a three-year phase-in. Consumer access to services is enhanced by eliminating the agency middleman. Colorado could further expand this program by opening the program immediately instead of the planned three-year phase-in. In addition, individuals in the HCBS-Developmental Disabilities waiver program could also be given the choice of personal support services on a consumer directed basis.

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[42] Definitions taken from Web site: www.HCBS.org//glossary
[43] From Web site. www.chcpf.state.co.us/SysChange/cdas

At Which Streamlining Problem is the Option Targeted?

Consumer direction is intended to increase a consumer's autonomy and control of their own services, improve the quality and reliability of attendant support, and decrease the cost to Medicaid for providing the service. It streamlines access to personal care attendant services by allowing consumers to acquire those services directly by hiring their own caregivers. Consumer direction addresses the shortage of professional personal care aides and promises more services for the same amount of money.[44]

Other States' and/or Private Sector Experience with Option

Several states have established consumer-directed programs in the past, including Colorado.[45] The focus recently has been on the Cash and Counseling Demonstration programs, which began in 1998. The U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation sponsor the projects. Demonstration programs have been implemented in **Arkansas, New Jersey and Florida**.

- **Arkansas** used an extensive outreach effort to identify applicants interested in "cashing out" their traditional agency-provided personal assistance services. Applicants were then divided between a demonstration project group and a control group receiving services in the traditional manner. Consumers, with assistance from counselors, developed a plan for using the cash benefits. These funds were used primarily to hire personal care providers, and also to purchase assistive equipment, personal care supplies and non-prescription medications. Almost all consumers used the fiscal intermediary to prepare payroll documents (including federal and state taxes and unemployment insurance) and provide check writing and bookkeeping services. Two-thirds of the participants hired family members to provide personal care and three-fourths lived in rural areas where professional aides are hard to find.[46]

  Arkansas considers the demonstration program a success and intends to allow the control group and other populations to enroll. The program attracted large numbers of consumers, about 10-15% of all people receiving personal assistance services. Client satisfaction was significantly greater in the cash and counseling demonstration group, when compared to the control group, and their quality of life improved. Program fraud and consumer exploitation was minimal, and the few cases were detected and corrected quickly. The strong counseling component is credited for avoiding abuse. The program was designed to be budget-neutral. Preliminary cost analysis shows that demonstration program clients used more care than those in the control group because the controls were less likely to receive paid assistance and received less care than was allowed under the program. In the second year of the program, decreased spending for long-term care Medicaid services and other Medicaid spending (mostly hospital inpatient services) offset the higher level of personal care services spending.[47]

  The existing **Colorado** program differs from the Arkansas Cash and Counseling demonstration in several ways: 1) Colorado participants do not receive cash, but get a monthly allocation of funds which the intermediary services organization uses to pay the attendant for services provided. Consequently, Colorado did not need to obtain an "income disregard waiver" from the Social Security Administration. 2) The Colorado program included home health agency services in the client allocation, because many clients use those services for attendant care. 3) Colorado has a built-in savings incentive in its program.

[44] National Conference of State Legislatures, "State Health Notes," Vol.24, No. 394, April 24, 2003.
[45] Colorado has operated the consumer-directed Home Care Allowance program since 1978, providing services to over 14,000 individuals in 2002.
[46] Barbara Phillips and Barbara Schneider, "Moving to Independent Choices: The Implementation of the Cash and Counseling Demonstration in Arkansas, Final Report," Mathematica Policy Research, Inc. Princeton, N.J., May 2002.
[47] Dale S, Brown R, Phillips B, Schore J, Lepidus Carlson B, "The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas," *Health Affairs*, November 19, 2003.

How Implementation of Option May Free Up Dollars

Consumer-directed care can streamline access to services by reducing an administrative layer and giving consumers direct access to services by allowing them to hire their own personal caregivers. Allowing participants to recruit friends or family as workers expands the availability of caregivers. These programs can also reduce overall program expenditures to free up dollars that can be used to increase coverage. Under Colorado's current program, the fiscal intermediary selected by competitive bid costs 12% of program allocations. This compares favorably with the 34% overhead costs of home health agencies.[48] Costs will be tallied in the program and evaluated at a later date. Even during the start-up phase of the program, savings have been generated.[49]

Notable Advantages and Disadvantages of Option

+ Promotes personal responsibility, self-sufficiency and self-reliance by giving consumers greater control over their lives and greater flexibility in their daily schedules.

– Program critics are concerned about program abuse and consumer exploitation.

What Can be Done to Implement or Further This Option

- The Department of Health Care Policy and Financing could expedite expansion of this option by increasing its outreach and training efforts on the existing Consumer Directed Attendant Support program, by shrinking the planned three-year phase-in of the Consumer-Directed Care for the Elderly to implement statewide all at once, and by expanding consumer-direction to other program populations such as individuals with developmental disabilities.

8. Long-Term Care

[**Note:** This option write-up was authored by an invitee to the CCMU Summit on Streamlining the Health Care System: Options for Colorado, who submitted it for inclusion in this report.]

What is the Option?

Long-term care should be considered as a part of all publicly funded systems, as something that reaches across all ages and all other groups. The state could establish a comprehensive long-term care system that is fully integrated with acute care services as part of a truly comprehensive care system.

At Which Streamlining Problem is the Option Targeted?

The current system is fragmented and lack of coordination leads to increased costs and decreased quality. Colorado has two single entry points for the Medicaid system, but there is no connection to Medicare or private pay. Anyone with a long-term care need that is severe will need Medicaid if that person lives long enough. Adding long-term care insurance into the picture can add further complications. This system is very complex and many who tout themselves as "Medicaid experts" do not understand this system, thereby excluding an entire category of people. Once there is entry into the system, the whole service delivery concept is even more complex. Services are divided into long-term and acute, but in reality many acute services really meet long-term care needs. According to data from the Kaiser Family Foundation, the dual eligible population (i.e., those who are eligible and covered both by Medicare and Medicaid) is the most expensive to serve. However, all efforts at managing care focus on everyone except this population. Colorado could look at long-term care as something to consider as part of all publicly funded systems, as something that reaches across all ages and all other groups.

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[48] Colorado Department of Health Care Policy and Financing, Consumer Directed Attendant Services Section 1115 Waiver Proposal, July 1999.
[49] Personal correspondence from Bill West, CDAS Program Administrator to Dann Milne, August 2003.

Other States' and/or Private Sector Experience with Option

No state has fully implemented this option, however successful pieces of the option are available all over. Programs in **Wisconsin, Massachusetts, Florida** and **Kansa**s stand out as the closest to a comprehensive system. Because the vast majority of long-term care is provided by the public sector, there are no private sector programs that are well known or that truly represent this population.

How Implementation of Option May Free Up Dollars

Currently Colorado spends almost a quarter of the Medicaid budget on nursing facilities. This is for fewer than 10,000 people, an all time low. Colorado provides home and community based services to 30% more clients for less than 50% of the cost. While there may be a need for some institutional care, it should be the last resort. Colorado has made huge strides over the past two years to reduce inappropriate utilization, but could go farther. The Department of Health Care Policy and Financing estimates that if 30% of the current home health population moved to a more appropriate personal care model, the initial savings could be over $4 million. Due to fragmentation and lack of primary and preventative care for persons with severe disabilities, Colorado is constantly paying for preventable hospitalizations. This is due to an antiquated approval system for equipment, a difficult time accessing technology, and the false separation of acute and long-term care. This also stems from providing a limited menu of services with no flexibility and out all-or-nothing system. The savings potential is not known but could easily top $250 million.

