

STATE OF COLORADO FY 2010-11 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13 Change Request for FY 2010-11 Budget Request Cycle											
Decision Item FY 2010-11		Base Reduction Item FY 2010-11			Supplemental FY 2009-10			Budget Amendment FY 2010-11			
Request Title: Evidence Guided Utilization Review (EGUR)		Health Care Policy and Financing			Dept. Approval by: John Bartholomew JB			Date: January 25, 2010 1/19/10			
Department: Health Care Policy and Financing					OSPB Approval:			Date: 1-25-10			
Priority Number: BA-12											
	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,553,778,279	2,604,453,282	0	2,604,453,282	3,043,000,452	118,359	3,043,118,811	282,653	3,043,401,464	598,368
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	926,152,259	1,120,729,217	0	1,120,729,217	1,148,287,104	(11,201)	1,148,275,903	(68,169)	1,148,207,734	(107,019)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,228,606	167,690,592	0	167,690,592	355,125,060	(1,672)	355,123,388	(59,236)	355,064,152	(76,760)
	CFE/RF	2,731,396	2,846,657	0	2,846,657	2,836,488	0	2,836,488	0	2,836,488	0
	FF	1,475,414,226	1,313,186,816	0	1,313,186,816	1,536,751,800	131,232	1,536,883,032	410,058	1,537,293,090	782,147
(I) Executive Director's Office;	Total	22,200,548	27,834,289	0	27,834,289	36,883,007	(384,276)	36,498,731	313,992	36,812,723	243,708
(C) Information Technology	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contracts and Projects,	GF	5,299,911	6,708,927	0	6,708,927	6,205,903	(134,052)	6,071,851	78,498	6,150,349	22,944
Information Technology	GFE	0	0	0	0	0	0	0	0	0	0
Contracts	CF	540,118	538,643	0	538,643	2,488,901	0	2,488,901	0	2,488,901	0
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,486,391	0	20,486,391	28,087,875	(250,224)	27,837,651	235,494	28,073,145	220,764
(I) Executive Director's Office;	Total	4,586,288	4,576,355	0	4,576,355	5,204,383	536,208	5,740,591	1,000,000	6,740,591	1,536,208
(E) Utilization and Quality	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Review Contracts,	GF	1,142,390	1,359,148	0	1,359,148	1,470,343	134,052	1,604,395	250,000	1,854,395	384,052
Professional Services	GFE	0	0	0	0	0	0	0	0	0	0
Contracts	CF	54,949	54,949	0	54,949	86,596	0	86,596	0	86,596	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,388,949	3,162,258	0	3,162,258	3,647,444	402,156	4,049,600	750,000	4,799,600	1,152,156

STATE OF COLORADO FY 2010-11 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13											
Change Request for FY 2010-11 Budget Request Cycle											
Decision Item FY 2010-11	<input type="checkbox"/>	Base Reduction Item FY 2010-11	<input type="checkbox"/>	Supplemental FY 2009-10	<input type="checkbox"/>	Budget Amendment FY 2010-11	<input checked="" type="checkbox"/>				
Request Title:	Evidence Guided Utilization Review (EGUR)										
Department:	Health Care Policy and Financing			Dept. Approval by:	John Bartholomew			Date:	January 25, 2010		
Priority Number:	BA-12			OSPB Approval:				Date:			
		1	2	3	4	5	6	7	8	9	10
		Prior-Year		Supplemental	Total	Base	Decision/	November 1	Budget	Total	Change
		Actual	Appropriation	Request	Revised	Request	Base	Request	Amendment	Revised	from Base
	Fund	FY 2008-09	FY 2009-10	FY 2009-10	FY 2009-10	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	(Column 5) FY 2011-12
(2) Medical Services Premiums	Total	2,526,991,443	2,572,042,638	0	2,572,042,638	3,000,913,062	(33,573)	3,000,879,489	(1,031,339)	2,999,848,150	(1,181,548)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	1,112,661,142	0	1,112,661,142	1,140,610,858	(14,606)	1,140,596,252	(448,668)	1,140,147,584	(514,015)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	167,097,000	0	167,097,000	352,549,563	(2,181)	352,547,382	(67,002)	352,480,380	(76,760)
	CFE/RF	2,631,068	2,746,329	0	2,746,329	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,289,538,167	0	1,289,538,167	1,505,016,481	(16,786)	1,504,999,695	(515,669)	1,504,484,026	(590,773)
(2) Medical Services Premiums; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	3,405	3,405	52,001	55,406	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	509	509	7,766	8,275	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	(3,914)	(3,914)	(59,767)	(63,681)	0
Non-Line Item Request:	None.										
Letternote Revised Text:	Of the base FY 2010-11 cash funds request amount, \$85,347,585 shall be from the Health Care Expansion Fund; \$784,875 shall be from the Colorado Autism Treatment Fund; \$250,000 shall be from the Coordinated Care for People with Disabilities Fund; \$3,026,893 shall be from the Comprehensive Primary and Preventive Care Fund; \$1,725,479 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund; \$27,040,854 shall be from the Nursing Facility Cash Fund; \$212,806,547 shall be from the Hospital Provider Fee Cash Fund; and \$21,498,147 shall be certified public expenditures.										
Cash or Federal Fund Name and COFRS Fund Number:	CF: Health Care Expansion Fund 18K; FF: Title XIX										
Reappropriated Funds Source, by Department and Line Item Name:	None.										
Approval by OIT?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	N/A: <input checked="" type="checkbox"/>								
Schedule 13s from Affected Departments:	None.										

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BA-12
Change Request Title:	Evidence Guided Utilization Review

SELECT ONE (click on box):

- Decision Item FY 2010-11
- Base Reduction Item FY 2010-11
- Supplemental Request FY 2009-10
- Budget Request Amendment FY 2010-11

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

- Not a Supplemental or Budget Request Amendment
- An emergency
- A technical error which has a substantial effect on the operation of the program
- New data resulting in substantial changes in funding needs
- Unforeseen contingency such as a significant workload change

Short Summary of Request:

The Department requests an increase of \$282,653, with a reduction of \$68,169 General Fund in FY 2010-11, and an increase of \$481,092 with a reduction of \$91,942 General Fund in FY 2011-12, in order to provide an evidence guided utilization review program. This request amends the previously submitted November 6, 2009 Base Reduction Item-1 "Prevention and Benefits for Enhanced Value (P-BEV) request. P-BEV requests the consolidation of utilization review functions for acute care services under a single vendor. This request seeks to provide that vendor with the resources needed to improve health care for Medicaid clients while reducing Medicaid expenditures.

Background and Appropriation History:

In 2006, SB 06-208 established the Blue Ribbon Commission for Health Care Reform ("the Commission"). The Commission was to study and establish health care reform models that expand health care coverage and decrease health care costs for Colorado residents. The Commission was authorized to examine options for expanding cost effective health coverage for all Colorado residents in both the public and private sector markets, with special attention given to the uninsured, underinsured, and those at risk of

financial hardship due to medical expenses. The Commission provided a final set of recommendations to the General Assembly on January 31, 2008.¹

Consistent with Governor Ritter's vision and the Commission's recommendations for a system based on shared responsibility, where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents, the Department is continuing to purposefully and systematically advance its health care reform efforts; this request is the next in that series of steps.

In FY 2007-08, the Department presented its Building Blocks to Health Care Reform request, which offered to centralize Medicaid and Children's Basic Health Plan Eligibility; provide a Medical Home for over 270,000 children enrolled in Medicaid and the Children's Basic Health Plan; increase rates for physicians and dentists; enhance the Children's Basic Health Plan mental health benefit; enroll 200,000 Medicaid clients in an integrated care delivery model; and, fund the Colorado Regional Health Information Organization (CORHIO).

