MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	April 9, 2018
SUBJECT	Department of Health Care Policy and Financing BA16 Comprehensive Claim Cost Control (Arrived March 20, 2018)

The Governor submitted a budget amendment for the Department of Health Care Policy and Financing, regarding comprehensive claim cost control measures, on March 20, 2018. Due to the late submission and the need to introduce a budget, the JBC tabled action on the request.

If the JBC wants to approve the request, in part or in whole, the JBC could either attempt to make the corresponding funding adjustments during the conference committee on the Long Bill, or introduce separate legislation for the budget changes. Making the changes during the conference committee on the Long Bill would be more expedient, but might be viewed as less transparent and offering less opportunity for stakeholder input and full debate by the General Assembly.

For example, the Colorado Hospital Association recently raised concerns with the JBC staff that operational decisions about how to implement the proposals described below, such as which products and vendors to use and whether there are sufficient resources to handle appeals in a timely manner, could significantly influence the administrative burden on hospitals of implementing the proposals. The Colorado Hospital Association raised concerns that it has not received sufficient information about the proposals from the Department, or had sufficient time to review the information, to formulate a position. The Colorado Hospital Association suggested a pilot program rather than statewide implementation. This is emblematic of the kinds of concerns that could be raised about authorizing the Department's request through a conference committee action.

The discussion below focuses on the policy merits of the request, rather than the best procedural course of action, should the JBC want to fund the request in part or in whole.

REQUEST

The Governor proposes implementing four new initiatives intended to control Medicaid expenditures:

- Create a resource control unit of six people (5.4 FTE in the first year) dedicated to controlling costs
- Deploy cost and quality technology for the Regional Accountable Entities and providers that identifies the most effective providers and medications to help steer clients to the best health outcomes and reduce expenditures
- Implement a comprehensive hospital admission review program, including pre-admission certification, continued stay reviews, discharge planning, and retrospective claims reviews
- Purchase commercial technology that would periodically update billing system safeguards that identify and reject inappropriate claims

The new executive director for the Department, Kim Bimestefer, has identified these procedures as industry best practices currently missing from the Department's oversight of the Medicaid program.

The Department projects these initiatives will result in a net savings of $2.0 million total funds, including $817,761 General Fund, in FY 2018-19. This is based on implementation costs of $8.0 million total funds, including $1.9 million General Fund, offset by projected savings of $10.0 million total funds, including $2.7 million General Fund. The projected savings increases in the second year to $48.5 million total funds, including $13.3 million General Fund, when all four initiatives are fully implemented.

RECOMMENDATION

The table below summarizes the staff recommendation. Each component of the request and the staff recommendation is discussed in more detail under the subheadings below.

BA16 Comprehensive Claim Cost Control					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2018-19					
Resource control unit	*860,399*	*353,576*	*76,625*	*430,198*	*3.6*
Cost and quality technology	*3,000,000*	*1,040,250*	*459,750*	*1,500,000*	*0.0*
Technology	3,000,000	1,040,250	459,750	1,500,000	
ACC Savings	0	0	0	0	
Prescription drug savings	0	0	0	0	
Hospital admission review	*(3,631,584)*	*(1,231,630)*	*(158,659)*	*(2,241,294)*	*1.4*
Staff	102,668	51,334	0	51,334	1.4
Reviews	2,075,000	307,741	136,009	1,631,250	
Savings	(5,809,252)	(1,590,705)	(294,668)	(3,923,878)	
Billing system safeguards	*1,650,000*	*130,031*	*57,469*	*1,462,500*	*0.0*
Installation and licensing	1,650,000	130,031	57,469	1,462,500	
Savings	0	0	0	0	
TOTAL	**1,878,815**	**292,227**	**435,185**	**1,151,404**	**5.0**
FY 2019-20					
Resource control unit	*872,295*	*359,523*	*76,625*	*436,147*	*4.0*
Cost and quality technology	*1,000,000*	*346,750*	*153,250*	*500,000*	*0.0*
Technology	1,000,000	346,750	153,250	500,000	
ACC Savings	0	0	0	0	
Prescription drug savings	0	0	0	0	
Hospital admission review	*(10,680,974)*	*(3,215,946)*	*(465,835)*	*(6,999,192)*	*2.0*
Staff	111,230	55,615	0	55,615	2.0
Reviews	3,150,000	546,131	241,369	2,362,500	
Savings	(13,942,204)	(3,817,692)	(707,204)	(9,417,307)	
Billing system safeguards	*(6,497,635)*	*(2,050,410)*	*(259,653)*	*(4,187,573)*	*0.0*
Installation and licensing	2,700,000	468,112	206,888	2,025,000	
Savings	(9,197,635)	(2,518,522)	(466,541)	(6,212,573)	
TOTAL	**(15,306,314)**	**(4,560,083)**	**(495,613)**	**(10,250,618)**	**6.0**