Notable Advantages and Disadvantages of Option

+ This option could lead to a better system in terms of quality and cost.

– This is a complex area. Many of those involved in the health policy arena are not interested in this and see it as a side issue rather than a central issue. Also, true streamlining could upset the status quo, including the current entitlement attitude of some providers in the system.

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What Can be Done to Implement or Further This Option

- The State could study ways to make it easier for patients to stay out of nursing homes by, among other things, providing preventive care for persons with severe disabilities and streamlining the approval system for equipment, making it easier to access technology, and eliminating the separation between long-term and acute care.

- The State could encourage nursing homes to ask patients on a semi-annual basis their preferences for level of care in the event of an acute medical problem.

9. Small Efficiency Fixes to Medicaid and CHP+

[**Note**: The small efficiency fixes discussed in this section were suggested by an invitee to the "CCMU Summit on Streamlining the Health Care System: Options for Colorado."]

What is the Option?

In recent years, the Colorado Medicaid and CHP+ programs have operated under very restrictive budgets. Each year the Department of Health Care Policy and Financing looks for ways to reduce expenditures for existing programs and to operate programs more efficiently. With the serious revenue shortfalls over the past two years in Colorado, this belt-tightening took on a new intensity. Many provider groups and consumer advocates joined state staff in recommending ways to reduce expenditures or enhance revenues.

Providers and advocates have recommended several program changes that need to be explored for their feasibility, effect on operations, administrative costs, and client care and outcomes. Examples include:

- Obtain federal financial participation for Medicaid services provided to inmates who become inpatients in hospitals or nursing facilities. The Health and Human Services Regional Office (Region VIII) has said that federal funds are available for such purposes. **Montana** and **South Dakota** have been claiming those funds.

- Pay tiered rates for Medicaid alternative care facilities (assisted living). Tiered rates may result in a reimbursement system that ties payment more closely to care delivered than the single payment rate system now in place. Paying more for high-cost clients would give assisted living facilities incentives to maintain clients with more intensive care needs in their facilities. This approach is similar to the existing case-mix reimbursement system for Colorado nursing facilities, but with only three tiers, it would be administratively much simpler.

- Conduct utilization review for drugs for clients in home and community based services waiver programs. Currently, Medicaid clients in nursing facilities receive ongoing drug utilization reviews. The drugs an individual receives are reviewed for drug interactions. The review could be expanded to community-based long term care clients, who have similar chronic conditions, to look at over-utilization, drug interactions, adverse drug reactions, efficacy and cost. This would provide a systematic mechanism for evaluating effectiveness and costs.

- Merge the Home and Community Based Services (HCBS)-Elderly/Disabled waiver and the HCBS-Persons Living with HIV/AIDS waiver programs. The programs used the same operational infrastructure and criteria. The merger could result in a small reduction in administrative costs.

- Continue efforts to substitute lower-cost community-based care for higher-cost long term nursing facility care. There remain significant opportunities in long term care. The Colorado Nursing Facility De-Institutionalization project clearly demonstrated the feasibility of identifying nursing facility residents and transitioning them to community living. Long term care Single Entry Point agencies were paid an incentive payment to place hard-to-place clients into community living. About 80 clients were identified and returned to community living each year at a net savings of $350,000-$500,000 each year. This program should be expanded and intensified.

- Intensify efforts to substitute lower-cost personal care services for higher-cost home health nursing and aide services. Colorado was ranked sixth in the nation in percent of clients age 65 and over receiving home health agency services in 2001. Most states provide personal care, either as an optional Medicaid service or through an HCBS waiver program. Additional administrative procedures would need to be put in place, but as this substitution may apply to over 5,000 clients, the effort could yield substantial savings.

At Which Streamlining Problem is the Option Targeted?

There exist small streamlining improvements that can be made in Medicaid and CHP+ programs to save money and redirect expenditures to coverage expansion.

Other States' and/or Private Sector Experience with Option

- Many states have implemented strong personal care programs to substitute for higher cost home health agency services. Examples are **Kansas**, **Texas**, **Utah** and **Washington**.

- The **Centers for Medicare and Medicaid** is now giving grants to states to develop and demonstrate various approaches to transitioning (de-institutionalizing) clients from nursing facilities.

- Several states, including **Florida** and **Minnesota**, are working on consolidating waiver programs. The Centers for Medicare and Medicaid Services has been supportive as long as access to services applies equally to all client groups covered by the waiver program.

How Implementation of Option May Free Up Dollars

State staff can explore and implement new ways of obtaining federal funds for Medicaid and CHP+ through these program budgeting and revenue enhancement techniques.

Notable Advantages and Disadvantages of Option

+ Taken together, implementation of the small efficiency fixes described in this section could yield significant savings.

– Analysis of the small efficiency fixes requires effort by state staff at a time when they are spread very thin and the departments have many vacancies.

What Can be Done to Implement or Further This Option

The Departments of Health Care Policy and Financing and Human Services could assess the feasibility and cost saving opportunities of these program options with a goal of redirecting the savings to coverage expansion.

10. Other Delivery and Organization of Care Option

Telemedicine. Telemedicine can streamline the delivery of care by removing the physical obstacle of distance between provider and patient. Technological advances in healthcare under development will one day allow patient care to be managed remotely which will provide patients better access to specialists and better monitoring of their conditions. The State could review its reimbursement practices to ensure they are supportive of telemedicine services wherever they are cost-effective.

B. Streamlining Health Care Financing and Payment Systems

11. Targeting Prescription Drugs

What is the Option?

Preferred drug list programs can streamline the selection and prescribing of the most cost-effective drug choices available. States use a team of researchers and practitioners to evaluate medical evidence on various categories of medications for common conditions and to determine which drugs are clinically cost-effective. The teams use reported clinical findings. "Drugs that are low cost and are proven to be clinically effective are included on the preferred drug list, while drugs not included on the list must be prior authorized, which typically reduces their use substantially." [50]

Preferred drug lists can be used to improve the cost-effectiveness of Medicaid drug programs and generate substantial savings. A program such as this can be coupled with the new federal Pharmacy Plus waiver initiative to extend drug coverage to low-income elderly and disabled populations who do not currently qualify for Medicaid.

The Pharmacy Plus waiver initiative gives states flexibility to design pharmacy benefit packages that differ from the regular Medicaid drug benefit for demonstration populations. States may extend drug coverage to Medicare beneficiaries or people with disabilities with incomes up to 200% of the federal poverty level. Pharmacy Plus programs must be budget neutral to the federal government and provide access to primary care. **Florida, Illinois, Maryland, South Carolina**, and **Wisconsin** have been granted Pharmacy Plus waivers by the Centers for Medicare and Medicaid Services.

At Which Streamlining Problem is the Option Targeted?

Preferred drug lists streamline drug therapy decisions by providing practitioners guidance in determining which are the most effective drugs. Preferred drug lists also streamline the competitive mechanisms in pharmaceutical markets by making pharmaceutical companies sensitive to price.