In FY 2008-09, the Department offered a coordinated set of requests:

- DI-5 Improved Eligibility and Enrollment Processing
- DI-6 Medicaid Value-Based Care Coordination Initiative
- BRI-1 Pharmacy Technical and Pricing Efficiencies
- BRI-2 Medicaid Program Efficiencies

In sum, these requests offered to streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan; deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado; improve quality of service for clients; and implement an automated prior authorization system for drug prescriptions, changes to the reimbursement rates of drugs using a state maximum allowable cost

¹ The Commission's report is available on its website, <http://www.colorado.gov/208commission/>

structure, and changes in federal requirements with regard to pharmacy claims submitted by physicians and hospitals.

In alignment with these reform efforts, in this budget cycle the Department now requests authority for a third phase, one which takes into careful consideration the difficult economic decisions facing the State by offering a General Fund savings while still adhering to the principles of adopting best practices to avoid delivering acute and chronic care that is deemed unnecessary, improving provider access, and enhancing program integrity through the use of technology and data systems.

This series of requests began with the Department's November 6, 2009 Budget submissions, including BRI-1: "Prevention and Benefits for Enhanced Value" (P-BEV). Through the Prevention and Benefits for Enhanced Value request, the Department would generate service efficiencies while improving the quality of service for clients through a series of initiatives focused on enhancing quality and health outcomes:

- Consolidating Utilization Review Functions
- Expanded Procedures for Dental Hygienists
- Non-Emergency Medical Transportation Policies Reform

The cornerstone of those initiatives is a transition to evidence guided utilization review. As part of last fiscal year's Medicaid Program Efficiencies request, the Department was granted \$300,000 total funds in FY 2009-10, FY 2010-11, and FY 2011-12 in order to perform a comprehensive evaluation of the current fee-for-service benefit package and propose changes to ensure that the program was able to provide a comprehensive, coordinated, customer-centered and outcome-based continuum of care. Historically, benefit and eligibility expansions had focused on the scope of services received by clients, and not the quality of care or the client outcomes. The focus on reimbursement systems had previously relegated quality and outcomes to secondary goals. This request continues the Department's focus on ensuring that appropriate care is delivered in the most efficient manner possible.

The Department has contracted with a consultant to assist the Department in establishing refined benefit definitions so that they incorporate a wide range of concepts critical to a health outcomes-based program and evidence-based care. In addition, the Department is instituting the Accountable Care Collaborative, in which care coordinators will be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospital and community care, and importantly serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. Using a primary care case management/administrative services organization (PCCM/ASO) contract model allows the Department to implement reform quickly, by hiring expertise externally and adopting a few off-the-shelf improvements immediately, while simultaneously working on the programmatic need to shift Colorado Medicaid to an outcome-based system.

Although this is a multi-year process, the Department identified the following areas as short-term benefits collaborative goals: establishing a process for endorsing best medical practices and benefit determination; establishing a process for consideration and endorsement of new procedures and equipment; defining and/or refining the amount, duration, and scope of the services provided; defining a systematic process for consideration of requests to exceed amount, duration, scope, and frequency limitations when medically indicated; establishing a process to use for outreach to stakeholders seeking input on benefit definition and limitations; and, exploring the feasibility of consolidating the prior authorization review process for mandatory and optional services to one reviewing agency.

In addition, the Accountable Care Collaborative (ACC) is establishing a framework for community-focused identification of: what health outcomes are appropriate; minimum standards of care; fee-for-service benefit packages; regulations to prevent waste and abuse; and outdated rules and system edits that limit efficiency. The ACC seeks to develop a collaboration model between Regional Care Coordination Organizations (RCCOs), providers, and a statewide Health Data and Information Organization (HDIO) that allows for geographically specific determination of best practices as well as incentives to adhere to those practices.

As the next step in meeting these goals, the Department determined that its prior authorization review processes needed to be modernized and improved. In order for the goals of the ACC and the Benefits Collaborative to be fully achieved, a mechanism for monitoring actual client utilization and provider services as compared to best practices should be in place; the Department continually seeks to ensure that only medically necessary procedures are performed in the best interests of our clients. The first step in transitioning to evidence guided utilization review is to consolidate its current acute care utilization reviews. The Department believes that utilization review can better be handled by a single contractor, and simultaneously produce a savings to the State's General Fund. The new, single contractor will drive the initial phase of the evidence guided utilization review concept.² The request for this consolidation was made in the Department's November 6, 2009 Base Reduction Item-1, "Prevention and Benefits for Enhanced Value."

Due to the expiration of current utilization review contracts, the Department is preparing a request for proposals (RFP) to re-bid and enhance its current acute care utilization review structure. The RFP would position the Department for a comprehensive overhaul of its utilization review functions, following other states that in recent years have adopted advanced approaches to control medical costs and reduce unwarranted variation in care. The Department seeks to adopt best practices to address unnecessary medical expenditure. By more clearly defining benefit limits, and exceptions to those limits that require prior-authorizations, and by consolidating administrative functions for utilization and prior-authorization reviews, the Department can more efficiently guarantee access to care for its clients while ensuring that only medically necessary services are provided.

This request identifies the utilization review portions of the BRI-1: P-BEV request for informational purposes, but formally request only the incremental portion specific to the program as described, below.

² It is important to note that prior authorizations for pharmacy services and long term care services are not included in this request because the delivery structure for those benefits fundamentally differs from that of most acute care services. After the evidence guided utilization review program is established, the Department may consider expanding the scope of the program.

General Description of Request:

The Department requests an increase of \$282,653, with a reduction of \$68,169 General Fund in FY 2010-11, and an increase of \$481,092 with a reduction of \$91,942 General Fund in FY 2011-12, in order to provide an evidence guided utilization review program. This request amends the previously submitted November 6, 2009 Base Reduction Item-1 “Prevention and Benefits for Enhanced Value (P-BEV) request. P-BEV requests the consolidation of utilization review functions for acute care services under a single vendor. This request seeks to provide that vendor with the resources needed to improve health care for Medicaid clients while reducing Medicaid expenditure.

Evidence Guided Utilization Review

The Department requests to perform a comprehensive reformation of its benefit definitions and utilization review practices. Through this initiative, the Department is continuing to follow through on the Blue Ribbon Commission for Health Care Reform’s recommendation “to enhance quality and lower cost.”³

This request was originally part of the Department’s November 6, 2009 Base Reduction Item-1 (BRI-1), “Prevention and Benefits for Enhanced Value.” However, since the release of BRI-1, the Department has further refined and enhanced the scope of the Request in order to better meet the needs of its program.

The Need to Modernize the Current Utilization Review System

Analysis of the Department’s utilization review programs by external reviewers describe fragmented, outdated practices that have failed to keep pace with best practices among commercial and public health plans.⁴ The Department’s current review activities focus on demand management strategies including prospective review of a handful of high-cost procedures, out-of-state admissions, occupational and physical therapies, durable medical equipment, transportation, and behavioral health services. The activities are performed by

³ Blue Ribbon Commission for Health Care Reform. “Final Report to the Colorado General Assembly.” January 31, 2008, p. 14.

⁴ Mercer, “Colorado Office of the State Auditor: Controls Over Medicaid Claims for Durable Medical Equipment and Supplies, Laboratory, and Radiology Services Performance Audit.” October, 2009.

disparate vendors, without standardized procedures, and often utilizing slow paper-based reviews that delay access for clients. In addition to these prospective reviews – or prior authorization reviews (PARs) – the Department’s vendors also review claims data (retrospective reviews) to ensure appropriateness of hospital admissions, coding, and billing. These activities suffer from similar challenges.

