

Managing Medicaid in Colorado

The Promise of Medicaid Managed Care



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An old idea is back on the table as Colorado policymakers search for ways to control Medicaid costs.

Enrollment in Health First Colorado, the state's Medicaid program, has grown rapidly, and the state's costs have grown, too. More than 1.3 million Coloradans are covered by Medicaid, and the shared federal-state program now accounts for 26 percent of the state General Fund, up from 18 percent in fiscal year 2001-2002.

The program's growth has policymakers searching for ways to control costs without cutting services for Coloradans who depend on Medicaid for access to health care.

One idea is Medicaid managed care. It's an idea that Colorado has tried in the past and largely abandoned.

However, most states have turned to Medicaid managed care to get their costs under control — with varying levels of success. Colorado still has a handful of programs that use elements of managed care.

Takeaways

- **The term “managed care”** can have different meanings when it comes to health care, but most managed care systems involve contracted arrangements, medical homes and capitated payments. Many experts view capitated payments as the critical element for controlling costs.
- **Managed care in the Medicaid program** involves the outsourcing of the financial risk of health costs for Medicaid enrollees, possibly leading to greater budget savings and predictability.
- **Colorado has launched programs** that use elements of Medicaid managed care. They offer some promise of controlling costs, but the approaches are very different.

In a managed care system, the state Medicaid agency contracts with managed care organizations (MCOs) — usually private insurance companies that work with providers to serve Medicaid patients. MCOs bear the financial risk if spending is higher than expected but also have the potential to reap financial rewards if they control costs. As a concept, Medicaid managed care appears straightforward, but there are numerous nuances and variations to its implementation, and it isn't always clearly understood. In this paper, the Colorado Health Institute (CHI) examines the three elements of a managed care system:

- Contracted agreements with managed care organizations;
- The use of a medical home, a health care provider whose goal is to improve the coordination of care to enhance quality and reduce unnecessary costs;
- Capitated payments, which allot a specific amount of money to a MCO for every patient. The insurer is then responsible for covering all health care needs, regardless of cost. This means the insurer bears the financial risk when care exceeds the capitated payment amount.

The Centers for Medicare & Medicaid Services (CMS), the federal agency overseeing Medicaid, highlights the promise of this approach, saying it could allow states to “reduce Medicaid program costs and better manage utilization of health services.”¹

Managed care also offers legislators the promise of greater certainty over the annual Medicaid budget. Once the payment rate is set in the contract, any

Colorado’s Medicaid program has seen huge enrollment growth in recent years, and spending as a share of the state general fund has also grown.