Pharmaceuticals continue to be the fastest growing segment of the Medicaid program. The Urban Institute reports that Medicaid expenditures for outpatient drugs increased by over 16% annually between 1990 and 2000, from $4.8 billion to $21 billion. Drug costs for Colorado Medicaid increased by 10.95% from fiscal year 2001-2002 to fiscal year 2002-2003.[51]

Other States' and/or Private Sector Experience with Option

Oregon, Michigan and Washington, among others, have adopted evidence-based approaches for providing cost-effective drug therapies in recent years.

- **Oregon** began creating an evidence-based formulary for the fee-for-service portion of its Medicaid program in 2001. The Oregon Health Resource Commission is in the process of assessing the effectiveness of 25 classes of prescription drugs. The Commission selects a reference drug(s) based on which is the most clinically effective drug in the class. Medicaid will cover the cost of drugs in that class up to the price of the reference drug, no matter what particular drug the physician prescribes. If the Commission is unable to find evidence that one drug is more effective than the others, it bases its cost-effectiveness assessment on the lowest cost drug. The Commission places these drugs and others within 105% of its cost on the reference list.[52] Physicians are currently using the reference list as a guide and can still

[50] Academy Health, "State of the States--Bridging the Health Coverage Gap," State Coverage Initiatives, January 2003, p. 26.

[51] Colorado Department of Health Care Policy and Financing, Expenditure History by Service Category. http://www.chcpf.state.co.us/Budget/Med%20Services%20Premiums/Historical%20Premiums%20Expenditures%20by%20Service%20Type.pdf

[52] Ibid.

prescribe other drugs without prior authorization by writing "Do Not Substitute" on the prescription. The Commission has reviewed and implemented five classes of drugs so far. The drug list is estimated to save the state $30 million dollars per biennium.[53]

- **Michigan** adopted a similar evidence-based drug program in 2002. The Pharmaceutical and Therapeutic Review Board is assessing 40 drug classes to determine reference drugs. The reference drugs and drugs priced below them are placed on the preferred drug list. Pharmaceutical companies can lower the price of their drugs to have them added to the list. Drugs not on the preferred list must be prior authorized. State officials report that the program has saved the state about $800,000 per week for Medicaid fee-for-service clients since its phased implementation in February 2002.

- The State of **Washington** implemented a similar program in 2002. The State has appointed a Pharmacy and Therapeutics Committee, has developed a preferred drug list, and is exploring consolidation of best-value drug purchasing across state agencies. The Evidence-Based Practice Center of the Oregon Health Sciences University provided analysis of the clinical studies of 12 classes of the most costly and highly prescribed drugs. The Medicaid program's Drug Utilization and Education Committee became the Pharmacy and Therapeutics Committee, allowing the State to comply with federal Medicaid requirements and to adopt the preferred drug list immediately. Medicaid savings are estimated at about $12 million per year.[54]

- **Massachusetts** has successfully used a preferred drug list and a tiered co-payment system to encourage the use of less expensive medications.[55]

How Implementation of Option May Free Up Dollars

Savings are achieved when substitutions occur from current drug usage to lower-cost, therapeutically equivalent drugs.

Notable Advantages and Disadvantages of Option

\+ Programs in other states have saved millions of dollars while promoting the use of proven, effective medications.

\+ Federal Medicaid law permits using preferred drug lists in this manner.

– Requiring prior authorization for all prescribed drugs not on the preferred drug list can be cumbersome.

– Pharmaceutical companies and representatives of special needs populations and persons with disabilities oppose preferred drug lists and reference pricing.

What Can be Done to Implement or Further This Option

- The State could pass enabling legislation to couple a preferred drug list cost-containment program with a new Pharmacy Plus initiative to extend pharmacy coverage to additional low-income elderly and disabled populations.

- The State could join an intrastate purchasing cooperative to share administrative costs and maximize purchasing power.

- Private purchasers and payers could structure pharmacy benefits in a similar manner to encourage enrollees to select less expensive pharmaceuticals.

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[53] Kathleen Weaver, MD, Reigning in Runaway Pharmaceutical Costs, presented at NASHP's 16th Annual State Health Policy Conference, Portland OR, August 5, 2003. http://www.nashp.org/Files/Weaver.pdf

[54] Letter from Ida Zudrow, Doug Porter, Doug Connell; State of Washington; January 8, 2003.

[55] Kim Gordon, "Colorado Rx: Options for a Prescription Drug Assistance Program for Low-Income Coloradans," Colorado Coalition for Medically Underserved, February 2003.

12. Joint Purchasing and Program Consolidation

What is the Option?

Colorado purchases health care for many different populations across many agencies, including Medicaid, CHP+, corrections, and state employees and higher education, among others. Streamlining and consolidating the purchase of health care across these groups, or just certain benefits such as pharmaceuticals, could reduce administrative costs and improve purchasing power. This could also allow for the consolidation of similar programs, such as indigent care programs, into programs that are easier to understand and easier for the public to access.

At Which Streamlining Problem Is the Option Targeted?

This option is targeted at streamlining the purchase of the array of health insurance benefits currently paid for by the State. Consolidating these purchasing efforts could lead to administrative savings and allow the state to better leverage its considerable buying power.

Other States' and/or Private Sector Experience with Option

- A **North Carolina** lawmaker recently introduced legislation to create an Office of Health Care Purchasing. This office would coordinate health care purchasing for Medicaid, the state children's health insurance program (SCHIP), state employees and teachers, state-run hospitals, and prisons. The intent of the joint purchasing is to give the state leverage in negotiating the costs of benefits. Estimated savings would come from lower reimbursement rates, reducing fraud, and decreasing inefficiencies.[56]

- A newly established **Washington** State health care authority will implement joint purchasing strategies for all health purchases procured by the state. This includes the needs of the Departments of Health, Social and Health Services, Corrections, and Labor and Industries.[57]

- States are joining together to create the Northern New England Tri-State Coalition, a multi-state joint purchasing initiative for prescription drugs. **Maine**, **New Hampshire**, and **Vermont** joined together to issue a Request for Information for a pharmacy benefit manager. The selected pharmacy benefit manager holds a separate contract with each state and manages the prescription benefit for the Medicaid programs in each state.[58]

- In 1999, **Georgia** created the Department of Community Health to coordinate health issues for the state, including health policy, purchasing, and regulation. Providing coverage for over 2 million people in the state, the agency consolidates purchasing for Medicaid, SCHIP and public employees. Through a contract with a pharmacy benefit manager, Georgia has steadily reduced the growth rate for pharmaceutical expenditures, controlling for increased enrollment, from a rate of 26% in FY 2000 to a rate of 5% during FY 2002.[59]

How Implementation of Option May Free Up Dollars

Consolidation of purchasing, and programs as appropriate, could reduce administrative costs and result in better prices through leveraged buying.

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[56] Kane D, "Health Plans Face Revamp, *Raleigh News and Observer*, July 16, 2003. http://newsobserver.com/news/story/2696851p-2500640c.html

[57] State of Washington, House Bill 1299, 2003-2004 Biennium. http://www.leg.wa.gov/wsladm/billinfo/dspBillSummary.cfm?billnumber=1299

[58] Kaye, N. "Affording Prescription Drugs: State Initiatives to Contain Cost and Improve Access." National Academy for State Health Policy, July 2002. http://www.nashp.org/_docdisp_page.cfm?LID=666CB5DC-7948-11D6-BD1700A0CC76FF4C#table1

[59] Georgia Department of Community Health, Department of Community Health Annual Report for FY 2002. http://www.communityhealth.state.ga.us/departments/dch/v4/top/audiences/home/issues/annual_report/dch_annual_02.pdf

Notable Advantages and Disadvantages of Option

+ Streamlining programs and consolidating purchasing would allow for administrative savings as well as simplification of benefit packages and programs.