The Department’s review activities do not currently address outpatient hospital services, one of the Department’s largest and fastest growing cost categories and the subject of intensive review activities among commercial plans and other states. The Department’s review activities do not include concurrent review strategies to control excessive patient utilization (e.g. frequent emergency department visits, or extended stays in a hospital setting beyond the average duration) and to efficiently transition patients from acute settings into intermediate care or home-based care settings.

Colorado is currently experiencing Medicaid fee-for-service utilization that is well beyond national averages. Table 1, below, presents a number of ambulatory care and inpatient services for which Colorado averages demonstrate patterns of utilization that are significantly beyond the norm. As will be described below, the Department proposes to modernize its utilization review program and will target these utilization “outliers” to provide immediate savings while also providing the most appropriate care for our clients.

Table 1

2009 HEDIS Measure ^(a)	Colorado Medicaid HMOs ^(b)	Colorado Medicaid FFS ^(c)	2008 HEDIS National Medicaid Avg
Ambulatory Care Visits/1000 member months (mm)^(d)			
Outpatient ^(b)	279.1	368.9	317.8
Emergency Department	21.6	63.9	60.9
Ambulatory surgery	15.8	11.2	5.5
Observation stays	0.9	2.5	2.0
Inpatient Utilization			
Discharges/1000 mm	7.7	11.8	8.3
Days/1000 mm	27.8	45.9	30.6
Average Length of Stay	3.6	3.9	3.6

(a) Colorado HEDIS© reported by Health Services Advisory Group (HSAG) July, 2009.

(b) Includes two plans representing approximately 15% percent of program clients.

(c) Includes PCPP program.

(d) Does not include FQHC data.

The Department’s Evidence Guided Utilization Review (EGUR) reform proposal builds on the proven efforts of other states, Medicare, and advanced commercial plans. The approach focuses on four core strategies:

- Stabilize medical costs by adopting best practices in medical review as developed by other states that have successfully contained growth in medical spending.
- Enhance access to information to enable rapid cost-containment interventions based on utilization trends, cost modeling, event notification, provider profiling, and client health status.

- Engage providers through streamlined and automated medical review, profiling, education, and incentives.
- Empower clients to access preventive care services and to limit high-cost services in a responsible way.

Investment in Utilization Review

As part of this request, the Department requests an increase of \$250,000 General Fund in FY 2010-11 and FY 2011-12 to its Utilization and Quality Review Contracts, Professional Services Contracts line item to implement the evidence guided utilization review concept. The increase in General Fund is completely offset by savings in the Medical Services Premiums line item from increased utilization review; further, it will give the Department access to an additional \$750,000 federal funds, yielding a total funds increase of \$1,000,000 for utilization review.

Through the Department's November 6, 2009 Base Reduction Item-1, "Prevention and Benefits for Enhanced Value," the Department is seeking to consolidate acute care, fee-for-service utilization review functions under a single contractor that would qualify as a federally recognized Quality Improvement Organization (QIO). As a QIO, the contractor would be subject to a 75% federal match and would be the Department's primary partner in modernizing utilization review. By transferring funds, the Department can add additional federal funds to the same general fund expenditure through the enhanced federal match. As stated previously, this request amends and extends the P-BEV request. The entirety of the utilization review requests, from current appropriation through the P-BEV request to this current EGUR request, are presented in table B.1. The additional incremental funding requested as part of this EGUR request is identified in Row E of that table. Additionally, the Department has provided summary tables itemizing the various components of the P-BEV and EGUR budget requests as related to just the utilization review components of those requests; see tables A.1 and A.2. Because this request is an amendment to P-BEV, the Department believes that the two requests should be considered simultaneously. For informational purposes, Tables H.1 and H.2 present the

incremental component, or just the EGUR request, by long bill group and by fiscal year; tables I.1 and I.2 present the combined P-BEV and EGUR requests.⁵

Multiple studies have demonstrated the impact of utilization management and medical review practices. While no study has been specific to the Colorado experience, return on investment estimates have ranged from two times the cost of the program to nine times the cost of the program.⁶ An aggregated review of available studies suggests a return of approximately three-and-a-half times cost on prior authorization and utilization review.⁷ For purposes of this request, the Department takes a conservative view of estimated savings, but believes any savings will more than fund the additional costs to completely modernize the medical review program. For savings calculations, the Department has taken half of the five year average for the percentage of denied prior authorizations across all currently reviewed expenditure, or 8.10%, for calculating avoided costs in Tables D.1 and E.2 (described below).⁸

Understanding the current fiscal environment, the Department is proposing to institute this comprehensive reform in phases, ensuring that each phase is capable of covering its own costs of implementation as well as achieving additional savings over time. This is the next series of components in the Department's ongoing reform efforts and stems directly from work already accomplished.

As the current utilization review contract is expiring, the Department released a request for proposals (RFP) in January 2010 to solicit bids for a new utilization review vendor, expected to begin work in July 2010. The newly contracted QIO would be responsible for

⁵ Note that the P-BEV request included additional initiatives related to Non-Emergency Medical Transportation (NEMT) and procedures to be performed by dental hygienists. Tables A.1 and A.2 do not present this information as they are related only to utilization review. The NEMT and dental components of the P-BEV request can be viewed in tables I.1 and I.2.

⁶ See Shutan, Bruce, "The DM Rx: Disease Management Programs Producing Fast and Meaningful Outcomes, Impressive ROI," Employee Benefit News, Vol. 18, No. 13, October, 2004. and KePro Care Management Solutions, <http://www.kepro.org/services/utilrev.aspx>.

⁷ Dove, Henry G and Duncan, Ian, "An Introduction to Care Management Interventions and their Implications for Actuaries," Society of Actuaries, October 15, 2004, p. 8.

⁸ Colorado Foundation for Medical Care, "Medicaid Acute Care Annual Report," FY 2005 through FY 2009.

prior authorization and retrospective reviews of utilization. Additionally, the new QIO would be required to interface with technology upgrades in future years, as the Department incorporates technology and systems changes in later phases of this reform.

Upon execution of the new contract, the Department and its QIO contractor will begin a two-fold process: 1) increasing the number of targeted utilization reviews, and 2) develop the technical requirements for implementing a comprehensive utilization management system.

Expansion of the Utilization Review Contract

As part of this request, the Department is seeking to expand the utilization review program. To do this, the Department is requesting \$1,000,000 total funds, \$250,000 General Fund in FY 2010-11 and in FY 2011-12. The Department's calculations are contained in Table B.2 and B.3. This increase in funding is offset, in its entirety, by savings in the Medical Services Premiums Long Bill group (described below).

The proposed evidence guided utilization review reform seeks, among other objectives, to adopt best practices for the Department to continue to address the estimated 20-30 percent of acute and chronic care that is deemed unnecessary, according to national researchers.⁹ Additionally, the proposal seeks to improve provider access and enhance program integrity through use of streamlined technology and data systems.

Furthermore, the Department believes evidence guided utilization review reform will lead to enhanced quality and improved health outcomes. Research has repeatedly shown excessive and unwarranted variations in care lead not only to waste, but poor outcomes as well. A landmark study of Medicare patients by researcher Elliot Fisher and colleagues at Dartmouth found an inverse relationship between health care spending and health care quality. The Department's proposal seeks to create mechanisms to reward providers who practice consistent with research evidence and best practices.