FIGURE 1. Medicaid Enrollment by Fiscal Year

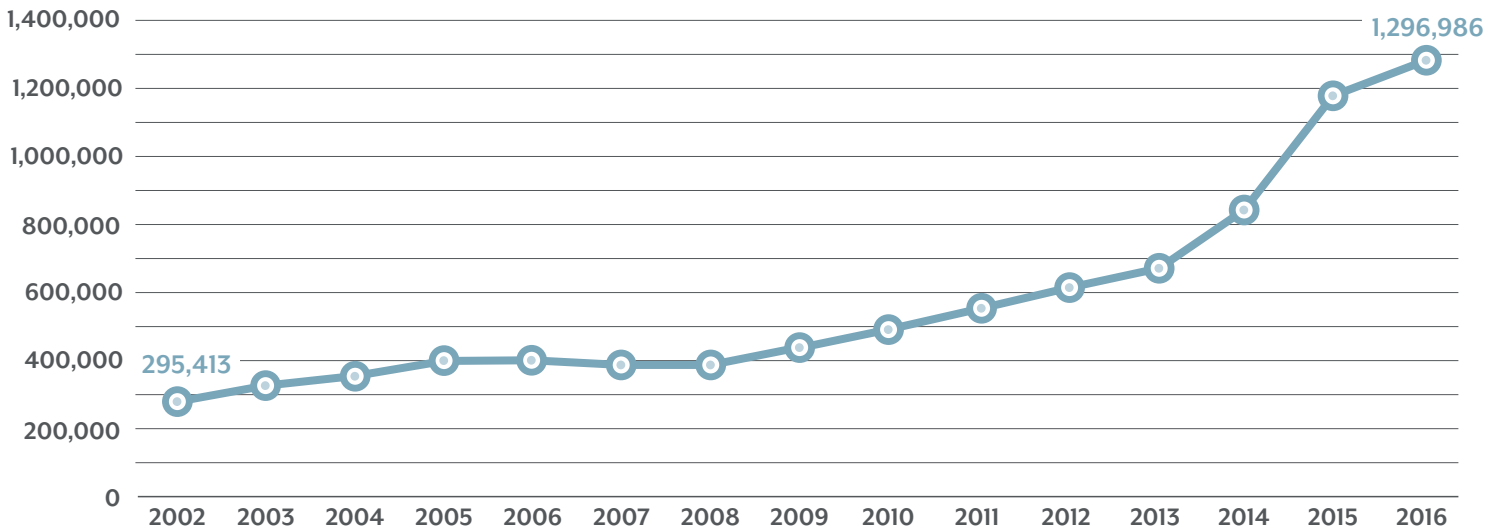
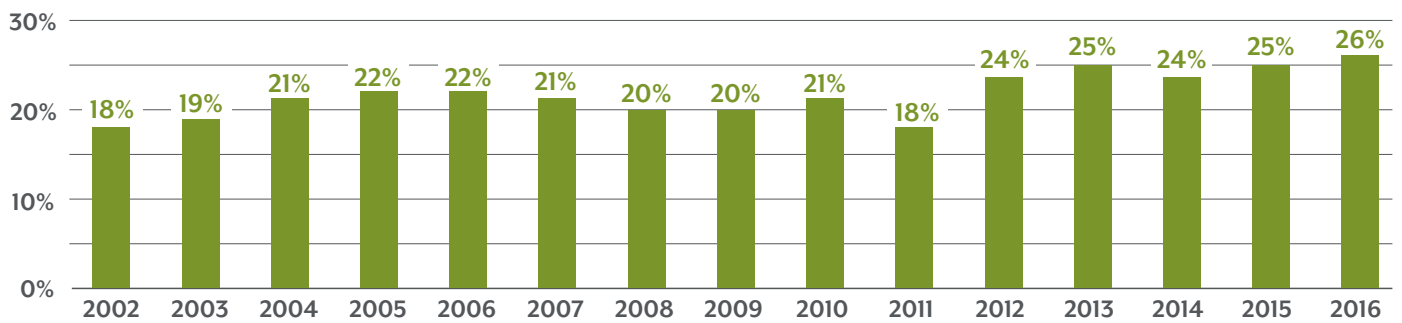


FIGURE 2. HCPF Spending as a Percent of General Fund by Fiscal Year



change in spending becomes the responsibility of the MCO.

But is managed care really the cure-all for Medicaid some claim it to be?

Colorado experimented with managed care in the 1990s — unsuccessfully. Payment disputes between the state and MCOs spurred lawsuits, and Colorado ended its managed care program.

But past failure does not mean another try would be doomed. Much has changed over the years. Health

systems have a lot more data to make better decisions, and policymakers have the benefit of seeing what has and has not worked in different programs in Colorado and in other states.

Colorado has the option to stay the current course, which offers more familiarity and less disruption or adopt a full managed care model, which would be riskier but may — or may not — bring greater savings and more budgetary certainty in the long run.

The state’s Medicaid program has already successfully leveraged many managed care

techniques, and CHI is exploring whether an even bigger bet on Medicaid managed care could work in Colorado. This introductory report examines the elements of managed care and initiatives in Colorado Medicaid that draw upon managed care principles. Future reports will look at other states' experiences with Medicaid managed care and quantify the potential risks and rewards of a new approach.

Medicaid Managed Care 101

Medicaid managed care, in some version, has been around for decades. While details may vary, three main factors characterize Medicaid managed care: a contractual arrangement between the state and a MCO to oversee health care delivery in the Medicaid program; medical homes that coordinate a Medicaid member's health care; and a payment system based on capitation.