– This is a large task that encompasses many different departments and populations of beneficiaries. A large-scale change to purchasing would require coordination between departments, may require legislative changes, and would need to be accomplished over several years.

What Can be Done to Implement or Further This Option

- The State could consolidate the purchase and negotiation of rates for the benefit programs for state employees with those for higher education employees as well as retiree benefits. These beneficiaries have common needs and the State could gain administrative savings by combining purchasing and contracting efforts through the elimination of redundant processes.

- Purchasing of health benefits for various state programs and employees could be accomplished through one contracting process that allows for variations in benefits as required by the program served.

- Departments purchasing health care could examine the programs offered, look for similarities in benefits or populations served, and combine those programs for greater efficiency and improved access and service to the populations served.

13. Leveraging More Federal Dollars with State and Local Funds

What is the Option?

Colorado could streamline the complex health care financing system by focusing on ways of leveraging additional federal funds for indigent care in the state. By combining separate funding sources, federal matching funds for Medicaid and CHP+ can be leveraged and economies of scale and efficiencies in program operations can be obtained. These efforts can be tied directly to coverage expansion. The State could impose provider taxes equivalent to the amount currently spent by providers on uncompensated care, re-finance state-only funded services, or use local government funds to draw down matching federal funds.

The largest opportunity for streamlining and focusing financing is in hospital care. Colorado hospitals spend over $144 million each year in actual costs to cover unreimbursed care to the uninsured. The source of these funds is cost-shifting in the form of higher rates to paying patients and health plans. This fragmented cost-shifting activity could be organized and streamlined into ways of delivering better health care. Other states tap into these revenues by imposing a health services or hospital tax in order to obtain federal matching funds through their Medicaid program or SCHIP. Colorado could expand coverage of its Medicaid and CHP+ programs by lowering their eligibility requirements to cover more uninsured families and return the tax revenues along with the federal match to hospitals in the form of Medicaid and CHP+ payments to hospitals.[60] Provider taxes need to be applied evenly across a provider group and there is a federal maximum limit of 6% of gross revenues for the amount of the tax.

Several states are now working to add or expand taxation of groups of health care providers to raise revenues. These revenues could then be returned to the provider group and other providers after matching with federal funds, in terms of higher Medicaid or SCHIP payments. Provider taxes could be applied to provider groups such as physicians, hospitals, home health agencies, nursing facilities, residential treatment centers, pharmacies, ambulance services, or all health care providers. Since

[60] Barbara Yondorf, “Colorado Health Care Spending on the Uninsured Medically Indigent,” prepared for the Colorado Coalition for the Medically Underserved, March 2003. http://ccmu.org/pdfs/CCMUColMIExpenditures.pdf

all providers in a class must be taxed, provider groups with a high proportion of Medicaid participation are likely choices. Officials in Colorado are examining a nursing home provider tax.

While Colorado Medicaid has made substantial progress in refinancing state-only expenditures, some opportunities remain. A past example is the conversion of Residential Child Care Facilities to Residential Treatment Centers in 1997, using the Medicaid rehabilitation service, to draw down federal Medicaid matching funds for the mental health services being provided to Medicaid eligible children. There are some opportunities still left in Colorado. One, suggested by the Family Voices advocacy group, is to refinance early intervention services for children ages 0-3, provided with state-only funding through Developmental Disabilities Services.

Recent federal policy initiatives provide new prospects for states to expand health care coverage using local government dollars. The Centers for Medicare and Medicaid Services (CMS) has signaled a new flexibility in program design and financing for coverage expansion efforts. The new federal Health Insurance Flexibility and Accountability (HIFA) initiative has a waiver template as a tool, but states are not limited to those recommended provisions. Other proposals will be considered on an individual basis. CMS is willing to consider greater flexibility in enrollment options for expansion populations and potential variability in statewide coverage.

At Which Streamlining Problem is the Option Targeted?

Sufficient resources are not currently available in the state budget to support health care program expansions. These methods, such as a provider tax, identify current resources and tie them to health care services and potential program expansions. The system of financing care for the medically underserved could be streamlined to cover more people in Medicaid and CHP+ while better directing funds used for the uninsured.

Other States' and/or Private Sector Experience with Option

- Many states have provider taxes. Examples include **Massachusetts, Michigan, Minnesota, Missouri, New Mexico**, and **Washington**. **Massachusetts** has an Uncompensated Care Pool that is funded in part through an assessment of hospitals' private sector charges and a surcharge on payments from private sector payments to hospitals and ambulatory care centers. The pool pays for medically necessary inpatient and outpatient services that are provided by hospitals and community health centers to low-income uninsured and underinsured residents.[61] **Minnesota** applies a health care tax, which is 1.5% of gross receipts, to all providers of health care. Excluded from the tax are Medicaid, MinnesotaCare (a sliding scale, subsidized health insurance program for low-income and moderate-income uninsured people) and other state and federal sources. All the money goes to a dedicated health care fund. Minnesota receives a federal match for the provider tax funds it uses to pay for the Families and Children Medicaid Program. The provider tax is the main source of state funding for MinnesotaCare, and accounts for 31% of the program's total funding.[62]

- CMS recently approved a HIFA waiver for **New Mexico** that mandates enrollment of an expansion population in a particular region into a single local government-sponsored health plan. A recent **Michigan** HIFA waiver request proposed to expand coverage only in counties that choose to offer a county-sponsored health plan and finance the non-federal share of that coverage. That proposal is currently classified as inactive because of Michigan budget problems, but was not rejected by CMS.[63]

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[61] Barbara Yondorf, "A Framework for Considering Health Care Cost Containment," *Balancing Health Needs with Resources* Series, National Conference of State Legislatures, June 2003. See Massachusetts Uncompensated Care Pool Website, http://www.state.ma.us/dhcpf/pages/dhcpf_22.htm

[62] Ibid. Also see Nellie Hester, "State Options for Financing CCMU's Health Colorado Program, Denver, Colorado: Colorado Coalition for the Medically Underserved, 2003. http://ccmu.org/pdfs/CCMUFinancingOptions.pdf

[63] Caton Fenz, "Leveraging Local Funds to Expand Coverage in Lean Times," State Coverage Initiatives Issue Brief, Academy Health, February 2003, p.2. www.statecoverage.net

- **Local governments** help finance Medicaid service costs **in six states**, help finance administrative costs and perform administrative functions in four states, and do both in 11 states. (This does not count disproportionate share and upper payment limit efforts).[64]

How Implementation of Option May Free Up Dollars

Obtaining federal matching funds allows state or local funds already being expended for existing services to be reallocated for coverage expansion and other uses.

Notable Advantages and Disadvantages of Option

\+ Colorado can draw down significant additional matching funds via this option, bringing millions of additional dollars into the Colorado economy

– Colorado's tax and expenditure limitation laws mean that in order to impose any kind of provider tax, voter approval would be required.

