MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	March 16, 2017
SUBJECT	Health Care Policy and Financing Comebacks CU School of Medicine Supplemental Payments

➔ CU SCHOOL OF MEDICINE SUPPLEMENTAL PAYMENTS

STATUS

The JBC tabled the issue to provide sufficient time for the University of Colorado to respond to the staff recommendation.

NEW INFORMATION

The JBC staff met with representatives of the University of Colorado and has some information that may inform the JBC's decision.

1 **Could the financing proposal be modified to free up General Fund for budget balancing and/or to spread the benefit to a broader range of providers?**

The original staff recommendation suggested there were alternative ways to structure the financing to free up General Fund for budget balancing and/or to spread the benefit to a broader range of providers. The simplest way to do this (though not the only possible option) that adds the least number of additional complicating factors would be to reduce the General Fund for the Health Sciences Center and ask University Physician, Inc. to increase the proportion of the supplemental payments that they pay back to the Health Sciences Center in order to keep the medical school whole. This would reduce the net benefit to the physicians, but free up General Fund that could be used for budget balancing and/or to spread increased rates to a broader population of providers.

The University of Colorado does not believe this is possible or appropriate, because it would divert federal funds intended for serving Medicaid clients to pay for the medical school. The University of Colorado is comfortable with diverting the General Fund to pay for the medical school because of the "shared mission" to care for the underserved.

If there is a shared mission and that is sufficient to justify diverting the General Fund to pay for the medical school, then the JBC staff believes that should be a sufficient argument to divert the federal funds. It is unknown what the federal Centers for Medicare and Medicaid Services (CMS) would approve, or even if they would have jurisdiction over how University Physicians, Inc. spends the money they receive from Medicaid after the services have been rendered to Medicaid clients.

The additional information provided by the University of Colorado does not change the JBC staff's belief that the financing could be modified to free up General Fund. It is important to note that in order to reduce the General Fund for specialty education the JBC would need to sponsor a bill to change the requirements for the higher education distribution formula that were established in H.B. 14-1319.

2 Does the proposal inappropriately give an unfair advantage to a specific provider?

The original staff recommendation noted that the proposal gives preferential treatment to one provider and that the proposal has not been reviewed or recommended by the Medicaid Provider Rate Review Advisory Committee. The original staff recommendation went on to note that analysis by the Medicaid Provider Rate Review Advisory Committee indicates Medicaid clients access specialty care at the same rate as those privately insured and that the proposal could result in a transfer of utilization from other providers that are not as well compensated rather than an increase in access for Medicaid clients.

The University of Colorado argues that the rate at which Medicaid clients access specialty care does not tell the whole story. Medicaid clients tend to be sicker than the overall population, and so the expected utilization of specialty care should be higher than the overall population. Also, Medicaid clients wait longer to see specialists than the privately insured, with 38 percent of Medicaid clients being seen within 10 days of scheduling an appointment versus 48 percent of commercial pay clients.

The University of Colorado quoted a survey from the Colorado Health Institute that found safety net clinics reporting greater difficulty securing specialty referrals for uninsured and Medicaid patients than privately insured patients. Also, the University of Colorado shared feedback from Denver Health that identified difficulty finding specialty care for the following services that Denver Health does not have the expertise to handle.

High Volume	Medium Volume	Low Volume
Complex cardiothoracic surgery	Orthopedic oncology	Orthopedics/foot & ankle subspecialty
Complex hematology/oncology	Biliary, pancreatic and esophageal motility disorders	Congenital orthopedic pediatric disorders
Radiation oncology	Pulmonary hypertension	Medical toxicology
Allergy and immunology	Interstitial lung diseases	Structural interventional cardiology
Otolaryngology		Pituitary neurosurgery
Opthalmology		Specialty endocrine surgery
Urology		
Dermatology		

The University of Colorado provided survey data suggesting specialists are reluctant to see Medicaid clients, and for reasons beyond just reimbursement. Respondents to the survey perceived issues in the Medicaid population with missed appointments, non-adherence to treatment and recovery plans,

limited family and friend supports, behavioral health complications, medical complications, litigiousness, low education, aggressiveness, and waiting room effects. The implication being that provider biases, as much as reimbursement levels, tend to funnel Medicaid clients to mission driven organizations, such as medical schools, that are willing to accept Medicaid patients. The consultant advising the University of Colorado reports that in other states private practice providers have been supportive of increased payments for care provided by medical schools that see high volumes of Medicaid patients. The consultant views increased rates for care provided by medical schools as a response to imbalances in the Medicaid market, rather than a cause of market distortion.