Together, these elements can create incentives that have the potential to hold down costs and improve quality. Here's the theory behind these three elements of Medicaid managed care:

Contracts: MCOs compete to win a state contract based on many factors, including the ability to offer health services at the lowest possible cost. This competition, it is thought, will result in less government spending.

Medical Homes: A centralized and coordinated approach can reduce avoidable spending on medical care. In addition, medical homes emphasize preventive care, which can help patients lead longer and healthier lives.

Capitated Payments: States pay MCOs a set amount to provide care for each enrollee, called a capitated rate. This contrasts with traditional fee for service (FFS) payments in which the state reimburses providers for each individual service, a system that some believe can create incentives to provide more services without proper consideration of cost and quality. In a FFS system, the state bears the burden when costs are higher than anticipated. In a capitated system, the MCO bears this risk and has an incentive to control costs. MCOs may also get to keep cost savings generated by effective care management. At the same time, MCOs often must meet quality benchmarks to reduce the likelihood that MCOs cut corners in providing appropriate care. Capitation is at the heart of Medicaid managed care.

More states are adopting capitated approaches for their Medicaid programs. According to the Kaiser Family Foundation, 39 states — including Colorado — have adopted capitated payments in contracts with MCOs. Colorado uses this approach sparingly, but for other states it has become the dominant model for Medicaid. In 28 states, it covers at least 75 percent of their Medicaid population.²

Medicaid managed care, however, could have pitfalls for states.

States and MCOs must agree on a contract that is mutually workable and sustainable. If payment rates are too low, MCOs won't participate or care quality might deteriorate. And if the payment rates are too generous, a state might not save as much money as it could. Finding the "sweet spot" for payment rates is not easy.

TABLE 1. Three Medicaid Initiatives in Colorado that Use Managed Care Techniques

	Accountable Care Collaborative*		Medicaid Prime	Denver Health Medicaid Choice
Operated By	Regional Care Collaborative Organizations	Behavioral Health Organizations	Rocky Mountain Health Plans	Denver Health
Areas Served	State of Colorado	State of Colorado	Garfield, Gunnison, Mesa, Montrose, Pitkin and Rio Blanco counties	Denver, Adams, Arapahoe and Jefferson counties
Caseload	1,052,000	1,052,000	38,000	89,000
Caseload Growth Rate (Prior Year)	+13%	+13%	+7%	+28%

* Note: The ACC is evolving to a next phase soon and is anticipated to more fully integrate physical and mental health services.

Colorado knows something about this. The state legislature passed a bill in 1995 requiring that 75 percent of Medicaid enrollees be moved into a managed care plan. The bill set payment rates for the new MCOs at 95 percent of the FFS rates.

But the Colorado Department of Health Care Policy and Financing (HCPF) and some MCOs became embroiled in a controversy shortly after the program started. MCOs sued, arguing the state wasn't paying them as much as they deserved.

Colorado lost these lawsuits. Facing new costs and increased uncertainty, it ended the state's first major Medicaid managed care experiment. And Colorado is not alone in this regard. For example, Connecticut adopted a Medicaid managed care model in 1995 but became dissatisfied with its effectiveness and costs and returned to a FFS system in 2012.³

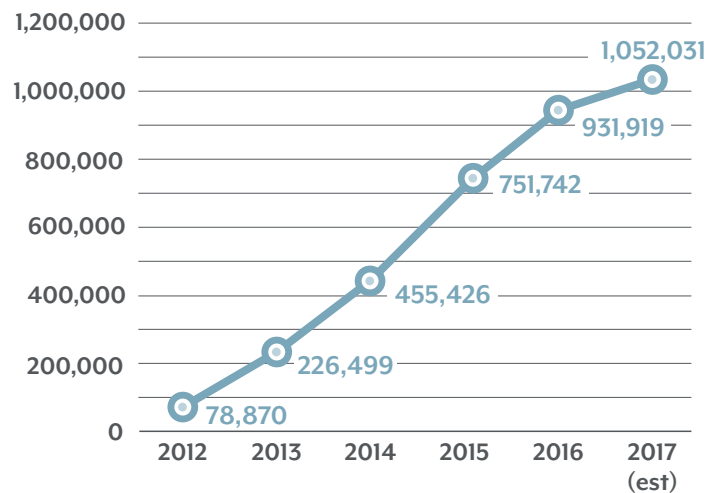
Since that bruising experience more than 20 years ago, Colorado has adopted a different approach to using managed care in its Medicaid program.