⁹ Becher EC and Chassin MR. "Improving The Quality of Health Care: Who Will Lead?", *Health Affairs*, 20(5), 164-179, 2001.

The proposed evidence guided utilization review would focus on high-growth, high-cost medical spending categories, including radiology, hospital outpatient services, selected outpatient therapies, ancillary services, emerging technologies, and selected client groups such as high risk deliveries and pre-term newborns. As part of this request, the Department proposes an increase in medical review hours to allow for expanded review. In addition to additional prospective and retrospective review hours, evidence guided utilization review funding would allow for concurrent review selected activities such as inpatient outlier days.

Moreover, evidence guided utilization review would involve working in a new, collaborative relationship with providers to define best practices and review policies. To that end, the Department would sponsor provider panels that would convene on a regular basis to review the literature on selected topics and document best practices. This activity would serve to encourage the development of community-wide standards, confirming local best practices while shaping medical review policy around best research evidence.

The expansion of utilization review under evidence guided utilization review would involve continuing the work of the Benefits Collaborative and Accountable Care Collaborative. As provider panels and client and stakeholder sessions yield newly documented best practices and community standards, the Department will require its QIO to integrate these standards with evidence-based clinical guidelines – such as the Milliman Care Guidelines and McKesson’s InterQual decision support criteria – and adjudicate its reviews based on those standards through the technology system described below.

Technological Enhancements for Utilization Review

As part of this request, the Department seeks to implement two key technological initiatives that would allow for more effective utilization review. First, the Department would develop the systems capability to perform and enforce prospective utilization reviews on hospital claims. Second, the Department would, in conjunction with its utilization review vendor, develop a rapid, web-based PAR system allowing providers to

submit prior authorization requests through a web portal and receive timely and/or automated responses.

The Department estimates that the required changes to the Medicaid Management Information System (MMIS) will cost \$318,976 total funds, \$79,744 General Fund in FY 2010-11, and \$637,952 total funds, \$159,488 General Fund in FY 2011-12. The Department's calculations are contained in Table C.1. This increase in funding is offset, in its entirety, by savings in the Medical Services Premiums Long Bill group (described below).

Depending on the type of service, the Department receives claims via a number of different claims forms. In particular, inpatient and outpatient hospital claims are submitted on a form known as the "UB04." At present, the MMIS does not have the ability to set amount, duration, scope, and frequency limits on claims submitted through the UB04 form. This prevents the Department from enforcing prospective utilization review for these claims. To allow for prospective utilization review (prior authorizations) on claims submitted on the UB04 form, a system change is required. This system change would allow the Department to control costs and utilization based upon the benefits definitions, community standards, and best practices stemming from the Benefits Collaborative and the Accountable Care Collaborative.

Based on information provided by the Department's fiscal agent, the Department estimates that changes to allow prior authorizations on UB04 claims would require a total of 2,976 programming hours, starting in approximately October 2010. System changes are estimated to be complete in June 2012. Once these changes are effective, the Department may submit additional budget actions to account for additional savings as a result of new utilization review requirements. Any requirements will be developed in conjunction with the Department's utilization review contractor and the Benefits Collaborative, in the future.

Simultaneously, the Department and the utilization review contractor would collaborate to develop a set of technical requirements for revamping the utilization review process by

accessing appropriate technologies. A central barrier to the Department's understanding of its medical utilization patterns is access to data. Currently, program administrators must wait for information systems specialists to manipulate data and present actionable reports. There are frequently delays due to backlogs and other priority projects. As part of the Department's RFP process, the Department would require its vendor to create reports and tools which allow for intuitive access so program administrators could rapidly identify cost trends and intervene, if necessary.

The Department's goal is to use current technologies to streamline the prior authorization process and reduce administrative burdens for providers and the Department. To accomplish these goals, the Department proposes the implementation of a rapid, web-based utilization review and management system. The Department anticipates that this system will include:

- the ability for provider to submit prior authorization requests through a web portal and receive timely and/or automated responses
- screening/assessment web and fax templates to enable prevention- and diagnostic-based authorizations
- a central "dashboard" to assist provider decision making, including rapid notification of events such as a patient presenting at the emergency department or being admitted to the hospital
- research databases to enable evaluation and documentation of review policies
- enhanced provider collaboration and communication to define community standards and best practices as supported by research
- web-based provider education modules to communicate these community standards and to inform providers of medical review policies

As part of the Department's RFP process, the Department will seek a vendor that has as many of these components in a ready-to-go framework as possible. However, in order to develop a permanent utilization and management system, the Department will require changes to its MMIS to allow the integration of any solution. The Department anticipates completing these system changes in parallel with the UB04 system changes. Because the

specific requirements cannot be determined until after the Department procures a contractor, the Department's estimate, in Table C.1, is a placeholder based upon informational discussions with Department and its fiscal agent's technical staff. If a change in funding is required, the Department would submit a future budget action to request an adjustment.

Estimated Savings

To offset the required investment in the evidence guided utilization review program, the Department has identified a number of initiatives which the new vendor will be required to immediately implement. In particular, the Department will require the vendor to focus on two areas of utilization which, with proper management, have a large potential for savings. The Department will begin its increased review process by targeting 1) "outlier" days, and 2) frequent utilizers of emergency departments. The administrative cost to implement these ideas is included in the Department's request, above; to increase funding for utilization review, additional funding would not be required.

The Department's estimated percentage of savings for these two review categories is conservative and based upon its current utilization review experience. From FY 2004-05 through FY 2008-09, the Department's current utilization review contractor has reported an average of 16.20% cost avoidance per year. The cost avoidance percentage was calculated by examining all of the expenditure categories currently given prospective reviews (those requiring prior authorizations) and accounting for those expenditures that were denied authorization.¹⁰ The Department has chosen to conservatively estimate savings, using half of this percentage for its savings calculations, yielding \$1,031,339 in total fund savings from these two review categories in FY 2010-11 and \$1,146,892 in FY 2011-12.

The Department's savings assumptions are in line with the experience of other modernized utilization review programs. As described on page 12 of this document, return on

¹⁰ Colorado Foundation for Medical Care, "Medicaid Acute Care Annual Report," FY 2005 through FY 2009.

investment for utilization review programs in other locations is calculated to be approximately 2 times the investment amount, at the most conservative end. On a \$1,000,000 investment, as the Department proposes, that would equate to \$2,000,000 in savings. Half of that return on investment would equate to \$1,000,000 in savings. This is near the Department's stated savings figures in this request, which are based on an assumption of half of its current utilization review experience.

Outlier Day Review

The Department currently pays hospitals based on diagnosis related groups (DRGs) that are calculated based on the average costs and lengths of stay for a particular diagnosis. If a patient exceeds the average designated length of stay, the Department then begins to pay for the additional days, or "outlier" days. In FY 2008-09, the Department spent approximately \$18.3 million on these outlier days. Currently, the Department anticipates immediately reviewing outlier expenditure on the following categories: maternity claims without complications; claims for low-birth weight neonatal clients; and, claims for other hospital claims without complications. Outlier days for these claims cost the Department \$3.6 million in FY 2008-09. In some cases, the utilization is appropriate and no savings can be achieved. However, the Department anticipates that a number of claims can be reduced or mitigated via appropriate utilization review, discharge planning, and case management. The Department estimates that, with enhanced review activities, it can achieve an 8.10% reduction on this subset of claims, generating an estimated \$360,300 total funds savings in FY 2010-11 and \$400,365 total funds savings in FY 2011-12. The Department's calculations are contained in Table D.1.

