Executive Summary

The Colorado Regional Integrated Care Collaborative

Managing Health Care for Medicaid Recipients with Disabilities:

Final Report on the Kaiser Permanente Colorado Coordinated Care Pilot Program

Charles Michalopoulos
Michelle Manno
Anne Warren
Jennifer Somers

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Overview

Coordinated care programs are designed to address problems that can arise when individuals with multiple chronic conditions seek health care. They might need attention from several doctors, which can result in duplicative tests or prescriptions for contraindicated medications. Coordinated care programs attempt to minimize these problems by helping individuals make appropriate use of the health care system. Such programs may be an important policy option for aged and disabled Medicaid recipients, who account for almost 75 percent of Medicaid spending.

This report presents two-year results from an MDRC evaluation of a pilot coordinated care program run by Kaiser Permanente Colorado, which is part of the Kaiser Permanente managed care consortium. Kaiser Permanente Colorado care managers assessed each individual's health care and social service needs, provided educational information about medical conditions, coordinated care across providers, and helped individuals make and keep medical appointments. The program aimed to improve the quality of care while reducing Medicaid costs by helping individuals use appropriate care that is intended to reduce hospital admissions and emergency department visits.

To understand whether the Kaiser Permanente Colorado program had effects, about 2,600 blind or disabled Medicaid recipients in two Denver-area counties were assigned at random to either a program group, which had access to the coordinated care program, or a control group, which did not.

Key Findings

- **Care managers faced a number of challenges implementing the program.** For example, they had difficulty contacting eligible individuals, who did not always have a permanent address or phone service.

- **The program increased the use of specialists and nonphysician providers, but had little effect on other aspects of health care use.** The frequency of primary care visits, hospital admissions, emergency department visits, and use of prescription medications was similar for the program and control groups. The program did increase the use of specialists, perhaps because individuals could use specialists from the Kaiser Permanente system. It also increased care from providers who are not medical doctors, such as optometrists and physical therapists.

- **Results from other coordinated care programs suggest how to improve program design.** More effective programs have used in-person contact, targeted individuals at high risk of hospitalization, and focused on managing transitions from hospital to home. In contrast, Kaiser Permanente Colorado care management occurred mostly by telephone, included a broad cross-section of disabled Medicaid recipients, and did not have information on hospital admissions outside the Kaiser Permanente system.

Although the program had only modest effects on health care use, they were generally more positive than for a similar pilot run by Colorado Access. This disparity may reflect differences in the pilots. For instance, Kaiser Permanente care managers and providers used one electronic records system, which was not the case for Colorado Access. In addition, the evaluation did not measure quality of care, use of social services, and patients' satisfaction with care, which were all program goals.

Preface

Within the Medicaid system for low-income individuals, the elderly and individuals with disabilities account for only 25 percent of recipients but almost 75 percent of spending. Many individuals in this high-needs group face multiple chronic conditions, which can result in the use of expensive prescription medications or frequent trips to the hospital emergency room. These problems may be exacerbated by the fee-for-service Medicaid system, which provides little incentive for health care providers to avoid duplicative care, to provide preventive care, or to keep track of the entirety of a patient's health care needs.

One promising idea for helping this high-needs group is to use health care professionals — care managers — to assess an individual's health care needs and to work with doctors to make sure those needs are being addressed. Many states have some form of coordinated care for Medicaid recipients, but few rigorous studies have been conducted on the effects of such services for a broad group of recipients with disabilities. This report helps to fill the gap by presenting results from a pilot coordinated care program that was operated in the Denver area by Kaiser Permanente Colorado. Conceived by the Colorado Department of Health Care Policy and Financing and the Center for Health Care Strategies, the evaluation included more than 2,600 Medicaid recipients with disabilities, some of whom were assigned at random to be eligible for the Kaiser Permanente coordinated care program.

Several aspects of the Kaiser Permanente program stand out. First, care managers and Kaiser Permanente doctors used the same electronic health care system, which provided care managers with access to information about the person's appointments, prescribed medications, test results, and admissions to hospitals in the Kaiser Permanente system that could be used in communicating with clients and doctors. In addition, program group members could use Kaiser Permanente specialists, who generally did not see other Medicaid recipients. The coordinated care program also built on the organization's considerable experience — for example, using an existing service to intervene with individuals who made frequent visits to the emergency room. Finally, Kaiser Permanente used a multidisciplinary care team that included nurses to help with medical needs, social workers to help with behavioral health problems, and community specialists to help individuals with other social service needs.