Managed Care and Colorado Medicaid: A Measured Approach

Colorado's Medicaid program has focused on placing its enrollees in medical homes, largely avoiding a statewide adoption of a more aggressive capitated payment structure.

Only about 10 percent of Colorado Medicaid members are in a program with capitated payments for physical health services. However, every member is in a program with capitated payments for behavioral health services. Why the difference? Behavioral health carve-outs, named because they are "carved out" from physical health benefits, became widespread in the 1990s. They were seen as a way to control the rapid growth in behavioral health spending that occurred in the 1980s, when states loosened regulatory controls and the number of psychiatric inpatient facilities ballooned. These carve-outs spawned organizations that could specialize in managing behavioral health, offering the potential for better and more coordinated care that could also reduce overall spending. Behavioral health carve-outs have sometimes been criticized because they may

FIGURE 3. ACC RCCO Enrollment by Fiscal Year



fragment care across behavioral and physical health care, potentially creating barriers for primary care providers to serve the behavioral health needs of their patients.^{4,5}

Still, Colorado is taking some important steps down the Medicaid managed care road. The Department of Health Care Policy & Financing (HCPF) has launched three initiatives that rely, at least in part, on managed care tenets.

In this section, CHI analyzes each initiative according to the three characteristics of Medicaid managed care: contracts, medical homes and capitated payments.

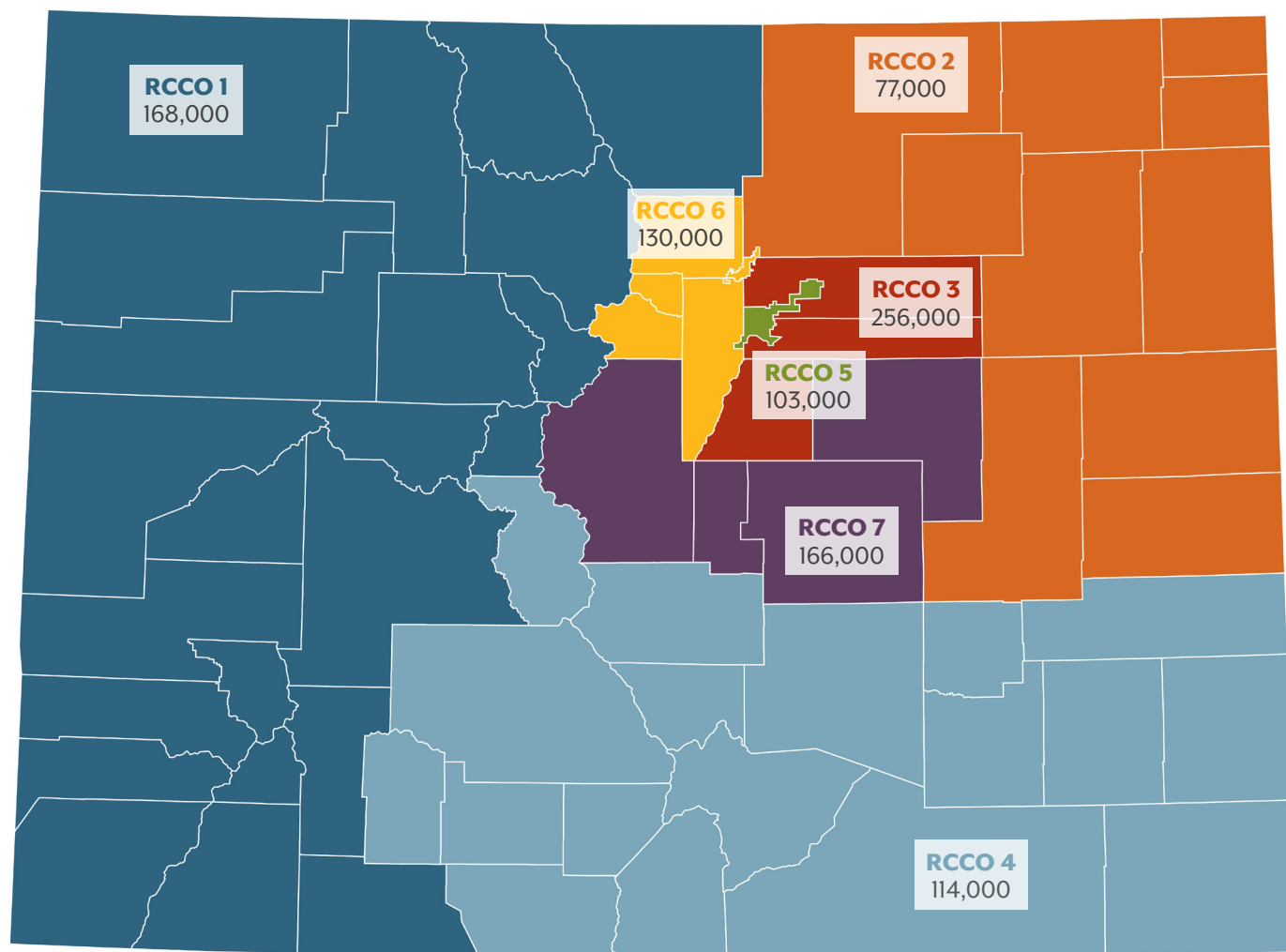
The paper does not examine Access KP, a short-lived pilot program that adopted a capitated payment model for some Medicaid members in Adams, Arapahoe and Douglas counties. The first year of the pilot program ran through June 2017, and it was not renewed for a second year.