What the State Can Do to Implement or Further the Option

- The State could examine the feasibility and desirability of using provider money spent on uncompensated care or currently unmatched state or local expenditures on health care for the uninsured to leverage more federal funds to increase access to care.

14. Consolidated Financing Mechanisms: Single Purchaser and Single Payer

What is the Option?

This option involves the consolidation of the current patchwork of multiple purchasers and payers into either a single purchaser or single payer system. Its goal is to reduce the huge administrative costs associated with the current system of securing financing for care (e.g. insurance) and making payments to providers and to ensure coverage for all residents of the state. A consolidated financing system would replace current health insurance programs and cover all residents of the state. This option would streamline eligibility and enrollment processes as well as reduce and simplify the myriad administrative procedures and costs associated with health care coverage. Funds for the program would be collected by the State and could be administered by the State or a health care authority. The State could pursue a single payer option, similar to the Canadian system, or a single purchaser option, similar to the Federal Employee Health Benefit Plan (FEHBP). Under the Canadian approach, the State would cover all residents with the same benefit package and pay providers directly for care. Under the FEHBP option, the State would act as a single purchaser of health care from a variety of private insurance plans during an annual enrollment period. State residents would choose the plan they want and the designated state administrator would pay insurance plans based on the number of enrollees.[65]

At Which Streamlining Problem Is the Option Targeted?

This option aims to dramatically reduce the administrative costs associated with the current system of multiple public and private financing mechanisms and sources of funds. It is estimated that 31% of health care expenditures in the U.S. are for administrative costs, as opposed to 16.7% of health care expenditures in Canada.[66, 67] FEHBP's administrative costs (not including the administrative

[64] Ibid., p.1 and footnote 6.

[65] Barbara Yondorf, "Five Approaches to Achieving Health Insurance Coverage for All Coloradans," prepared for the Colorado Coalition for the Medically Underserved, July 2000.

[66] Woolhandler S, Campbell T, Himmelstein D. "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine* 2003; 349: 768-775.

[67] The authors of this study define total health care administrative costs to include the administrative costs of health insurers, employer health benefit plans, hospitals, practitioners' offices, nursing homes, and home care agencies. On a per capita basis, health care administration costs $1,059 in the US and $307 in Canada.

costs incurred by participating health plans, providers or federal agencies) account for only 0.1% of benefit payments.[68] A consolidated financing mechanism is also designed to ensure coverage for all residents.

Other States' and/or Private Sector Experience with Option

While several other states, including **California**, **Maine** and **Maryland**, have examined consolidated financing mechanisms to increase health care coverage for state residents, **none have implemented such a program**.

- In 2001, the **California** Health and Human Services Agency implemented the Health Care Options Project with funding from the U.S. Department of Health and Human Services. Under the project, nine proposals to expand health care insurance coverage in California were examined. Of the nine options, three proposed various single payer options that would provide universal coverage to California residents. The Lewin Group, Inc., a health care research and consulting group, analyzed all of the options and found that the single payer options would offer the state a net savings. While spending on health care services would increase due to increased utilization by the uninsured and underinsured, a decrease in costs associated with administrative savings and bulk purchasing of prescription drugs would lead to a total net cost reduction of $3.7 billion to $7.6 billion annually.[69]

- **Maryland** contracted for a similar analysis of universal health care plans. Two plans were analyzed: a single payer model funded by current state and federal spending and new taxes,[70] and a "multi-payer" model like the single payer model that also allowed employers to opt-out of the government program and provide coverage directly to employees. Both plans would cover all residents of Maryland and extend coverage to an estimated 760,000 uninsured residents. The single payer model would reduce health care spending in Maryland by $345.8 million (1.7% of total spending). The multi-payer model would increase costs by $207 million (1.1%) in 2001. Administrative savings offset the increased costs associated with covering all residents. The administrative savings projected for the multi-payer model are less than the savings projected for the single payer model.[71]

How Implementation of Option May Free Up Dollars

Consolidating financing and streamlining eligibility and enrollment processes can gain significant administrative savings that can be applied to coverage of the uninsured. Dollars currently spent on determining eligibility would be saved because all residents would be eligible for covered services. Additionally, the enrollment process would be streamlined and provide dollar savings as well.

Notable Advantages and Disadvantages of Option

\+ Significantly reduces administrative cost and eliminates cost shifting.

\+ All state residents would have health care coverage all of the time.

– No other state provides universal coverage. Multi-state employers might find this disruptive to their benefits management and may be less likely to have employees in Colorado. Colorado

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[68] Thorpe KE, Florence CS, Gray B. Market Incentives, Plan Choices, and Price Increases. Health Affairs 1999; 18(6).

[69] The Lewin Group, "Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California: Final Report," prepared for The California Health and Human Services Agency, April 22, 2002. http://www.healthcareoptions.ca.gov/final/CA%20Report%20-%20Medi-Cal.pdf

[70] New taxes include an employer payroll tax (employer and employee contribution), and taxes on tobacco products, alcohol products and personal income.

[71] John F. Sheils and Randall A. Haught, "Analysis of the Costs and Impact of Universal Health Care Models for the State of Maryland: The Single-Payer Model and Multi-Payer Models--Final Report," The Lewin Group, prepared for The Maryland Citizens' Health Initiative Education Fund, Inc., May 2, 2000.
http://www.lewin.com/NR/rdonlyres/e6z6hdupjvkiqg6fsxzwlgmypualtd3
nxegukd4xqrxwuw5aeygfwcfckvknqxvwuv4ksoqitlzdk36uhixk5i7onve/575.pdf

could become an attractive place to move for those who are uninsured or sick unless special rules were developed to deal with “immigrants” from other states seeking health care coverage.

– Depending on how the option is implemented, Colorado could see a net loss of jobs, particularly in health insurance sales, enrollment, eligibility determination, and premium collection.

What Can be Done to Implement or Further This Option

- The State could commission a study to determine the cost, savings and feasibility of using a consolidated financing mechanism in Colorado.

15. Employer Pay-or-Play [72]

[**Note**: The employer pay-or-play option was suggested by an invitee to the “CCMU Summit on Streamlining the Health Care System: Options for Colorado.”]

What is the Option?

Under an employer pay-or-play option, employers must either pay a tax—the proceeds of which are used to help uninsured individuals purchase coverage—or provide coverage through the workplace (“play”). Employer-provided health insurance is a relatively efficient mechanism for enrolling people in coverage and paying for their care. The employee share of the premium for coverage is automatically deducted from the employee’s paycheck. The employer collects the money from his employees, adds his contribution, and sends a monthly check to the insurer. An employer pay-or-play requirement encourages employers to provide coverage to all of their employees. If they don’t, they are subject to a state tax that helps pay the cost of coverage for their employees who aren’t covered at the workplace. Funds collected by the state in this manner may be used to draw down matching federal dollars, to the extent that the funds are used to cover uninsured people through Medicaid or CHP+.

At Which Streamlining Problem Is the Option Targeted?

This option is targeted at the inefficient system for getting coverage for working families who do not currently qualify for a public health insurance program such as Medicaid or CHP+, and are not offered health insurance at the workplace. The only option for the uninsured is to try to seek coverage on their own. Individual coverage has high transaction costs since the insurance is sold and administered on a person-by-person or family-by-family basis. This option would streamline the system by making it easier and simpler for people to get and pay for coverage. It would have the added advantage of reducing cost shifting, since employers who provide coverage would no longer have to pay inflated rates to pay for the uninsured employees of employers who don’t provide coverage.