Frequent Emergency Department Utilization Review

In many cases, clients who receive care in an emergency department (ED) could have received preventive care which would have eliminated or reduced the need for a client to visit the ED. In particular, there is a small subset of clients which visit hospital EDs 6 or more times per year; these clients make up only 3.3% of the total number of clients who visit EDs, but comprise over 18.6% of the Department's expenditure for ED claims.

These clients average more than 9 visits to an ED per year. Clients who use the ED frequently may have other, non-emergent health issues, such as a chronic disease or a mental health condition.

In order to reduce ED visits, the Department would have its utilization review contractor develop a classification system for avoidable ED usage, and perform case management through client and provider outreach. This proposal is modeled on a successful program by Parkland Community Health Plan, in Dallas, Texas. Parkland is the largest HMO in Dallas, covering a number of surrounding counties, and containing significant Medicaid enrollment. Parkland has a number of key similarities to the Colorado Medicaid program, including the utilization of a medical home model. Parkland's analysis indicated a 5% reduction in ED visits per thousand in the first two months of the program, growing to a 40% reduction by the end of the first year.

The Department's goal would be to reduce utilization, and the subsequent average cost per visit, for just those clients visiting the ED 6 or more times in a year by the 8.10% described, above. The Department believes that modest goals are appropriate for the beginning of this initiative, as the results achieved by Parkland may not be directly applicable to Colorado's program, despite some similarities. The Department estimates that such a reduction would generate \$671,039 total funds savings in FY 2010-11, and \$746,527 million total funds savings in FY 2011-12.

Future Evidence Guided Utilization Review Initiatives

In addition to the ideas outlined above, the Department assumes that the savings generated from the review activities undertaken by the new QIO can stimulate further review activities to be determined by the Department in consultation with its QIO vendor. Benefits collaborative work, gathering input from stakeholders to define appropriate limitations in the amount, duration, quantity, and scope of benefits, as well as the technical expertise of the vendor should yield even further savings.

Should this request be funded, an immediate area to target for additional savings would be various radiology procedure claims as submitted on the UB04 claims forms once system changes are completed (see page 15 of this document). Table F.1 presents the potential savings from this category of service. In July 2009, the Department began reviewing radiology claims submitted on the CO-1500 form, where the Department already has the ability to prior authorize claims. Taking the average number of radiology units reimbursed over the first three months of this new review program and comparing it to the average number of radiology units reimbursed over the previous year (adjusted to current caseload) yields a 4.29% decrease. Applying that decrease to estimated UB04 expenditure would result in an estimated FY 2012-13 reductions of \$2,420,100 total funds. As system changes would be completed, there would be no additional cost for realizing this savings.

The Department is not currently requesting these funds reductions, as they are contingent upon the systems change funding in this request and the savings would be realized in future years outside of the current budget cycle. However, the savings figures are presented to demonstrate the Department's future plans for evidence guided utilization review and the potential return on investment to the people of Colorado.

In addition to radiology, possible areas of program expansion include, but are not limited to:

- Site-of-service prior authorization policy for low-acuity outpatient surgeries and invasive procedures; this would follow Pennsylvania and other states who have actively steered cases to lower-cost settings such as ambulatory surgery centers.
- A 14-day re-admissions review policy, providing incentives for higher quality discharge planning and case management, and initially targeting ambulatory-sensitive admissions.
- Utilization threshold policies based on client diagnoses as determined by predictive modeling and other analytics; this would ensure appropriate access while preventing unwarranted utilization.

- Expanded client “lock-in” programs -- similar to the existing Client Over-Utilization Program for prescription drugs -- that seek to curb utilization by overly high-utilizing clients.
- Client registry systems such as the Colorado Immunization Information System and the new Prescription Drug Monitoring Program for controlled substances, which allow providers to view client utilization data and intervene at the point of care; benefits include community-wide care coordination, lower costs and enhanced population health outcomes.

The Department will submit additional budget actions in the future to account for any savings achieved through these or any other initiatives. The system changes requested here would allow for a fully automated prior authorization process and thus allow the Department to substantially increase the number of reviews performed without significantly increasing costs.

Consequences if Not Funded:

The Department would not be able to provide efficiencies to obtain savings resulting from its proposed changes. The Department would continue to operate existing programs, but it is unlikely that any cost efficiencies will be achieved under current practices. Without these savings, the Department can not continue to improve quality of care for existing clients.

The Department is committed to focus on cost, quality, and access to health care, and is taking a pragmatic approach to achieving the Governor’s and the Blue Ribbon Commission for Health Care Reform’s vision of effective health care for Coloradans. In the current fiscal climate, the Department continues to advance on this front while finding efficiencies in the system, cutting waste, and bringing more transparency to the system. The Department views each of the steps outlined in this change request as critical so as to not reverse the gains made in implementing broader health care reform in the State of Colorado. Moreover, beyond the immediate General Fund savings as presented in this change request, the Department’s proposed initiatives are a significant opportunity to mitigate long term expenditure growth by providing better quality health outcomes for clients.

Calculations for Request:

Summary of Request FY 2010-11					
Long Bill Group	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$282,653	(\$68,169)	(\$59,236)	\$0	\$410,058
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$313,992	\$78,498	\$0	\$0	\$235,494
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,000,000	\$250,000	\$0	\$0	\$750,000
(2) Medical Services Premiums	(\$1,031,339)	(\$448,668)	(\$67,002)	\$0	(\$515,669)
(2) Medical Services Premiums Long Bill Group Total (ARRA Adjustment)	\$0	\$52,001	\$7,766	\$0	(\$59,767)

Note: This table matches the schedule 13, column 8; this table presents the incremental difference this EGUR request has upon the previously submitted P-BEV request (presented in column 6).

Summary of Request FY 2011-12					
Long Bill Group	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$481,092	(\$91,942)	(\$74,509)	\$0	\$647,543
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$627,984	\$156,996	\$0	\$0	\$470,988
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,000,000	\$250,000	\$0	\$0	\$750,000
(2) Medical Services Premiums	(\$1,146,892)	(\$498,938)	(\$74,509)	\$0	(\$573,445)

Note: This table presents the incremental difference this EGUR request has upon the previously submitted P-BEV request for the out-year. It does not match the schedule 13. The department intends this request to amend the P-BEV request, and since the out-year impact of P-BEV is not distinctly represented on the schedule 13, the schedule 13, column 10, presents the combined impact of the two requests. See the FY 2011-12 combined request table, below.

Summary of Combined Prevention and Benefits for Enhanced Value (P-BEV) and Evidence Guided Utilization Review (EGUR) Requests FY 2010-11					
Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$401,012	(\$79,370)	(\$60,908)	\$0	\$541,290
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	(\$70,284)	(\$55,554)	\$0	\$0	(\$14,730)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,536,208	\$384,052	\$0	\$0	\$1,152,156
(2) Medical Services Premiums	(\$1,064,912)	(\$463,274)	(\$69,183)	\$0	(\$532,455)
(2) Medical Services Premiums Long Bill Group Total (ARRA Adjustment)	\$0	\$55,406	\$8,275	\$0	(\$63,681)

Note: This table represents the combined impact of the P-BEV and EGUR requests. Since both request for FY 2010-11 appear on the schedule 13 (columns 6 and 8, respectively), this table is presented for informational purposes only. Please see table I.1 for more detail.