Accountable Care Collaborative (ACC)

HCPF in 2011 launched this groundbreaking effort to rethink how it delivers care to Colorado's Medicaid enrollees. The ACC has grown rapidly, and today it covers more than one million of Medicaid's nearly 1.3 million members.

Seven Regional Care Collaborative Organizations (RCCOs) manage the program, connecting enrollees to primary and specialty care.

MAP 1. Colorado RCCOs by Enrollment



Colorado is leveraging some, but not all, characteristics of managed care in the ACC.

- **Contracts:** RCCOs bid for contracts to manage specific areas of the state. These contracts specify details of the arrangement, including the population covered and how quality will be measured. Different types of organizations can serve as RCCOs. Currently, they include insurance companies, community alliances of safety net providers, physicians, and hospitals, among others. RCCOs are responsible for connecting patients to primary care physicians and specialists and coordinating their care across multiple providers. The RCCOs do not provide actual health care services. A portion of payments to RCCOs is passed along to primary care medical providers (PCMPs). HCPF contracts separately with PCMPs to serve as medical homes.
- **Medical Homes:** This is the managed care characteristic most prominently used by the ACC.

Medicaid members are connected to PCMPs who provide a medical home, coordinate their medical care, encourage preventive services and refer them to a specialist when needed.

- **Capitated Payment:** In one sense, the ACC approach is based on a capitated payment system because the state pays RCCOs and providers a fixed per-member, per-month (PMPM) fee. HCPF can adjust per-enrollee payments based on whether quality goals are met. However, the payments reimburse the RCCOs and providers only for providing care coordination and medical homes, while actual medical services are still paid on a FFS basis. HCPF describes this payment system as “managed fee for service.” In this system, RCCOs and PCMPs bear little financial risk, because HCPF will pay when the cost to care for a Medicaid member is more than expected. This payment system creates only modest incentives to control costs and improve care quality. Colorado

has adopted a more fully capitated approach for behavioral health. Behavioral health organizations (BHOs) provide behavioral health services to Medicaid enrollees and are paid a fixed PMPM fee from HCPF. The BHOs bear the financial risk in this system, giving them greater incentives to control costs.