The University of Colorado does not turn away Medicaid clients, but some specialties impose limits on the number of appointments in a given time period to ensure financial viability, which leads to the disparities in wait times noted above. The University of Colorado estimates 30 percent of overall patient volume is attributable to Medicaid and 48 percent of pediatric care is attributable to Medicaid.

The additional information provided by the University of Colorado provides some rationale and justification for a differential payment for care provided through the School of Medicine.

3 Does the proposal promise enough improved performance for the increased payment?

The original staff recommendation raised a two-pronged concern about the promised performance that: (1) payments are not tied to performance such that there are financial consequences for failure to achieve the expected performance; and (2) the promised performance may be low for the additional financing provided.

The University of Colorado was unsure how payments might be tied to performance and did not commit to a position, but reiterated confidence that the performance objectives outlined in the Proposed Use of Additional Funding would be achieved. Staff from the University of Colorado appeared open to discussing further with the Department of Health Care Policy and Financing the possibility of tying a portion of the supplemental payments to achievement of the goals in the Proposed Use of Additional Funding. The Proposed Use of Additional Funding is reproduced in the table on the next page.

Proposed Use of Additional Funding (in Millions)		Descriptions	Measurement or Outcome
Expand Patient Volume	$ 32.8	Expand physician and advanced practice provider patient volumes for primary and specialty care for adults and children. CUSOM physicians saw 164,756 unique Medicaid Patients in 2016. Current Year Common Procedure Codes (CPT) count for Medicaid patients is 942,202, these are individual services provided to patients.	Increase the number of Medicaid visits provided by CUSOM physicians by approximately 10,000 patients which will result in approximately 56,000 patient services provided. Of the 10,000, 1,500 are anticipated to be Primary Care patients receiving full medical home services.
Expand Access and Enhance Care Using Medical Home Model	$ 17.9	Expand full medical home services from 5,500 to 7,000. Medical homes may be provided by Internal Medicine, Behavioral Health, Family Medicine, Geriatrics, Obstetrics, and Infectious Disease (HIV) as well as enhanced comprehensive services to children.	
Expand Targeted Rural Patient Access	$ 5.3	Expand in-person specialty services in and outside of the Denver metropolitan area by recruiting additional specialty providers and/or increasing time available from current providers; e.g., rheumatology for adult patients and expanded specialty care for children in Durango, Colorado Springs, and Pueblo.	10 FTE Pediatric and Adult Subspecialtists. While specialties vary and each specialist can only accommodate so many visit and services per week, an increased level of services will be delivered via this additional provider capacity.
Expand Telemedicine	$ 2.1	Expand adult and pediatric specialty reach to rural locations through telehealth and e-consults in partnership with local rural providers. Provide technology and specialist time in areas identified by rural communities.	Current estimates are that telemedicine has the opportunity to increase Child Health Access by 10% which would represent 22,000 additional specialty outpatient visits for Colorado children. Increased telehealth visits should also enhance timeliness of specialty care access noted above.
Investment to Achieve Cost Reductions and Expand Transition of Care	$ 1.3	Reduction of the total cost of care through decreased ED utilization and readmissions as well as implementation of referral and utilization management tools that align with Colorado Medicaid strategies. Aligns with Colorado Medicaid strategies. Reduction in total cost of care by investing in 4 case managers and 2 pharmacists.	4 Case managers and 2 pharmacists
Investment in Evidence Based Outcomes	$ 1.0	Investment opportunities in current innovation activities underway that have evidence based outcomes such as Bridges to Care, SIM innovation grant, Patient Centered Medical Home, etc.	Higher quality performance and improved care models (eg embedded behavioral health). This programs seek to enhance primary care access, enhance behavioral health access and better coordinate a patient's physical and behavioral health. Combined the programs seek to improve health quality and lower costs.
HCPF Implementation	$ 0.8	Funding provided to HCPF for staff needed to implement the programs.	HCPF Implementation Staff
Additional Family Medicine Residencies	$ 0.5	Family Medicine Residency Training Program	Colorado Commission on Family Medicine to fund an additional resident per year for the first three years, totaling to three additional residents in FY 2019-20 and ongoing.
Targeted Scholarships (Rural services)	$ 0.2	Increase UPI Medical School Scholarships to target rural track students. Goals of reducing student debt and encourage practice in underserved areas.	Scholarships and rural track support
Total	**$ 61.9**		

Based on the Proposed Use of Funding, the School of Medicine expects to use $50.7 million to serve an additional 10,000 patients, which equates to an average cost per additional patient of $5,070.00. The supplemental payment is on top of whatever the School of Medicine earns from fee-for-service payments from treating those 10,000 patients. The FY 15-16 average Medicaid payment to University Physicians, Inc. per unique Medicaid client was $511.95. The Medicaid per capita expenditure for acute care was $2,916.33. The proposed funding per additional patient is significantly higher than current expenditures per client.