RESOURCE CONTROL UNIT

REQUEST

The Department proposes creating a resource control unit with the following six positions:

- Prescription drug expert to provide guidance and recommendations for prescription drug and specialty drug cost control strategies
- Program manager for performance-based payments, including payments for hospitals, primary care providers, prescription drugs, and the Accountable Care Collaborative
- Analyst to align payment methods with the cost and quality technology tools requested, so providers that use the tools earn higher performance payments
- Analyst to focus on cost, quality, and access in rural communities
- Senior executive service position to lead the unit
- Project manager to assist with identifying top opportunities for savings, with analysis of the highest performing Medicaid and commercial best in class programs, with reviewing industry innovations and emerging technologies, and with negotiations and management of vendors

In addition to the new positions, the request includes $500,000 for contract services for initiatives that may need outside analysis. The Department does not directly attribute any savings to these positions, but views these positions as critical to designing and implementing strategies such as those proposed in the other components of the request that would result in savings.

RECOMMENDATION

Staff recommends the first four positions (3.6 FTE in the first year) bulleted above and the requested contract services, but not the senior executive service position and project manager. In addition, staff recommends applying the JBC's common policies regarding benefits for new FTE, and different fund sources than the request based on the new cost allocation plan for the Department that was approved by the JBC.

The Department has identified four areas where more staff would help with strategic planning beyond just day to day program management, including prescription drug management, performance-based payments, cost and quality technology tools, and rural health. The JBC staff agrees these are areas where the Department needs to focus regardless of the executive director. However, the JBC staff is concerned about funding a senior executive service position and project manager for a new unit when the Department might have a new executive director with different priorities in November after the election.

If the current executive director wants to create a cost and quality unit, she could do so with existing resources by reorganizing staff within the Department. A senior executive service (SES) position is an at-will position and statutes allow higher compensation for these positions than would be possible for employees in the classified system (the request assumes an annual salary of $150,000). Statutes limit the number of SES positions statewide to 150 and the Department has been allocated more SES positions than it is currently using. In the time available to evaluate this request, the JBC staff was not able to reconstruct the history to determine whether the Department was never funded for the unutilized SES position, or if some previous administration decided to use the funding in a different manner for classified positions. Either way, the current executive director could create an SES position

by reallocating funding for classified positions as attrition occurs, or with a portion of the money recommended by the JBC staff.

It is important to note that while the General Assembly appropriates the funds for FTE, the executive branch makes the decisions about how to staff departments. The Department's actual hiring decisions could differ from the JBC staff recommendation. The JBC staff believes the policy arguments for the first four positions are the strongest, but if the Department wants to use the money for a senior executive service position and some combination of the other positions that fits the appropriation, it could do so.

If the JBC wants to approve the additional two positions, but apply the JBC's common policies, it would require an additional $249,988 total funds, including $124,995 General Fund, and 1.8 FTE in FY 2018-19.

COST AND QUALITY TOOLS

REQUEST

The Department proposes making data tools available to the Regional Accountable Entities and providers to help guide referrals and prescriptions to the most cost effective providers and practices. The Department estimates that development of the tools will cost $3.0 million and ongoing updates and maintenance will cost $1.0 million. The Department projects that utilization of the tools will save $10.0 million ($2.7 million General Fund) over and above the current projected savings for the Accountable Care Collaborative (ACC) in FY 2018-19, growing to a savings of $25.3 million ($6.9 million General Fund) in FY 2019-20, by funneling patients to more cost effective providers and pharmaceuticals.

The medical tool will use performance metrics to identify the providers with the best patient outcomes who are thereby the most cost effective. When new clients enter the Accountable Care Collaborative, the tool will suggest the highest performing primary care providers to steer patients to the most effective medical homes. Currently, new clients receive recommendations for providers based purely on geographic proximity. Similarly, when referrals are made for specialty care, the tool will suggest providers with the best health outcomes for Medicaid patients. The Department identified a private insurance carrier that achieved 85 percent of expenditures on the top 15 percent most effective providers in the carrier's network, and argued that this distribution was a function of using a similar tool to what the Department proposes. Clients and providers could still choose to override the suggestions from the tool to use the providers of their choice. Thus, the tool will not limit choices for clients actively involved in directing their own care, but will provide data to better inform client decisions.