Summary of Combined Prevention and Benefits for Enhanced Value (P-BEV) and Evidence Guided Utilization Review (EGUR) Requests FY 2011-12					
Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$598,368	(\$107,019)	(\$76,760)	\$0	\$782,147
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$243,708	\$22,944	\$0	\$0	\$220,764
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,536,208	\$384,052	\$0	\$0	\$1,152,156
(2) Medical Services Premiums	(\$1,181,548)	(\$514,015)	(\$76,760)	\$0	(\$590,773)

Note: This table matches the schedule 13, column 10, and presents the combined out-year impact of both the P-BEV and EGUR requests. Please see table I.2 for more detail.

Cash Funds Projections:

This request does not require any additional cash funds so a cash fund projection is not provided.

Assumptions for Calculations:

Where applicable, assumptions are noted in the relevant locations in each table in the appendix, and in the narrative above. All estimates are rounded to the nearest whole dollar. The Department has estimated projected expenditure and utilization based on historical information and assumptions about future changes in caseload or utilization. As actual experience with new programs is obtained, the Department would use the standard budget process to request adjustments to funding as appropriate.

Impact on Other Government Agencies: Not applicable.

Cost Benefit Analysis:

FY 2010-11 Cost Benefit Analysis	Benefit	Cost
Request	The request proposes a reduction in Medical Services Premiums of \$1,031,339 total funds and \$396,667 General Fund (after ARRA impacts). The net impact of the request is a decrease of \$68,169 General Fund	The request proposes costs for: a) the utilization review contractor, at \$1,000,000 total funds and \$250,000 General Fund; and b) MMIS system changes, at \$313,992 total funds and \$78,498 General Fund.
Consequences if not funded	None.	The State will not realize the General Fund savings, and the Department may be hindered in its ability to ensure that only medically necessary procedures are provided to our clients in alignment with best practices.

FY 2011-12 Cost Benefit Analysis	Benefit	Cost
Request	The request proposes a reduction in Medical Services Premiums of \$1,146,892 total funds and \$498,938 General Fund. The net impact of the request is a decrease of \$91,942 General Fund	The request proposes costs for: a) the utilization review contractor, at \$1,000,000 total funds and \$250,000 General Fund; and b) MMIS system changes, at \$627,984 total funds and \$156,996 General Fund.
Consequences if not funded	None.	The State will not realize the General Fund savings, and the Department may be hindered in its ability to ensure that only medically necessary procedures are provided to our clients in alignment with best practices.

See Table H.1 for Calculations.

After the MMIS system costs are complete, FY 2012-13 and beyond should witness comparable savings figures (saving 50% General Fund) at only the \$1,000,000 utilization review contractor cost (only at 25% General Fund). The Department should, therefore, see improved net savings to General Fund and total funds.

In addition to the quantifiable savings, the Department has also identified a number of qualitative benefits that would stem from this request:

- Ensuring that Medicaid is able to provide a comprehensive, coordinated, customer-centered and outcome-based continuum of care evaluation;
- Lowering costs while adhering to medical best practices;
- Providing increased access to services;
- Mitigating against future high-cost expenditures; and
- Empowering individual clients to manage their health in partnership with providers.

Implementation Schedule:

An implementation timeline is provided in Table C.2 for the MMIS changes that would make amount, duration, scope, and frequency benefits limits viable and subject to rapid utilization review in future years, generating greater future savings.

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2009). Program of medical assistance - single state agency.
(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

12-35-128, C.R.S. (2009). Tasks authorized to be performed by dental assistants or dental hygienists.

(1) The responsibility for dental diagnosis, dental treatment planning, or the prescription of therapeutic measures in the practice of dentistry shall remain with a licensed dentist and may not be assigned to any dental hygienists; except that a dental hygienist may perform dental hygiene assessment, dental hygiene diagnosis, and dental hygiene treatment planning for dental hygiene services; identify dental abnormalities for immediate referral to a dentist as described in sections 12-25-124 and 12-35-125; and may administer fluoride, fluoride varnish, and antimicrobial solutions for mouth rinsing as described in sections 12-35-124 and 12-35-125, and resorbable antimicrobial agents pursuant to rules of the Board. No dental procedure that involves surgery or that will contribute to or result in an irremediable alteration of the oral anatomy may be assigned to anyone other than a licensed dentist. Prescriptive authority may not be assigned to anyone other than a licensed dentist.

Performance Measures:

This Change Request affects the following Performance Measures:

- Improve access to and the quality of Medicaid health care as demonstrated through improvements in the Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures;
- Increase the number of options for clients enrolling in Medicaid to select a focal point of care.

The Department uses the measures above to help assure delivery of appropriate, high quality health care in the most cost-effective manner possible. This request would assist the Department in designing programs that result in improved health status for clients served and improved health outcomes. In addition, this request would assist the Department in expanding and preserving health care services through the purchase of services in the most cost-effective manner possible.

Table A.1						
Total FY 2010-11 Requests Regarding Medicaid Acute Care Utilization Review*						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
<i>November 6, 2009 Base Reduction Item - 1 "Prevention and Benefits for Enhanced Value" (P-BEV)</i>						
A	Current ACS Contract	(\$384,276)	(\$134,052)	\$0	(\$250,224)	BRI-1, Summary of Request FY 2010-11
B	Contract as Transferred to QIO	\$536,208	\$134,052	\$0	\$402,156	Would receive 75% federal match
C	BRI-1 Request	\$151,932	\$0	\$0	\$151,932	Row A + Row B
<i>January 25, 2010 Budget Amendment -12 "Evidence Guided Utilization Review" (EGUR)</i>						
D	Increase to Utilization Review Contract	\$1,000,000	\$250,000	\$0	\$750,000	Table B.2, Row A
E	MMIS Systems Changes	\$313,992	\$78,498	\$0	\$235,494	Table B.2, Row B
F	Reduction to Outlier Payments	(\$360,300)	(\$156,743)	(\$23,407)	(\$180,150)	Table B.2, Row C
G	Reduction to Emergency Department Frequent Utilizers	(\$671,039)	(\$291,925)	(\$43,595)	(\$335,519)	Table B.2, Row D
H	EGUR Utilization Review Impact	\$282,653	(\$120,170)	(\$67,002)	\$469,825	Row D + Row E + Row F + Row G
I	Total P-BEV and EGUR Request	\$434,585	(\$120,170)	(\$67,002)	\$621,757	Row C + Row H

* Note table is not adjusted for ARRA enhanced FMAP. Please see table H.1 for request adjusted for ARRA.

Table A.2						
Total FY 2011-12 Requests Regarding Medicaid Acute Care Utilization Review*						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
<i>November 6, 2009 Base Reduction Item - 1 "Prevention and Benefits for Enhanced Value" (P-BEV)</i>						
A	Current ACS Contract	(\$384,276)	(\$134,052)	\$0	(\$250,224)	BRI-1, Summary of Request FY 2010-11
B	Contract as Transferred to QIO	\$536,208	\$134,052	\$0	\$402,156	Would receive 75% federal match
C	BRI-1 Request	\$151,932	\$0	\$0	\$151,932	Row A + Row B
<i>January 25, 2010 Budget Amendment -12 "Evidence Guided Utilization Review" (EGUR)</i>						
D	Increase to Utilization Review Contract	\$1,000,000	\$250,000	\$0	\$750,000	Table B.2, Row A
E	MMIS Systems Changes	\$627,984	\$156,996	\$0	\$470,988	Table B.2, Row B
F	Reduction to Outlier Payments	(\$400,365)	(\$174,173)	(\$26,010)	(\$200,182)	Table B.2, Row C
G	Reduction to Emergency Department Frequent Utilizers	(\$746,527)	(\$324,765)	(\$48,499)	(\$373,263)	Table B.2, Row D
H	EGUR Utilization Review Impact	\$481,092	(\$91,942)	(\$74,509)	\$647,543	Row D + Row E + Row F + Row G
I	Total P-BEV and EGUR Request	\$633,024	(\$91,942)	(\$74,509)	\$799,475	Row C + Row H

* Note table is not adjusted for ARRA enhanced FMAP. Please see table H.2 for request adjusted for ARRA.