Expand Patient Volume	$32,800,000
Expand Access and Enhance Care	$17,900,000
Subtotal	$50,700,000
Additional Patients	10,000
Ave. Cost per Additional Patient	$5,070.00
Current Payments to UPI	$84,346,644
Unique Medicaid Clients	164,756
Ave. Per Unique Medicaid Client	$511.95
Medicaid Acute Care Per Capita	$2,916.33

In response, the University of Colorado says 10,000 is the low end of the anticipated expansion and the University hopes to exceed that estimate. The University of Colorado estimates that commercial payers currently pay two thirds more than Medicaid clients and that with the additional funding the School of Medicine will still rely on commercial payors to subsidize services for Medicaid clients. Per the University of Colorado:

> *Without supplemental funding in this proposal, market pressures on commercial reimbursement, the need to retain and attract outstanding faculty physicians, as well as other pressures on public funding sources, the CUSOM will face difficult choices including if it can maintain current staffing levels and maintain or expand its level of service to specialty services to Medicaid patients.*

The next item on the Proposed Use of Funds is $5,300,000 for an additional 10.0 FTE to increase specialty care in rural communities, or $530,000 per FTE. While this sounds high to the JBC staff, the University of Colorado explains that the cost of specialists and subspecialists in a remote location is typically twice total compensation, because of time away from practice, travel, and the cost of support staff and facility rentals in the outreach location.

With the additional information provided by the University of Colorado, the JBC staff is still concerned that the expanded services for Medicaid clients seems low for the increased funding that would be provided.

COPY OF ORIGINAL RECOMMENDATION

REQUEST: With the November budget the Department included an "informational request" estimating how funding would need to change to create a supplemental payment for physicians of the University of Colorado School of Medicine. When asked what an "informational request" means, staff for the Office of State Planning and Budgeting explained that the information was provided, "to demonstrate the commitment to increasing the cash fund allocations for [the University of Colorado School of Medicine] while waiting approval from [the Centers for Medicare and Medicaid Services]. The departments will continue to work together to complete an acceptable

interagency agreement." This led the JBC staff to assume that a formal request would be submitted at a later date, but nothing additional has been submitted.

The concept is that funding for the University of Colorado Health Sciences Center would be transferred to the Department of Health Care Policy and Financing, where it would be used to match federal funds and make a supplemental payment to enhance Medicaid reimbursement rates for physicians who are faculty of the School of Medicine and provide clinical care at the University of Colorado Hospital and Children's Hospital. Then University Physicians, Inc., a component of unit of the University of Colorado that is responsible for physician billing, would take a portion of the supplemental payments and give them back to the University of Colorado Health Sciences Center to hold education program harmless. The remainder of the supplemental payments would be distributed to the physicians. A small portion of the funds would come off the top for administrative costs at the Department of Health Care Policy and Financing and to pay for three additional family residency training placements.

Supplemental Payment to the University of Colorado School of Medicine Pursuant to H.B. 16-1408				
	Total Funds	Reappropriated Funds	Federal Funds	FTE
HCPF Administrative Costs	$824,863	$412,432	$412,431	6.0
Family Medicine Residency Training	$300,000	$150,000	$150,000	0.0
CU School of Medicine Supplemental Payment	$122,675,137	$61,337,568	$61,337,569	0.0
TOTAL	**$123,800,000**	**$61,900,000**	**$61,900,000**	**6.0**

House Bill 16-1408 made a change to the higher education statutes to allow this type of payment by adding the following section:

> *23-18-304. Funding for specialty education programs – area vocational schools – local district junior colleges. (1) (c) Specialty education services provided by the health sciences center campus at the university of Colorado as authorized by paragraph (a) of this subsection (1) [higher education fee-for-service payments] includes care provided by the faculty of the health sciences center campus at the university of Colorado that are eligible for payment pursuant to section 25.5-4-401, C.R.S. [Medicaid provider payments]*

The federal government allows supplemental payments to faculty at public medical schools up to an upper payment limit and CU testified to the JBC that approximately 30 states already make similar payments, which includes some states that make payments to broader groups that include public medical school faculty. When asked if any of those other states have removed direct state funding for their medical schools and replaced it with indirect funding from a separate nonprofit physician organization, the departments replied that they did not know.