Other States′ and/or Private Sector Experience with Option

- Currently **Hawaii** is the only state that requires employers to provide employee health insurance coverage. Under the 1974 Hawaii Prepaid Health Care Act, all employers must provide coverage for employees who work 20 hours or more per week. The law also requires employers to pay at least 50 percent of the health care premium for the employee. A premium supplemental fund provides subsidies for the purchase of health insurance to employers with fewer than eight employees and bankrupt firms.

- **California** enacted a law in October 2003 that requires employers to either purchase private coverage for their workers or pay fees to a state government insurance fund. Employers with 200 or more workers have until January 1, 2006, to provide coverage for their workers and

[72] Much of the material from this section comes from, Barbara Yondorf, Laura Tobler and Leah Oliver, “State Options for Expanding Health Care Access” *Balancing Health Needs with Resources* Series, National Conference of State Legislatures, forthcoming 2004.

dependents. Businesses with 50 to 199 workers have until 2007 to offer health insurance to employees only. Employers with fewer than 20 workers are exempt. Uninsured employees can not opt out of health insurance.[73]

- **Massachusetts, Minnesota, Oregon** and **Washington** enacted but did not actually implement pay-or-play laws during the late 1980s and early 1990s.

How Implementation of Option May Free Up Dollars

Implementation of an employer pay-or-play requirement should free up Medicaid and CHP+ funds currently being used to cover low-income individuals who are employed (or whose parents are employed) but not offered coverage at the workplace.

Notable Advantages and Disadvantages of Option

\+ Builds on current employer-sponsored coverage, which is the single major source of health insurance for most Americans under age 65.

\+ Maximizes the likelihood that uninsured workers will sign up for coverage.[74]

– It is not clear whether a state-imposed employer mandate would hold up if challenged under ERISA (the Employee Retirement and Income Security Act of 1974), which effectively prohibits states from requiring employers to cover their employees.[75]

– Raises labor costs for some employers who may respond by reducing wages or eliminating jobs.

What Can be Done to Implement or Further This Option

- The State could fund a study to determine the cost, savings, and feasibility of implementing a pay-or-play option in Colorado.

16. Other Financing and Payment System Streamlining Options

Debit Cards Linked to Flexible Spending Accounts. This option streamlines the use of Flexible Spending Accounts (FSA) for employees, potentially increasing employee participation and contribution to health care costs. The IRS has approved the use of debit cards linked to an employee's FSA. Employees can use the cards at their doctor's office, pharmacies, or with other health providers.[76] The reduction in paperwork to file a FSA claim may make FSAs more attractive to employees. The state could investigate adding this benefit to the FSA portion of the state employee benefit plan.

Streamline Indigent Care Financing. By streamlining the array of indigent care programs throughout the state, Colorado could reduce the administrative costs incurred at a state and local level and make the system more navigable for patients. State, local, and community providers spend significant amounts of time filling out application forms, tracking and reporting on various

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[73] "California Governor Signs Employer-Sponsored Health Coverage Bill," *Kaiser Daily Health Policy Report,* October 6, 2003. http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=20203

[74] For example, a 1997 report estimated that when employees have access to employer-sponsored coverage, 89% enroll. See: Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 And 1996," *Health Affairs* 16 no. 6, (November/December 1997).

[75] However it should be noted that several recent analyses ERISA have concluded that implementation of a pay-or-play requirement, as opposed to an employer mandate to provide coverage, probably could survive any legal challenges. This is because a pay-or-play requirement essentially imposes a tax on employers, which states are allowed to do, and simply waives the employer's tax obligation if he voluntarily offers his employees coverage. Thus the state is not mandating employer-sponsored insurance and presumably would not violate ERISA.

[76] Lieber, *Wall Street Journal*, September 2, 2003.

programs, and following varying rules to remain in compliance. By streamlining the eligibility, reimbursement, and coverage requirements across programs for the indigent, the state could reap administrative savings as well as make the indigent care system more efficient for patients. Additionally, the state could seek a federal waiver or demonstration project to remove some restrictions on the current categorical federal funds used for indigent care programs.

Take Greater Advantage of Public Health Pricing for Prescription Drugs. Under a federal program popularly referred to as the "340B drug pricing program," federally qualified health centers (FQHCs) can get deeply discounted prices for prescription drugs. If the Medicaid program were to encourage/require all Medicaid recipients to get their prescriptions filled by FQHCs if a Medicaid patient lives near an FQHC, the state could save money and streamline prescription drug purchasing. An analysis of 100 popular outpatient drugs found that 340B prices are, on average, at least 34% lower than wholesale prices.[77]

[77] Consumers Union, "Take Steps to Make Prescription Drugs More Affordable," SWRO Issues Pages for the 78th Texas Legislature, January 2003, http://www.consumersunion.org/consumeronline/reports/2003issuepapers/DrugCosts.pdf

C. Streamlining Benefits, Eligibility and Enrollment

17. Provide Core Benefits to Healthy Medicaid and CHP+ Children Under the Same Plan

What is the Option?
New federal authority under the Health Insurance Flexibility and Accountability (HIFA) initiative gives states flexibility to streamline existing programs to expand coverage using existing federal financial resources. Under Section 1115 of the Social Security Act states can get waivers to modify their Medicaid and SCHIP programs. States may be given greater flexibility to streamline benefit packages, create public-private partnerships, and increase cost-sharing for optional and expansion populations covered under Medicaid and SCHIP. In return, states are expected to cover more people.[78] The Centers for Medicare and Medicaid Services has released a HIFA waiver template to guide states in the waiver request process.[79]

The Colorado Department of Health Care Policy and Financing is investigating the feasibility of covering selected Medicaid and CHP+ populations (i.e., essentially all healthy kids) under the same core benefits package. The goal is not to cut benefits for Medicaid or CHP+ children. Rather, one of the goals is to realize savings from administrative efficiencies that could be used to expand coverage or extend coverage to additional uninsured populations. Another goal is to make it easier for the state to administer an employer buy-in program, under which the state would help to pay the employee share of coverage for low-income children covered through employer-sponsored plans. By having a core benefits plan with covered services that more closely mirror employer plans, it should be easier for the state to administer an employer buy-in program.

The Department is conducting a feasibility study and operational analysis to determine if there are groups of children (essentially healthy, non-special needs kids) in Medicaid and CHP+ who use services similarly. The results of the data analysis will assist in project planning and program design. For healthy children, the Department is looking into a single, standard defined benefits package plus wrap-around coverage for those children who it turns out need additional services.[80] The Department will hold a series of meetings and do a number of presentations on the draft proposal during fall 2003 to get public input. Questions on which the Department will seek public input include:

- Program Design: Should the Department consolidate the publicly funded health care programs for children and families (i.e., Medicaid and CHP+) or should it continue to have separate programs?

- Delivery System for Children with Special Health Care Needs: Are children with special health care needs best served with a core benefit package with wrap-around services or a specialty network?

- Priorities for Increased Coverage: If additional funding is made available should it be used to increase the income eligibility standard for children in Medicaid/CHP+ from 185% to 200% of the federal poverty level? Or should it be used to expand coverage to the parents of children enrolled in Medicaid/CHP+, most of whom are eligible for coverage currently only if their family income is less than about 36% of the federal poverty level?