The pharmacy tool will suggest to providers the most cost effective medications based on diagnosis information entered by the provider. The Department is working with other insurers in Colorado to use the same pharmacy tool across all insurers, so that providers are not being encouraged or incentivized to use different systems with different insurers. Kaiser already uses a similar proprietary pharmacy tool and analysis of data from the All-Payer Claims Database suggests Kaiser's average expenditure per member per month for pharmacy has decreased from $44 in 2014 to $38 in 2017, while the average for all commercial payers has increased from $50 in 2014 to over $66 in 2015.

Providers can still override the suggestions from the pharmacy tool, as long as the alternative meets any applicable prior authorization review criteria.

RECOMMENDATION

Staff recommends approval of the request with modifications to: (1) assume no savings (for now); and (2) add a reporting requirement to monitor implementation progress and outcomes. The Department makes a solid case that implementing the tools should result in savings, but the Department's estimate of the savings is overly rough, and may overlap with projected savings from other Department initiatives. Also, the projected savings are largely dependent on changes in provider and client behavior that may or may not occur at the rate the Department expects. Finally, the Department might be depending too heavily on the Regional Accountable Entities to perform outreach and training related to the tools and instead might need some statewide budgeted resources for outreach and training. For these reasons, the JBC staff recommends monitoring the implementation progress and outcomes before projecting a reduction in expenditures.

For the medical tool, the Department's actuary estimates that the Department spends $166,494,242 annually on potentially avoidable costs at hospitals for care that is unplanned and could be prevented through improved care, care coordination, or effective community-based care. By directing care to the most effective providers, the actuary estimated the Department could reduce potentially avoidable costs at hospitals by 20 percent. The Department set a target of reducing potentially avoidable costs by 10 percent to identify savings of $16.6 million. The Department noted at least one private insurer that spends 85 percent on the top 15 percent most effective providers, but it is not clear to the JBC staff that this distribution is purely the result of implementing a medical tool similar to what the Department proposes, or that the Department could achieve a similar distribution of expenditures. Then, the Department assumed it could earn savings of at least another $3.4 million from reducing potentially avoidable costs on physician services, laboratory and radiology, and federally qualified health centers to arrive at a nice even and round $20 million in savings annually ($10 million in FY 2018-19 for a half-year of implementation).

For the pharmacy tool, the Department assumes savings equal to one percent of expenditures, noting the success of Kaiser's pharmacy tool. However, it is important to note that Kaiser's pharmacy tool is only one piece of Kaiser's overall care coordination efforts and other elements of care coordination might contribute to the trend in pharmacy expenditures for Kaiser. Also, Kaiser's pharmacy tool is integrated with Kaiser's electronic health record system and all doctors within the network must use it. Utilization of the Department's pharmacy tool will be voluntary and the level of integration with electronic health record systems will likely vary, as will the level of use of electronic health records.

The projected savings are dependent on clients and providers adapting to the tools and changing behaviors. For example, when the medical tool suggests the most effective primary care providers, a client has to select those providers, instead of selecting providers who might be closer geographically. When a physician refers a patient for specialty care, the referring physician or client needs to use the tool to identify the most effective providers, or the Regional Accountable Entity needs to somehow intervene and provide information from the tool, in order to guide the client to the most effective care. For the pharmacy tool, providers need to change their procedures to consult the tool in order for it to change prescribing practices.

The projected savings from the medical tool are described as additional savings attributable to the ACC. The Department already estimates the ACC will result in at least $120.9 million in savings in FY 2018-19, composed of two pieces. First, according to the Department's annual report, Phase I of the Accountable Care Collaborative saved $21.6 million in FY 2016-17 over FY 2015-16, which is built into the Department's per capita expenditures assumptions and carries forward into FY 2018-19.[1] Implementation of Phase II of the Accountable Care Collaborative (ACC) is projected to save another $99.3 million in FY 2018-19. The projected savings from the medical tool would add another $20 million to this total assumed savings from the ACC.

To monitor the implementation progress and outcomes, the JBC staff recommends the following request for information:

N Department of Health Care Policy and Financing, Executive Director's Office - The JBC requests that the Department work with the Governor's Office of Research and Evidence-Based Policy Initiatives to design a program evaluation for the medical and pharmacy cost and quality tools designed to guide primary care attribution, specialty care referrals, and prescriptions to the most cost effective providers and practices. The JBC requests that the Department annually report on the status of implementation and the performance of these initiatives by November 1 each year through November 1, 2020.