Results: A 2016 evaluation found that the ACC maintained quality and yielded savings up to \$900 per enrollee per year after four years.⁶ Other researchers found that health care expenditures and the volume of certain health care services declined after implementation of Colorado’s ACC. Interestingly, the researchers also found that these impacts were similar to those observed in Oregon, which adopted a capitated approach for its Medicaid system.⁷

The next phase of the ACC, expected to begin in 2018, will increase incentives to control costs and improve quality, but medical providers will still be reimbursed largely on a FFS basis. For more information on ACC Phase Two, see CHI’s publication, “The Route to RAEs: Analyzing the Next Phase of the Accountable Care Collaborative in Colorado.”

Rocky Mountain Health Plans – Medicaid Prime

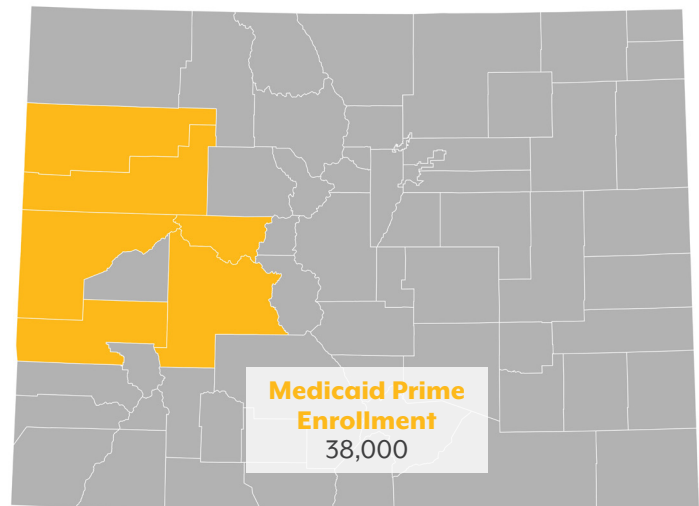
Rocky Mountain Health Plans (RMHP), a health insurance company that has operated in western Colorado for more than 40 years, launched its Medicaid Prime program in 2014 as a component of the ACC. It stemmed from a law passed in 2012 (HB12-1281) that directed HCPF to establish a pilot program for new payment methods in the Medicaid program. Medicaid Prime serves about 38,000 Medicaid members in six Western Slope counties.⁸

RMHP receives a PMPM payment from the state to cover the medical needs of those enrolled in Medicaid Prime. RMHP in turn makes capitated payments to primary care providers, who serve as medical homes for their patients. RMHP also is responsible for paying for other services such as hospital and specialty care, though those payments are based on a FFS approach. Medicaid Prime does not cover mental health services, though RMHP works with mental health centers to enhance the integration of physical and mental health services.

This is how Medicaid Prime stacks up on the three managed care characteristics:

- **Contract:** RMHP serves as the MCO contracting

MAP 2. Areas Served by Medicaid Prime



directly with the state. The terms of the contract dictate the capitated payment from HCPF and the quality standards that must be met. The contract provides RMHP with additional flexibility in creating a provider network, setting different rates and more.

- **Medical Home:** RMHP uses medical homes to help achieve savings while meeting quality targets. Providers, in order to participate and share in potential savings, must adopt the medical home model.
- **Capitated Payment:** HCPF and RMHP negotiate a PMPM fee to cover all services for its Medicaid Prime enrollees. The state pays the monthly capitated amounts to RMHP, which then pays participating primary care providers a capitated amount to cover their Medicaid Prime enrollees. The amount varies by provider, adjusted to account for the health status of enrollees. This risk adjustment process is designed to reduce the incentive for providers to accept only the healthiest enrollees. If the cost of providing care comes in under budget and quality standards are met, the savings are shared by HCPF, RMHP and the care providers. About 71 percent of the savings are returned to HCPF. Of the remainder, providers receive 90 percent and RMHP receives 10 percent. But RMHP and providers are on the hook if costs exceed the budgeted amount. This payment system creates substantial incentives for RMHP and providers to control costs.