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[78] Gretchen Engquist and Peter Burns, Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States, State Coverage Initiatives Issue Brief; www.statecoverage.net
[79] See http://cms.hhs.gov/hifa/hifatemp.pdf
[80] Colorado Department of Health Care Policy and Financing, "Preliminary Federal HIFA Waiver Planning Project," 2003, pp. 5, 9.

At Which Streamlining Problem is the Option Targeted?

One of the main goals of the Colorado HIFA proposal that is under development is to streamline eligibility determination and enrollment for low-income, uninsured children. Under the HIFA proposal, a healthy children's program would be created where Medicaid and CHP+ children who use the same services would be enrolled in the same standard plan for traditional health insurance benefits. By covering all Medicaid and CHP+ children under the same core benefits plan, the state may be able to realize economies of scale in purchasing and contracting for the care of this population.

Other States' and/or Private Sector Experience with Option

Although no state has enrolled healthy Medicaid and SCHIP children on the same core benefits plan through SCHIP, as of October 2003, 16 states covered SCHIP and Medicaid children under the same core Medicaid benefits plan. In most, but not all of these states, SCHIP children are covered by the same package of benefits as Medicaid children. **Arkansas** is an example of a state where not all benefits are the same. There, ARKids First A provides psychological services as medically necessary while ARKids First B covers outpatient mental and behavioral health up to $2,500 per year with a $10 co-pay.[81]

The concept of a core benefits package with wrap-around coverage or carve-out benefits is not new. Thirty states that have separate SCHIP programs and contract with managed care organizations carve out at least one SCHIP service. The services most commonly carved out are dental, all or some mental health services, all or most substance abuse services, and health-related special education. Examples of other services that are sometimes covered separately include target case management, early intervention services, personal care, and ancillary therapies. According to a February 2003 report by the Center for Health Care Strategies, Inc.:[82]

> ***California*** *augments the regular SCHIP benefits package with additional specialty services available for children with severe physical and developmental conditions and those with serious emotional disturbances . . . In* ***Connecticu****t, children with physical or developmental problems or serious mental or substance abuse disorders are eligible for services additional to those offered as standard SCHIP benefits . . . In* ***Montana****, children with serious emotional disturbances may receive unlimited services from the state's public mental health program once they exhaust the benefits in the basic SCHIP plan.*

How Implementation of Option May Free Up Dollars

Additional dollars may be freed up as a result of risk-sharing, risk-leveraging, and economies of scale in purchasing realized by providing core benefits to healthy Medicaid and CHP+ children under the same benefits plan.

Notable Advantages and Disadvantages of Option

\+ For the most part, a child can stay in one program with one set of rules instead of cycling between the Medicaid and CHP+ programs as family income or size changes or as a child ages.

– Efficiency savings realized from having a single core benefits plan might be offset by two types of additional costs: 1) those associated with keeping track of two populations and possibly differing co-pay requirements under one plan; and 2) the cost of administering the wrap-around services necessary to meet federal requirements.

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[81] American Academy of Child and Adolescent Psychology, "SCHIP Update—October 2003." http://www.aacap.org/legislation/schip/2003_1.pdf

[82] Harriet B. Fosc, Stephanie J. Limb and Margaret A. McManus, "SCHIP Innovations for Children with Special needs in Managed Care," Center for Health Care Strategies, Inc., February 2003. http://www.chs.org/publications/pdf/ips/schip.pdf

What the State Can Do to Implement or Further the Option

- Colorado could design a benefit package that meets the needs of the majority of Medicaid and SCHIP children, while assuring that children with special health care needs are identified and receive the special services they need.

18. Streamline Medicaid and CHP+ Enrollment and Eligibility

What is the Option?

Streamlining the eligibility and enrollment process for Medicaid and CHP+ would improve access to care for low-income children by reducing barriers to enrollment, reducing State and county administrative costs by simplifying eligibility procedures, and reducing the cost of health care administration through the elimination of multiple processes.

Standardization of forms and processes for eligibility and enrollment into Medicaid and CHP+ could also reduce administrative costs. A great leap forward occurred when the Medicaid and CHP+ programs went to a single, short application form in 1998. The single application form greatly streamlined the application process for consumers and allowed coordination of enrollment processes for the two programs. By federal law, applications of those children who are likely to be eligible for Medicaid were sent to county department of human services offices for Medicaid eligibility determination. In 2002, that was streamlined by housing Medicaid technicians in the CHP+ offices. Also beginning in 2002, the hospital-based Colorado Indigent Care Program began screening children for the CHP+ program to assure enrollment in the program that best meets their needs.[83]

Further steps to streamline eligibility could be taken. Families face barriers of time and energy in making application for health care coverage. Many do not bother to apply because they fear rejection. Several states have addressed this problem by putting the Medicaid and SCHIP programs on the Internet. Families can fill out a single health care coverage application at a public library, a school or a home. Eligibility determination and assignment to the appropriate health care program can be accomplished quickly.

A computerized application process promises to simplify state administrative processes and reduce handling costs. A common data set would be available to program administrators as clients move back and forth between Medicaid and CHP+ programs as their eligibility changes. A Web-based single application can also streamline the process for consumers and remove barriers to applying for health care coverage in advance of needing services. Additionally, it may provide greater payment-source clarity to providers because of earlier eligibility determination decisions.

States are also seeking other ways to streamline the eligibility determination process. Research has found that several strategies could be used to increase enrollment while reducing administrative costs. The strategies would focus on eliminating or simplifying the asset test to create time savings for applicants and eligibility workers. Another strategy would allow self-certification of income or income deductions to reduce administrative time. Self-certification of income or assets could result in net savings to the program without changing the eligibility standard.[84]

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[83] Children's Basic Health Plan Policy Board, "Children's Basic Health Plan Annual Report-SFY2002," Colorado Department of Health Care Policy and Financing, 2002.

[84] Lisa Chimento, Moira Forbes, Joel Menges, Anna Theisen and Nalini Pande, "Simplifying Medi-Cal Enrollment: Opportunities and Challenges in Tight Fiscal Times," Medi-Cal Policy Institute Issue Brief, June 2003. www.medi-cal.org

At Which Streamlining Problem is the Option Targeted?

Streamlining enrollment and eligibility is designed to reduce the barriers to obtaining health care coverage for children and families by decreasing the hassles of enrollment. The existing public programs eligibility system in Colorado has over 60 different eligibility categories. This results in higher administrative costs. The existing system also results in episodic coverage, with people not enrolling until they have significant health problems. Waiting until a health problem becomes acute often results in less effective treatment and higher costs.[85]

Other States' and/or Private Sector Experience with Option

- **California** uses a Web-based single application form for children and families applying for its Medicaid and SCHIP programs. The four-page form can now be filled out and submitted online. Pilot testing of the Internet-based application showed that it "reduced the time required to complete the initial application, and also lowered the elapsed time between submission of the application and eligibility determination by several days through a combination of saved processing time and elimination of mail time."[86] California has worked with its public libraries and providers to make this application easily accessible. California officials see this as a key strategy in meeting their program enrollment goals.

- **Vermont** uses a Web-based application for all of its Medicaid and SCHIP clients.