While the program did increase the use of specialty care and nonphysician providers such as physical therapists, it had little impact on use of preventive care, in part because most individuals saw a primary care provider even without the program, so there was little room for improvement. Nonetheless, the evaluation provides unusually rigorous information about the effects of a typical program that may help in designing more effective services in the future.

Gordon L. Berlin
President, MDRC

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The Authors

Executive Summary

Coordinated care programs are designed to address and circumvent problems that can arise when individuals with multiple chronic conditions seek health care. Their health care needs might require the attention of several specialists, which can result in duplicative tests or prescriptions for contraindicated medications, especially if they don't have a primary care provider or their primary care provider is not keeping track of their overall health care use or needs. Lack of primary care might also mean that some chronic conditions remain undetected, which might require the patient to seek emergency care or to be admitted to the hospital, increasing health care costs. Coordinated care programs attempt to minimize these problems by using care managers to assess individuals' health care needs and help them make appropriate use of the health care system before a medical emergency occurs. Such programs may be an important policy tool for aged and disabled Medicaid recipients, who account for about 25 percent of the Medicaid population but almost 75 percent of Medicaid spending.[1]

This report presents results through two years from an evaluation conducted by MDRC of a pilot coordinated care program run in the Denver area by Kaiser Permanente Colorado, which is part of the Kaiser Permanente national managed care consortium based in Oakland, California. This pilot program and a similar program run by Colorado Access were part of the Colorado Regional Integrated Care Collaborative (CRICC), which was a multiyear partnership of the Colorado Department of Health Care Policy and Financing (HCPF), the Center for Health Care Strategies, local health plans and providers, and other stakeholders that was designed to improve care for high-needs Medicaid recipients.

As part of this program, Kaiser Permanente CRICC care managers undertook a number of activities, mostly by telephone. First, they made sure that each individual in the program had a primary care provider, who could be considered the individual's first contact for care and would have some responsibility for ensuring that the individual's health care needs were being addressed. Early on, the care manager also assessed each individual's health care needs and social service needs. These assessments were used to develop goals that are related to health care (such as reducing emergency department use) and social service needs (such as arranging for transportation to a doctor's office or helping the individual find stable housing). Based on the health assessment, care managers scheduled more frequent calls with individuals who were categorized as "high risk" based on their health and recent hospitalizations or emergency department use, or who had greater needs than others based on the care manager's clinical judgment. Depending on an individual's needs, care managers provided educational information on medical conditions, coordinated care across providers, and helped individuals use the

[1]Vladeck (2003).

health care system (for example, by making appointments for them and accompanying them to those appointments).

The goals of the Kaiser Permanente CRICC program were to encourage people to make greater use of preventive health care and thereby to reduce hospital admissions and visits to the emergency department in the long term. Since care managers might uncover unmet medical needs, use of other types of care — such as specialty care — might also increase in the short term.

To understand whether the program affected health care use in these ways, the evaluation used a random assignment design. Between June 2009 and September 2010, all blind or disabled Medicaid recipients in Jefferson and Denver counties who were eligible for the study and the program (and who were in the traditional Medicaid fee-for-service system) were assigned at random to a program group, which had access to the Kaiser Permanente CRICC coordinated care program, or to a control group, which did not have access to coordinated care. In total, 2,618 people were randomly assigned, with 70 percent (1,831 people) assigned to the program group and 30 percent (787 people) assigned to the control group. Random assignment ensures that the program and control groups were similar in all respects when they entered the study. Comparing subsequent outcomes for the two groups, therefore, provides reliable estimates of the effects of being assigned to the program group.

Maximus, the state's enrollment broker, sent a letter to program group members explaining that they had been assigned to Medicaid managed care and asking them to choose one of three managed care programs — Kaiser Permanente Colorado, Denver Health, or the Primary Care Physician Program — or to choose to remain in traditional fee-for-service Medicaid. Individuals who did not make a choice by the end of the month were automatically (that is, "passively") enrolled in the Kaiser Permanente Colorado system. Kaiser Permanente CRICC staff then attempted to recruit their enrollees into an enhanced version of their standard coordinated care services, which were available for up to two years. In addition to covering health care, the enhanced program focused on social and other nonclinical needs more intensively than the standard Kaiser Permanente Colorado services. Control group members remained in the fee-for-service system without coordinated care services for the two years of the evaluation.