Results: HCPF’s ongoing evaluation of the Medicaid

Prime pilot program shows that it is meeting or exceeding care quality standards. In addition, the program's emphasis on better coordinated care has led to greater access to important behavioral health services.⁹

But the program is relatively new, making it difficult to assess whether Medicaid Prime is successful at controlling costs. It is hard to estimate what costs would have been for the covered population in the absence of Medicaid Prime. Medicaid Prime also could lead to higher costs from the increased use of some services due to a greater emphasis on primary care medical homes and connecting patients to appropriate services like behavioral health. However, this increased use may reduce overall costs if it leads to improved health and less hospital care.

Denver Health Medicaid Choice

This program is furthest along the Medicaid managed care path. While it has all three hallmarks of a full Medicaid managed care program, it is available only in four metro Denver counties.

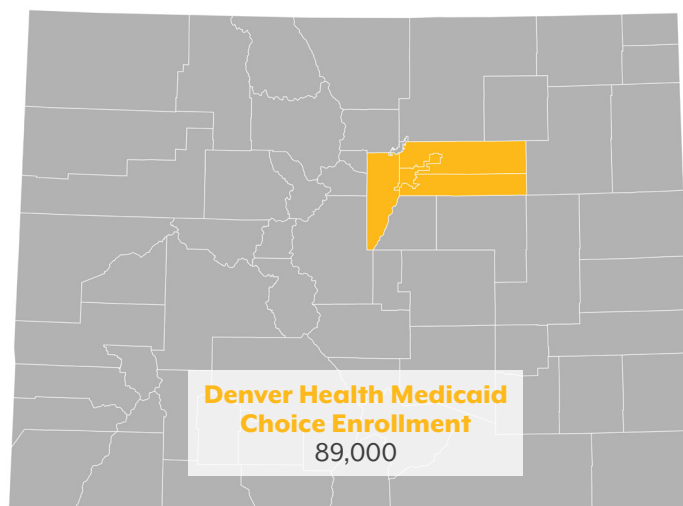
Launched in 2004 by Denver Health, a comprehensive care safety net organization, it now covers about 89,000 enrollees in Denver, Adams, Arapahoe and Jefferson counties.⁴

Denver Health Medicaid Choice (DHMC) uses a closed network, which means enrollees must use Denver Health physicians and facilities. Sometimes, enrollees receive care outside of Denver Health facilities, such as in emergencies or when Denver Health doesn't have the capacity or capability to serve a patient's needs. When this happens, Denver Health pays these outside providers on a FFS basis.

This is how DHMC stacks up on the three managed care characteristics:

- **Contract:** Denver Health acts as the MCO — handling the capitated payment contracts with HCPF — in addition to serving as the health care provider. The contract covers all types of care provided to DHMC enrollees.
- **Medical Home:** Because services are usually provided within Denver Health facilities, care coordination and the medical home are an intrinsic part of the program.
- **Capitated Payment:** HCPF pays Denver Health a monthly capitated fee that covers all health care

MAP 3. Areas Served by Denver Health Medicaid Choice



services used by enrollees. Actuarial experts analyze historical information on the characteristics of the population and its use of health care services. The actuarial analyses are combined with information on the FFS equivalent cost for each health care service, and this information serves as a benchmark for negotiations between HCPF and Denver Health to determine the capitated rate. If DHMC enrollees require care from non-Denver Health providers, Denver Health pays a FFS fee to those providers out of the capitated payments it receives from HCPF. Denver Health bears the financial risk if costs exceed HCPF's total payment. The capitated rates are renegotiated every year to reflect financial performance and experience. Compared with Colorado's other efforts to use elements of managed care in its Medicaid program, DHMC is the most comprehensive example of a full-risk capitated model. It covers the broadest range of health care services and creates strong incentives to control costs and improve quality across multiple types of providers.

Results: This more comprehensive approach to Medicaid managed care seems to be working well. Medicaid members enrolled in DHMC report higher satisfaction and receive higher care quality compared with members who receive care through the ACC, according to Denver Health. According to one actuarial analysis conducted for Denver Health, DHMC enrollees cost eight percent less than equivalent Medicaid enrollees in 2015.