How Implementation of Option May Free Up Dollars

Program administrative costs could be saved as handling and processing of paper applications is reduced. This can shift program expenditures from administration to program services. Access to health care would be improved as it becomes easier to apply for and obtain coverage for health care rather than accessing services only when care is urgently needed. Ninety percent federal matching funds are available for computer system development.

Notable Advantages and Disadvantages of Option

\+ Administrative costs can be reduced by streamlined handling of application forms.

\+ Access to health care coverage can be improved by reducing hassles in the application process for families.

– Design, development and implementation of new systems can be costly and time consuming.

– Program design would need to be done in conjunction with the development of the State's proposed HIFA waiver to combine Medicaid and CHP+ health care program for healthy children (assuming the waiver proposal goes forward). (For more information on the waiver, see Section 17, "Provide Core Benefits to Healthy Medicaid and CHP+ Children Under the Same Plan.")

What Can be Done to Implement or Further This Option

- State law was recently changed to permit staff at CHP+ offices to make Medicaid determinations in addition to county health departments of human services. Removing this barrier would allow for eligibility to be determined on a centralized (statewide) basis using computer applications. A working computerized application system from another state could be adopted for Colorado's needs at a relatively low cost.

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85 Janice Frates and Lucien Wulsin, "Seamless Coverage Systems: Innovative State and Local Approaches," California Program on Access to Care Report, April 2002.

86 Atlas, B., Chimento, L., and Shukla, P., "Business Case Analysis of Health-e-App," Falls Church, Va.: The Lewin Group, 2001.

- Changing the State's financial eligibility requirements could also result in increased program enrollment while reducing administrative costs. The complexity of the eligibility categories can be streamlined by changing the income or asset standard or processes. Self-certification could be done through a Department of Health Care Policy and Financing procedural change and help the Department reach its stated goal of "enrolling every eligible child in Colorado."[87]

19. Benefit Standardization

What is the Option?

Under this option the state would limit the number of different benefit plans that could be sold in the state. Administrative costs and enrollee/provider confusion about what their/the patient's plan covers could be reduced by limiting the nearly endless variety of benefit designs to a manageable number, perhaps 10 to 30, instead of hundreds. By streamlining the benefit packages available, consumers would find it easier to compare insurance products. Although Colorado does not currently limit the number of different plan designs that can be marketed, it does require all small employer insurers to market a state-designed Standard Health Benefit Plan and Basic Health Benefit Plan. In 2002, 14.5% of Colorado small employer groups were on the Standard Plan and 8.5% were on the Basic Plan.[88, 89] This suggests that many consumers find the Standard and Basic packages provide appropriate levels of coverage.

At Which Streamlining Problem Is the Option Targeted?

This option is targeted at the overwhelmingly wide array of benefit packages offered to Colorado consumers. Refining the benefits packages available would reduce the complexity of the health insurance market and make it easier to for consumers to understand and compare benefits and would reduce administrative costs.

Other States' and/or Private Sector Experience with Option

- The benefits provided by **Medicare supplemental insurance** (Medigap) are federally determined. Medicare supplemental insurance is limited to 10 different packages, each with varying levels of covered services and cost sharing. The packages are easy for consumers to compare. Providers across the country need to be familiar with just 10 possible Medicare supplemental policies that may cover their patients.

- **New Jersey** has developed standardized benefit packages and prohibits plans other than the five developed by the state-appointed oversight board from being sold in the individual and group markets. In the small group market, the plans consist of one HMO option and four indemnity plans that can also be offered as point-of-service or preferred provider organization plans. New Jersey also allows for the sale of riders.[90] Riders are forms that accompany an insurance policy that increase the policy's terms or coverage.

How Implementation of Option May Free Up Dollars

This option could reduce the marketing, education and overall administrative costs for insurers, thus lowering premiums. Additionally, this option would reduce search costs for consumers.[91]

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[87] Children's Basic Health Plan Policy Board, "Children's Basic Health Plan Annual Report-SFY2002," Colorado Department of Health Care Policy and Financing, 2002, pp. 2, 16.

[88] Colorado Division of Insurance, 2002 Small Group Activity Reports. http://www.ofm.wa.gov/accesshealth/research/43benefits.pdf

[89] Note that these percentages represent the number of groups and not the size of the groups or number of lives covered.

[90] Silow-Carroll S, Waldman E, Meyer J, Williams C, Fox K, Cantor J. "Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia," The Commonwealth Fund, November 2002.. http://www.cmwf.org/programs/insurance/silow-carroll_statestrategieslong_565.pdf

[91] "Option for Distilling the Current Array of Washington State Medical Benefit Packages," prepared for Washington State Planning Grant on Access to Health Insurance, June 2002. Funded by U.S. Department of Health and Human

Notable Advantages and Disadvantages of Option

+ Streamlining the benefit packages available would simplify comparison of health insurance products for individuals and businesses. As a result, consumers may have a better understanding of their benefits and may use them more appropriately.

+ Standardized benefit packages would reduce marketing, education, and administrative costs for health plans.

– Standardized benefit packages would not allow health insurers to market flexible benefit packages or market their benefits as providing a unique benefit to consumers. It could stifle innovations in benefit design and make it difficult to tailor benefit plans to the needs of different groups and individuals.

– Employers wanting coverage that does not fit into one of the state-proscribed plans may drop out of the state-regulated market and self-insure.

What Can be Done to Implement or Further This Option

- The Colorado Legislature could pass a bill authorizing the Division of Insurance or an independent authority or board to develop a limited number of plans which would be the only plans that could be marketed.

20. Other Benefit and Eligibility and Enrollment Option

Certify Full-Time College Student Status for Insurance. Most insurers require dependents between 19 and 22 years of age to prove that they are enrolled full-time at a college or university in order to continue coverage under their parents' policy after graduation from high school. Because different colleges and universities use different systems for counting credits and hours and have different definitions of what constitutes a full-time student, getting proof that a child is in school full-time can be a cumbersome process. Under this option, parents would be allowed to certify to this fact rather than providing proof from the college or university. This would streamline the eligibility determination process for parents, their children and insurers by reducing paperwork. Insurance plans already allow employees to certify to the dependent status of the other eligible dependents on their plan (e.g., spouses and dependent children under age 19).

Services, Health Resources and Services Administration, Grant # 1 P09 OA00002-01. http://www.ofm.wa.gov/accesshealth/research/43benefits.pdf

Conclusion

This report has briefly reviewed a number of different options for streamlining aspects of the Colorado health care system. The options range from broad changes, such as adoption of consolidated financing mechanisms, to smaller changes, such as addressing small inefficiencies in Medicaid and CHP+. Many of the options apply to state programs, but some could be implemented by private insurers, providers, or employee benefit plans.

Yondorf & Associates recommends that CCMU pursue the following action steps:

- Using summit participant feedback as a guide, decide which options are of most interest to CCMU;
- Perform an economic analysis to determine the savings opportunities for each option;
- Investigate ways to ensure that identified savings and efficiencies will be directed toward better access to care;
- Determine what, if any, legislative action is needed; and
- Identify appropriate collaborators and points of leverage for implementing change in the public and private sectors.

With more and more Coloradans either becoming uninsured or under-insured, and with the continued strain on Colorado's budget, it is imperative that ways are found to operate the health care system more efficiently and effectively. Streamlining the system offers the potential of freeing up dollars that might be used to expand access. It also offers the potential of improving health outcomes and improving patient, payer and provider satisfaction.