Table B.1						
Requested Increase to Utilization Review Funding						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
A	Acute Care Utilization Review Funding	\$1,375,906	\$345,428	\$16,520	\$1,013,958	Department Base Budget
B	Information Technology Contract Reviews	\$384,276	\$134,052	\$0	\$250,224	BRI-1 Table A.2
C	November 6, 2009 Request, P-BEV	\$151,932	\$0	\$0	\$151,932	BRI-1 Table A.1
D	Current Requested Acute Care Utilization Review Total	\$1,912,114	\$479,480	\$16,520	\$1,416,114	Row A + Row B + Row C
E	Increase to Utilization Review Contract, EGUR	\$1,000,000	\$250,000	\$0	\$750,000	Table B.2, Row A
F	Total Requested Funds for Acute Care Utilization Review	\$2,912,114	\$729,480	\$16,520	\$2,166,114	Row D + Row E

Table B.2						
Summary of FY 2010-11 Stand Alone Budget Amendment Evidence Guided Utilization Review (January 25,2010)						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
A	Increase to Utilization Review Contract	\$1,000,000	\$250,000	\$0	\$750,000	Department Request
B	System Changes	\$313,992	\$78,498	\$0	\$235,494	Table C.1, Row D
C	Reduction to Outlier Payments	(\$360,300)	(\$156,743)	(\$23,407)	(\$180,150)	Table D.1, Row I
D	Reduction to Emergency Department Frequent Utilizers	(\$671,039)	(\$291,925)	(\$43,595)	(\$335,519)	Table E.2, Row H
E	ARRA Adjustment	\$0	\$52,001	\$7,766	(\$59,767)	Assumes 6 months of the additional 11.59% federal funding.
F	Total	\$282,653	(\$68,169)	(\$59,236)	\$410,058	Row A + Row B + Row C + Row D + Row E

Table B.3						
Summary of FY 2011-12 Evidence Guided Utilization Review Stand Alone Budget Amendment Evidence Guided Utilization Review (January 25,2010)						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
A	Increase to Utilization Review Contract	\$1,000,000	\$250,000	\$0	\$750,000	Department Request
B	System Changes	\$627,984	\$156,996	\$0	\$470,988	Table C.1, Row D
C	Reduction to Outlier Payments	(\$400,365)	(\$174,173)	(\$26,010)	(\$200,182)	Table D.1, Row J
D	Reduction to Emergency Department Frequent Utilizers	(\$746,527)	(\$324,765)	(\$48,499)	(\$373,263)	Table E.2, Row H
E	Total	\$481,092	(\$91,942)	(\$74,509)	\$647,543	Row A + Row B + Row C + Row D

Table C.1				
Estimated Cost of Systems Changes to Accommodate Enhanced Resource Review				
Row	Item	FY 2010-11	FY 2011-12	Description
A	ACS Rate for MMIS Changes	\$126.00	\$126.00	ACS (the MMIS vendor) hourly rate.
B	Estimated Project Hours for UB04 System Change	992	1,984	From ACS estimate.
C	Estimated Project Hours for Utilization Review Technology	1,500	3,000	See Narrative
D	Total Cost	\$313,992	\$627,984	Row A * (Row B + Row C)

Table C.2			
Implementation Timeline for Enhanced Resource Review Administrative Reform			
Row	Item	Completion Date	Description
A	Enhanced Resource Review RFP Released	January 2010	Publish RFP for Enhanced Resource Review including: capacity to use a web interface for prior authorization review, using medical practitioners for review, and being a certified Qualified Improvement Organization (QIO).
B	RFP Awarded	April 2010	New utilization review vendor identified.
C	Contracts Effective	July 2010	New utilization review vendor will begin operations.
D	Increased Funding for Utilization Review	July 2010	The QIO will review "outlier" hospital days, emergency department frequent utilizers, dental for concurrent medical conditions, and any other immediately implementable cost categories identified by the Department and the QIO.
E	Define Technical Requirements	October 2010	The Department and its QIO will define technical requirements for the web-based, data warehouse, and prior authorization technology tools.
G	System Work	June 2012	Development, testing, and implementation of the web-based, data warehouse, and prior authorization tools.

Table D.1 Outlier Savings			
Row	Item	Total	Description
A	FY 2008-09 Cost of Outlier Days for Non-Complicated Deliveries	\$1,810,148	Based on FY 2008-09 paid discharges
B	FY 2008-09 Cost of Outlier Days for Other Hospital Claims Without Complications	\$729,753	Based on FY 2008-09 paid discharges
C	FY 2008-09 Cost of Outlier Days for Low-Birthweight Neonatal Children	\$730,609	Based on FY 2008-09 paid discharges
D	FY 2008-09 Cost of Outlier Days for Other Hospital Claims Selected for Review	\$331,915	Based on FY 2008-09 paid discharges
E	FY 2008-09 Total Cost for Selected Outlier Days	\$3,602,425	Sum of Rows A - E
F	Estimated Savings Percentage	-8.10%	1/2 * Average of yearly denied prior authorizations FY 2004-05 through FY 2008-09; CFMC annual reports.
G	Estimated Savings from Reducing Outlier Days (FY 2008-09 Dollars)	(\$291,796)	Row E * Row F
H	Estimated Inpatient Hospital Trend	11.12%	Based on growth in inpatient hospital expenditure from FY 2007-08 to FY 2008-09. (Exhibits for Medical Services Premiums, Exhibit N, page EN-1)
I	Estimated FY 2010-11 Savings	(\$360,300)	Row G * (1 + Row H) ²
J	Estimated FY 2011-12 Savings	(\$400,365)	Row I * (1 + Row H)

Table E.1				
Emergency Department Summary Statistics (CY 2008)				
Row	Item	1-5 Visits	6+ Visits	Total
A	Clients	129,833	4,437	134,270
B	Visits	208,055	40,132	248,187
C	Expenditure	\$29,258,883	\$6,693,058	\$35,951,940
D	Cost Per Client	\$225.36	\$1,508.46	\$267.76
E	Cost per Visit	\$140.63	\$166.78	\$144.86
F	Visits Per Client	1.60	9.04	1.85

Table E.2				
Estimated Savings from Reducing ED Visits by Frequent Utilizers				
Row	Item	FY 2010-11	FY 2011-12	Description
A	CY 2008 Expenditure for Frequent Utilizers	\$6,693,058	-	Table E.1, Row C
B	Estimated Outpatient Trend Cost Trend	11.25%	-	Average year-to-year growth in outpatient expenditure between FY 2005-06 and FY 2007-08
C	Estimated Expenditure for Frequent Utilizers	\$8,283,705	\$9,215,622	FY 2010-11: Row A * (1 + Row B) ² FY 2011-12: Row C * (1 + Row B) ³
D	Estimated Visits	40,132	40,132	Table E.1, Row B ⁽¹⁾
E	Estimated Cost Per Visit	\$206.41	\$229.63	Row C / Row D
F	Estimated Reduction in Visits Per Client	-8.10%	-8.10%	1/2 * Average of yearly denied prior authorizations FY 2004-05 through FY 2008-09; CFMC annual reports.
G	Estimated Reduction in Visits	(3,251)	(3,251)	Row D * Row F
H	Estimated Savings	(\$671,039)	(\$746,527)	Row E * Row G

(1) The Department's calculations are based on the assumption that the number of utilizers and visits remains constant over time. While this assumption may not be true in a period of increasing Medicaid caseload, it generates a conservative estimate of cost savings. The Department further controls for this by using a trend estimated to reflect changes in outpatient cost, rather than outpatient utilization.