A unique aspect of DHMC is its ability to serve as both payer and provider. Most parts of Colorado do not have such a system, making it hard to replicate the DHMC system statewide.

Additional Considerations for Colorado

Medicaid managed care seeks to transform the health delivery system by creating incentives for high-quality care and cost control.

Can it deliver? Some of the evidence is promising. In Colorado, analyses of the ACC, Medicaid Prime and DHMC suggest that managed care techniques might lead to cost savings while maintaining quality. However, savings so far have been modest in comparison with the total Medicaid budget, which suggests that Medicaid managed care may not be the panacea that some might hope for.

There are many important questions that need to be considered to understand whether broad adoption of a capitated approach for Colorado's Medicaid program is prudent. For example:

- Are the proper incentives in place for MCOs and providers to give lower-cost, higher-quality care? MCOs are often for-profit entities, and they may have different priorities than the state.
- How might savings from a capitated payment approach compare to the additional administrative costs this system could require? Both the state and the MCOs would incur administrative expenses.
- Does the system target the right spending? Older populations account for much of the growth in Medicaid expenses, but there are relatively few models in Medicaid managed care for providing long-term services and supports.

Some studies of Medicaid managed care programs in other states have found encouraging results. For example, one study of nine states found that they all saw cost savings of 0.5 to 20 percent.¹⁰ Surveys of Medicaid enrollees have given high marks to both MCOs and the ACC when it comes to customer satisfaction.^{11,12} And Medicaid managed care looks like a growth opportunity for businesses that serve as MCOs.¹³

However, the picture is not always rosy. Other peer-reviewed studies suggest the fiscal impacts of Medicaid managed care have ranged from modest

Behavioral Health Organizations

Although Colorado's Medicaid program has not widely adopted a capitated system for physical health services, it is a primary feature of how it contracts with behavioral health organizations (BHOs) to manage behavioral health services. BHOs have been operating for more than 20 years in Colorado, providing a broad range of behavioral health services, including many treatments for substance use disorder. Currently, HCPF contracts with five BHOs to cover all Colorado Medicaid members, including rural residents. Each Medicaid enrollee is assigned to a BHO, which helps to coordinate and manage their behavioral health care. The close relationships between BHOs and community mental health centers is an important characteristic of this "carve-out." In Colorado's Medicaid program, BHOs received about \$650 million to cover these services last year, about one-tenth of the \$6.8 billion budget for physical health. HCPF is moving toward greater integration of physical and behavioral health, and some aspects of the BHO model are expected to change, although capitation will likely remain. CHI plans to keep an eye on these developments.

cost savings to cost increases.¹⁴ Several states, including Illinois, Iowa and Kansas, have faced challenges in making their Medicaid managed care program work.¹⁵ In Iowa, MCOs have been losing hundreds of millions of dollars, and the state is relying on risk corridor payments from the federal government to address those losses.¹⁶ And Connecticut's Medicaid program has left the managed care game altogether, returning to a FFS payment structure after an unsuccessful run with capitated payments.

It should not be surprising that a Medicaid managed care model has such a varied track record. Each state's experience will be different because (1) there are many different choices in how to implement the model and (2) each state is starting from its own unique place. Therefore, the costs and benefits of Medicaid managed care are going to be specific to each state.

Medicaid managed care is a disruptive innovation. And there is no consensus on whether it's a positive or a negative disruption. While the concept is not new, the details of how states are approaching it continue to evolve.

Where Are We Now?

Colorado is making progress in using managed care techniques in its Medicaid program.

But as Medicaid spending rises, it's likely there will be calls to move faster toward a full Medicaid managed care system.

Should Colorado take a riskier — yet potentially more rewarding — full managed care approach?

Colorado's original experiment with Medicaid

capitation 20 years ago ended badly. The experience of other states has been mixed. Some are saving money and getting high marks for quality of care, while others are failing.

If Colorado does make a more complete move to Medicaid managed care, it will be imperative to avoid the pitfalls faced by other states.

Further research from CHI on Medicaid managed care will look at the experience of other states, examine these pitfalls and quantify the additional savings — and costs — of this new approach.

Endnotes

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