The Department estimates that the supplemental payments would increase Medicaid reimbursements to University Physicians, Inc. by 72 percent.

Supplemental Payments to UPI, Inc. under Proposal	$ 123,042,864
Less Funds Transferred from Department of Higher Education to Department of Health Care Policy and Financing	$ 61,900,000
Net New Funding to UPI, Inc. from Proposed Supplemental Funding Mechanism	$ 61,142,864
FY 2015-16 Medicaid claims payments to UPI, Inc.	$ 84,346,644
Percentage Increase to UPI, Inc.	72%

The Department submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services on September 30, 2016, seeking federal approval for the supplemental payments. The SPA requests retroactive approval to July 1, 2016. The Department anticipates the SPA could be approved by July 1, 2017, allowing supplemental payments to begin in FY 2017-18 based on FY 2016-17 claims data.

RECOMMENDATION: The JBC staff does not recommend any funding in the Long Bill for the supplemental payments to the University of Colorado School of Medicine physicians. The supplemental payments would provide a significant financial advantage to University of Colorado School of Medicine physicians compared to other providers. The Department's policy case for why these providers should receive preferential treatment is not robust, and the JBC views the primary rationale for the targeted payments as being that this financing option is not available to providers who are not employed by the School of Medicine.

The JBC staff can envision other ways to take advantage of the special financing opportunity that the University of Colorado has identified that don't provide preferential treatment to a special class of providers. For example, instead of transferring the current level of General Fund for the University of Colorado School of Medicine to the Department of Health Care Policy and Financing, the General Assembly could reduce the General Fund for the University of Colorado and then make up the difference with the federal matching funds through the supplemental payments. This would free up General Fund to address other state budget needs without any negative impact on the School of Medicine. Alternatively, the JBC could transfer the full current level of General Fund for the University of Colorado School of Medicine, send the supplemental payment to UPI, and then ask UPI to not only pay for the School of Medicine, but also for nursing programs at community colleges. This would free up General Fund that would otherwise be appropriated for the nursing programs. If UPI can make a private payment for the Medical School, why not a private payment for nursing programs at community colleges? The extra General Fund made available by either of these strategies could be used for Medicaid financing in an environment of reduced federal funding, applied for a completely different purpose such as K12 funding, or saved in the General Fund.

The proposed supplemental payments for the employees of the School of Medicine have not been reviewed or recommended by the Medicaid Provider Rate Review Advisory Committee. A significant focus of the proposed supplemental payments is expanding access to specialty care for Medicaid patients, but the Medicaid Provider Rate Review Advisory Committee's Rate Review Analysis Report indicates that Medicaid patients are not more or less likely to access specialty care than privately insured Coloradoans. It is not clear to the JBC staff that the Medicaid Provider Rate Review Advisory Committee would identify issues with access to care for Medicaid clients that would need to be addressed through a targeted rate increase.

According to the Proposed Use of Additional Funds submitted to the JBC, the majority of the additional money would be used to expand patient volume and expand access and enhance care

using a medical home model. The success of these initiatives would be measured based on CU School of Medicine physicians seeing an additional 10,000 Medicaid patients and providing them 56,000 services. The Department assumes that the majority of this would be new utilization. However, the JBC staff is concerned that a more likely result is a transfer of utilization from other providers that will not be as aggressive in pursuing Medicaid patients due to less favorable reimbursement rates. This could actually be counter-productive for Medicaid clients as they would be funneled to narrower group of providers.

One of the proposed uses of the funds is to expand targeted rural patient access, to be measured by the hiring of 10 FTE pediatric and adult subspecialists. The JBC staff sees this as a very large investment to get only 10 FTE targeted at rural patient access. Furthermore, the additional 10 FTE should not be viewed as being located in rural communities. According to the Department: "Due to the size and populations of rural communities it is more likely that FTE would not permanently reside in these locations. To enable the CUSOM to provide as much care as possible in rural areas, additional outreach clinic services would be set up or expanded throughout the state."

Everything else the Department is proposing to do with provider rates has a significant focus on performance payments. It is not clear to the JBC staff that the supplemental payments would be based on performance. The supplemental payments would go to only one provider.

If the General Assembly is going to authorize a 72 percent increase in payments for UPI, there should be a high return on the investment. The JBC staff believes the departments should be able to show a greater benefit for the Medicaid program and the state budget as whole than what has been proposed so far. In particular, the JBC staff would like to see a net General Fund savings and higher performance expectations than what has been described to the JBC so far.