Table F.1				
Estimated Radiology Savings from Evidence Guided Utilization Review				
Row	Item	FY 2012-13	FY 2013-14	Description
A	FY 2008-09 Radiology Expenditure from UB-04 Submissions	\$44,482,290	-	Actuals.
B	Year-to-Year Expenditure Growth Rate	6.12%	-	One quarter of the average year-to-to year radiology expenditure growth from last three fiscal years.
C	Projected Radiology Expenditure to be Reviewed	\$56,412,598	\$59,865,049	Row A trended to the appropriate year using Row B.
D	Savings Percentage	-4.29%	-4.29%	Radiology savings from claims submitted on CO-1500 claim forms. ¹
E	Total Estimated Radiology Savings	(\$2,420,100)	(\$2,568,211)	Row C * Row D

¹ The Department's first ever quarter (Q1 FY 2009-10) reviewing radiology claims submitted on CO-1500 claim forms saw this reduction in units allowed as compared to the average units from the previous fiscal year (adjusted for increasing caseload).

Table G.1: New Letternote Totals for Medical Services Premiums

Evidence Guided Utilization Review (EGUR) Only Cash Funds Report			
Cash Fund	FY 2010-11		
	Spending Authority	Request	Change
Health Care Expansion Fund	\$85,416,768	\$85,349,766	(\$67,002)
Total	\$85,416,768	\$85,349,766	(\$67,002)
Combined Prevention and Benefits for Enhanced Value (P-BEV) and Evidence Guided Utilization Review (EGUR) Cash Fund Impacts			
Cash Fund	FY 2010-11		
	Spending Authority	Request	Change
Health Care Expansion Fund	\$85,416,768	\$85,347,585	(\$69,183)
Total	\$85,416,768	\$85,347,585	(\$69,183)

Table H.1 Summary of Request FY 2010-11					
Initiative	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$282,653	(\$68,169)	(\$59,236)	\$0	\$410,058
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$313,992	\$78,498	\$0	\$0	\$235,494
MMIS Systems Changes	\$313,992	\$78,498	\$0	\$0	\$235,494
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,000,000	\$250,000	\$0	\$0	\$750,000
Increase Utilization Reviews	\$1,000,000	\$250,000	\$0	\$0	\$750,000
(2) Medical Services Premiums	(\$1,031,339)	(\$448,668)	(\$67,002)	\$0	(\$515,669)
Reduction to Outlier Payments	(\$360,300)	(\$156,743)	(\$23,407)	\$0	(\$180,150)
Reduction to Emergency Department Frequent Utilizers	(\$671,039)	(\$291,925)	(\$43,595)	\$0	(\$335,519)
(2) Medical Services Premiums Long Bill Group Total (ARRA Adjustment)	\$0	\$52,001	\$7,766	\$0	(\$59,767)

Table H.2 Summary of Request FY 2011-12					
Initiative	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$481,092	(\$91,942)	(\$74,509)	\$0	\$647,543
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$627,984	\$156,996	\$0	\$0	\$470,988
MMIS Systems Changes	\$627,984	\$156,996	\$0	\$0	\$470,988
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,000,000	\$250,000	\$0	\$0	\$750,000
Increase Utilization Reviews	\$1,000,000	\$250,000	\$0	\$0	\$750,000
(2) Medical Services Premiums	(\$1,146,892)	(\$498,938)	(\$74,509)	\$0	(\$573,445)
Reduction to Outlier Payments	(\$400,365)	(\$174,173)	(\$26,010)	\$0	(\$200,182)
Reduction to Emergency Department Frequent Utilizers	(\$746,527)	(\$324,765)	(\$48,499)	\$0	(\$373,263)

Table I.1					
Summary of Combined Prevention and Benefits for Enhanced Value (P-BEV)					
and Evidence Guided Utilization Review (EGUR) Requests					
FY 2010-11					
Initiative	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total of Requests	\$401,012	(\$79,370)	(\$60,908)	\$0	\$541,290
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	(\$70,284)	(\$55,554)	\$0	\$0	(\$14,730)
P-BEV: Consolidate Utilization Review Contract	(\$384,276)	(\$134,052)	\$0	\$0	(\$250,224)
EGUR: MMIS Systems Changes	\$313,992	\$78,498	\$0	\$0	\$235,494
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,536,208	\$384,052	\$0	\$0	\$1,152,156
P-BEV: Consolidate Utilization Review Contract	\$536,208	\$134,052	\$0	\$0	\$402,156
EGUR: Increase Utilization Reviews	\$1,000,000	\$250,000	\$0	\$0	\$750,000
(2) Medical Services Premiums	(\$1,064,912)	(\$463,274)	(\$69,183)	\$0	(\$532,455)
P-BEV: Dental Hygienists Procedure Expansion	(\$67,541)	(\$29,383)	(\$4,388)	\$0	(\$33,770)
P-BEV: Non-Emergency Medical Transportation Policies Reform	\$33,968	\$14,777	\$2,207	\$0	\$16,984
EGUR: Reduction to Outlier Payments	(\$360,300)	(\$156,743)	(\$23,407)	\$0	(\$180,150)
EGUR: Reduction to Emergency Department Frequent Utilizers	(\$671,039)	(\$291,925)	(\$43,595)	\$0	(\$335,519)
(2) Medical Services Premiums Long Bill Group Total (ARRA Adjustment)	\$0	\$55,406	\$8,275	\$0	(\$63,681)
P-BEV: ARRA Adjustment	\$0	\$3,405	\$509	\$0	(\$3,914)
EGUR: ARRA Adjustment	\$0	\$52,001	\$7,766	\$0	(\$59,767)

Table I.2					
Summary of Combined Prevention and Benefits for Enhanced Value (P-BEV)					
and Evidence Guided Utilization Review (EGUR) Requests					
FY 2011-12					
Initiative	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$598,368	(\$107,019)	(\$76,760)	\$0	\$782,147
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$243,708	\$22,944	\$0	\$0	\$220,764
P-BEV: Consolidate Utilization Review Contract	(\$384,276)	(\$134,052)	\$0	\$0	(\$250,224)
EGUR: MMIS Systems Changes	\$627,984	\$156,996	\$0	\$0	\$470,988
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$1,536,208	\$384,052	\$0	\$0	\$1,152,156
P-BEV: Consolidate Utilization Review Contract	\$536,208	\$134,052	\$0	\$0	\$402,156
EGUR: Increase Utilization Reviews	\$1,000,000	\$250,000	\$0	\$0	\$750,000
(2) Medical Services Premiums	(\$1,181,548)	(\$514,015)	(\$76,760)	\$0	(\$590,773)
P-BEV: Dental Hygienists Procedure Expansion	(\$72,562)	(\$31,567)	(\$4,714)	\$0	(\$36,281)
P-BEV: Non-Emergency Medical Transportation Policies Reform	\$37,906	\$16,490	\$2,463	\$0	\$18,953
EGUR: Reduction to Outlier Payments	(\$400,365)	(\$174,173)	(\$26,010)	\$0	(\$200,182)
EGUR: Reduction to Emergency Department Frequent Utilizers	(\$746,527)	(\$324,765)	(\$48,499)	\$0	(\$373,263)