HOSPITAL ADMISSION REVIEW

REQUEST

The Department proposes a comprehensive review of all hospital admissions, including pre-admission certification, continued stay reviews, discharge planning, and retrospective claims reviews. Currently, the Department has prior authorization review criteria for several diagnosis that would require hospitalization, but not all hospitalizations. According to the Department, most private insurers and many public insurers require more thorough hospital reviews than the Department's current practice. The reviews would use evidence-based-medicine standards published by InterQual. Medicaid generally has more favorable appeal procedures and standards than private insurers, if a provider needs to challenge a hospital review decision.

One of the aims of the reviews is to ensure that the Department knows in real time when a client is admitted or discharged from the hospital, rather than only discovering hospital admissions and discharges when bills are submitted. This will better enable the Regional Accountable Entities to manage care, for example by following up to help clients adhere to discharge plans and thereby decrease readmissions.

The Department requests funding for two positions to oversee the utilization management contract deliverables, perform outreach and education to providers, handle appeals, manage system changes, and ensure quality, with one position starting at the beginning of the year and the second position starting in January. In addition to the new staff, the Department requests $2.1 million in FY 2018-19 and $3.2 million in FY 2019-20 to perform the reviews, which includes payments to the vendor

[1] The Department no longer attempts to estimate the total annual savings from Phase I of the ACC, but only the annual incremental increase in savings, because the assumed savings from Phase I are inseparable from the overall per capita trends with nearly the entire Medicaid population enrolled in the ACC.

performing the reviews and one-time programming costs to integrate the reviews with the Department's billing system. The reviews would begin in January 2019. To account for delays between when services are provided and payment is rendered, and to be conservative, the Department did not project any savings until FY 2019-20, when the Department anticipates hospital utilization will decrease by $13.9 million total funds, including $3.8 million General Fund.

RECOMMENDATION

Staff recommends the request, but with modifications to: (1) apply the JBC's common policies regarding benefits for new FTE; and (2) assume savings in FY 2018-19 of $5.8 million total funds, including $1.6 million General Fund. This is a relatively straightforward change that is consistent with industry practices and can be implemented centrally. The savings are not dependent on providers adopting new behaviors. The Department has solid data on denial rates from other state Medicaid programs with similar review requirements. The Department is only estimating savings from denials based on non-compliance with evidence-based-medicine standards and not denials based on technical issues. Also, the Department is assuming half the rate of denials in other states to account for potential overlap with other concurrent Department initiatives that might reduce hospital admissions and length of stay. For these reasons, the JBC staff believes it is appropriate to assume savings, and to project that the savings will begin in FY 2018-19. The Staff calculation is based on 5 months of savings in FY 2018-19 to account for the average one-month delay between when services are provided and when payment is rendered.

One concern raised by the Colorado Hospital Association regarding this request is whether the request includes sufficient funds for the timely processing of appeals. The JBC staff assumes that the Department will bid for the review services and include minimum standards for timely processing of appeals. If the funding is insufficient for a bidder to provide timely processing of appeals, the Department would submit a supplemental request.

BILLING SYSTEM SAFEGUARDS

REQUEST

The Department proposes subscribing to commercial technology that would periodically update billing system safeguards that identify and reject inappropriate claims. The Department currently preforms minimum checks mandated by the federal Centers for Medicare and Medicaid Services (CMS) on claims. These checks look for compliance with standards of the National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUEs). The Department proposes additional checks against a broader set of CMS rules, the American Medical Association Billing Guidelines, and billing guidelines of specialty societies (i.e., the American College of Surgeons). This is the next step up among three potential tiers of commercially available billing system checks the Department could implement.

The Department estimates implementation and set-up costs of $1,650,000 total funds, including $130,031 General Fund, in FY 2018-19. Beginning in FY 2019-20, the ongoing licensing and update costs would be $2.7 million total funds, including $468,112 General Fund. The Department projects savings beginning in FY 2019-20 of $9.2 million total funds, including $2.5 million General Fund, from denying inappropriate claims. The Department's estimate is based on 1.0 percent of physician services, laboratory and radiology, federally qualified health centers, and net pharmacy expenditures.

RECOMMENDATION

Staff recommends approval of the request. Similar to the Hospital Admission Reviews, these billing system safeguards are relatively straightforward, are consistent with industry practices, and can be implemented centrally. The savings are not dependent on providers adopting new behaviors. The Department was not able to identify denial rates from others states or private providers making the same transition in the level of billing safeguards as proposed for Colorado, but the Department selected conservative estimates of the potential savings. Also, the Department should be able to get a better estimate from the contract provider based on a review of the Department's actual claims history to revise the forecasted savings prior to finalization of the FY 2019-20 budget, when the projected savings would be a factor.