Using data on health care use provided by the Colorado Department of Health Care Policy and Financing, this report estimates the effects of passive enrollment into the Kaiser Permanente Colorado system on the use of health care services. The results indicate that the Kaiser Permanente CRICC program increased use of specialty care and care by providers who are not doctors, such as physical therapists and optometrists. (See Table ES.1 for the estimated impacts of passive enrollment into the Kaiser Permanente CRICC coordinated care program on key

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Table ES.1

Estimated Impacts of CRICC Pilot, Months 1-24 After Month of Passive Enrollment

Outcome	Program Group	Control Group	Difference (Impact)
Use of outpatient services (%)			
Any type of visit with a primary care physician	73.7	71.0	2.7
Wellness visit	62.6	61.4	1.1
Nonphysician visit	23.3	19.9	3.4 **
Specialist visit	72.0	68.4	3.6 **
Hospital admissions and emergency department use (%)			
Ever admitted to a hospital	21.7	23.4	-1.7
Readmitted within 30 days	5.4	4.4	1.0
Ever used an emergency department	51.5	53.4	-2.0
Filling prescription medications (%)			
Filled any prescription medication	77.5	75.3	2.2
Sample size (total = 2,618)	1,831	787	

SOURCE: MDRC calculations based on Medicaid claims data from the Colorado Department of Health Care Policy and Financing and on Kaiser Permanente data.

NOTE: A two-tailed t-test was applied to differences between the outcomes for the program and control groups. Statistical significance levels are indicated as follows:
*** = 1 percent, ** = 5 percent, * = 10 percent.

outcomes across the two-year study period.) These effects were concentrated among individuals who had multiple chronic conditions or had used substantial Medicaid resources in the past (not shown in the table). Although the program did appear to affect health care use over the two-year period, the effects of the program were generally small and not statistically significant on the more immediate targets of the intervention: primary care, hospital admissions and readmissions, and emergency department visits. An implementation study suggests some reasons why the program may have had few effects. In particular, care managers struggled to engage individuals in coordinated care services. In addition, most care management was provided by telephone, while recent research suggests that intensive in-person contact may be needed in order for care coordination to be effective.[2]

Although the results suggest that Kaiser Permanente's CRICC program had relatively little effect on Medicaid use, the study had several limitations that are worth keeping in mind.

[2]Brown (2009).

First, the study did not have information about other types of outcomes, such as use of social services and quality of care, both of which were targeted by the Kaiser Permanente CRICC program. Second, just more than half of the program group remained in the Kaiser Permanente CRICC program and thus had access to its enhanced coordinated care services. Although the analysis attempted to adjust for this, the results may still have missed some areas where the program was effective. Finally, there is some evidence that coordinated care may take longer than two years to reduce hospital admissions, so the program might have had greater effects if it had been in operation for a longer time. Nevertheless, the small estimated effects are consistent with recent findings that suggest that coordinated care programs should have more intensive, in-person services than those that were included in the Kaiser Permanente CRICC program.

MDRC is releasing two additional reports in 2013 on related pilots. A report on another CRICC pilot program in Colorado, the Colorado Access Coordinated Care Pilot Program, was released in April. Like the Kaiser Permanente CRICC program, the Colorado Access CRICC program was found to increase the use of nonphysician providers.[3] However, the effects of the Colorado Access program were generally smaller than those presented in the current report. In addition to reports on the two Colorado pilots, a report will be released in fall 2013 on the Chronic Illness Demonstration Project, which provided coordinated care for high-needs Medicaid recipients with multiple chronic conditions in New York's fee-for-service Medicaid system.

[3]Michalopoulos, Manno, Kim, and Warren (2013).

About MDRC

MDRC is a nonprofit, nonpartisan social and education policy research organization dedicated to learning what works to improve the well-being of low-income people. Through its research and the active communication of its findings, MDRC seeks to enhance the effectiveness of social and education policies and programs.

Founded in 1974 and located in New York City and Oakland, California, MDRC is best known for mounting rigorous, large-scale, real-world tests of new and existing policies and programs. Its projects are a mix of demonstrations (field tests of promising new program approaches) and evaluations of ongoing government and community initiatives. MDRC's staff bring an unusual combination of research and organizational experience to their work, providing expertise on the latest in qualitative and quantitative methods and on program design, development, implementation, and management. MDRC seeks to learn not just whether a program is effective but also how and why the program's effects occur. In addition, it tries to place each project's findings in the broader context of related research — in order to build knowledge about what works across the social and education policy fields. MDRC's findings, lessons, and best practices are proactively shared with a broad audience in the policy and practitioner community as well as with the general public and the media.

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