

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:	Prevention and Benefits for Enhanced Value (P-BEV)			Dept. Approval by:	John Bartholomew		Date:	November 2, 2009 11/15/09			
Department:	Health Care Policy and Financing			OSP Approval:	<i>[Signature]</i>		Date:	11/3/09			
Priority Number:	BRI-1										
	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	2,574,951,366	0	2,574,951,366	3,043,000,452	118,359	3,043,118,811	0	3,043,118,811	117,276
	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	779,738,814	0	779,738,814	1,148,287,104	(11,201)	1,148,275,903	0	1,148,275,903	(15,077)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,228,606	170,040,016	0	170,040,016	355,125,060	(1,672)	355,123,388	0	355,123,388	(2,251)
	CFE/RF	2,731,396	2,839,847	0	2,839,847	2,836,488	0	2,836,488	0	2,836,488	0
	FF	1,475,414,226	1,622,332,709	0	1,622,332,709	1,536,751,800	131,232	1,536,883,032	0	1,536,883,032	134,604
(I) Executive Director's Office:	Total	22,200,548	27,451,189	0	27,451,189	36,883,007	(384,276)	36,498,731	0	36,498,731	(384,276)
(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	6,006,676	0	6,006,676	6,205,903	(134,052)	6,071,851	0	6,071,851	(134,052)
Information Technology	GFE	0	0	0	0	0	0	0	0	0	0
Contracts	CF	540,118	1,176,844	0	1,176,844	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	20,167,341	0	20,167,341	28,087,875	(250,224)	27,837,651	0	27,837,651	(250,224)
(I) Executive Director's Office:	Total	4,586,288	4,576,355	0	4,576,355	5,204,383	536,208	5,740,591	0	5,740,591	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	0	1,604,395	134,052
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	0	4,049,600	402,156

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 checked="" type="checkbox"/>	Supplemental FY 2009-10	<input type="checkbox"/>	Budget Amendment FY 2010-11	<input type="checkbox"/>				
Request Title:	Prevention and Benefits for Enhanced Value (P-BEV)										
Department:	Health Care Policy and Financing			Dept. Approval by:	John Bartholomew			Date:	November 2, 2009		
Priority Number:	BRI-1			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	Request	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	FY 2011-12
(2) Medical Services Premiums	Total	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(33,573)	3,000,879,489	0	3,000,879,489	(34,656)
	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	1,037,363,033	0	1,037,363,033	1,140,610,858	(14,606)	1,140,596,252	0	1,140,596,252	(15,077)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	(2,181)	352,547,382	0	352,547,382	(2,251)
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(16,786)	1,504,999,695	0	1,504,999,695	(17,328)
(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	(264,990,043)	0	(264,990,043)	0	3,405	3,405	0	3,405	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	509	509	0	509	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	(3,914)	(3,914)	0	(3,914)	0
Non-Line Item Request:	None.										
Letternote Revised Text:	^a Of this amount, \$85,414,587 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; 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:	BRI-1
Change Request Title:	Prevention and Benefits for Enhanced Value

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 \$118,359, with a reduction of \$11,201 General Fund in FY 2010-11, and an increase of \$117,276 with a reduction of \$15,077 General Fund in FY 2011-12, in order to 1) consolidate utilization review contracts as the first step towards development of a comprehensive evidence guided utilization review program; 2) an expanded set of dental procedures to be performed by dental hygienists; and, 3) improved non-emergency medical transportation policies.

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, 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 positioning the Department to further advance 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.

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:

- Consolidation of Current Utilization Review Functions
- Expanded Procedures for Dental Hygienists
- Non-Emergency Medical Transportation Policies Reform

The cornerstone of these initiatives is the consolidation of current utilization review functions. This consolidation is a first step towards a transition to “evidence guided utilization review.” The Department is currently preparing a Request for Proposals (RFP) to enhance its current acute care utilization review structure. This RFP would consolidate prior authorization review activities now provided to the Department by two vendors into one contract. As part of this effort, the Department will require its new vendor have the capacity to not only handle the consolidated current utilization review functions but also have the capacity to meet Departmental options within the contract to comprehensively overhaul the utilization review program, 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, and securing the services of a contractor that can handle the potentially increased scope of

utilization review practices is a necessary first step. Upon successful completion of the utilization review consolidation, the Department may request additional funding through the standard budget process to increase the scope of utilization review services to be performed by the contractor. 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.

In addition, the Department is seeking to further define benefits to focus on preventive care that avoids more costly emergency and acute treatment. By allowing dental hygienists to provide an expanded menu of dental services, clients will have better access to dental care and avoid more costly acute and emergency dental procedures. The Department has also been instructed by the Centers for Medicare and Medicaid Services (CMS) to provide non-emergency medical transportation reimbursement for pharmacy visits and repair trips for durable medical equipment. Reimbursing for these services allows for the Department better assists clients' receipt of preventive and maintenance care that will avoid more costly acute and emergency procedures while ensuring the Department remains in compliance with federal regulations.

General Description of Request:

The Department requests an increase of \$118,359, with a reduction of \$11,201 General Fund in FY 2010-11, and an increase of \$117,276 with a reduction of \$15,077 General Fund in FY 2011-12, in order to 1) consolidate utilization review contracts as the first step towards development of a comprehensive evidence guided utilization review program; 2) an expanded set of dental procedures to be performed by dental hygienists; and, 3) improved non-emergency medical transportation policies.

Consolidation of Current Utilization Review Functions

The Department requests an increase of \$151,932 total funds, but with a \$0 General Fund impact in FY 2010-11 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."² See Appendix Table A.1, A.2, and A.3 for additional calculations.

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 continued 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 organize and plan a series of stakeholder sessions and to assist the Department in establishing priorities and processes to refine benefits definitions so that they incorporate a wide range of concepts critical to a health outcomes-based program. 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.

² Blue Ribbon Commission for Health Care Reform. "Final Report to the Colorado General Assembly." January 31, 2008, p. 14.

Though this is a multi-year process, the Department identified the following areas as 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 is charged with: determining what health outcomes are appropriate; development of minimum standards of care; conducting a comprehensive review and revision of the traditional fee-for-service benefit package; updating regulations to prevent waste and abuse; and, removing outdated rules and system edits to increase efficiency.

As the next step in meeting these goals, the Department has determined that its prior authorization review processes must be modernized and improved. 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.

Consolidation of Acute Care Utilization Review Contracts

For FY 2010-11, the Department's first step would be to require that its acute care utilization reviews are performed by Quality Improvement Organizations (QIO). When utilization reviews are performed by QIOs, the Department receives a 75% federal match on its expenditure (see 42 CFR § 476). Currently, the Department contracts with two prior authorization review agencies: Affiliated Computer Services (ACS) and Colorado Foundation for Medical Care (CFMC). Some of ACS prior authorization review services receive a 75% federal match and some portion receives a 50% federal match. By

consolidating all prior authorization review under a contract with a QIO, the Department would increase its federal funds total from the consolidated contract to \$402,156 from an initial total of \$250,224. The Department's calculations are contained in Table A.1 and A.2.

The Department is releasing a request for proposals (RFP) in late 2009 to solicit bids for a new utilization review vendor, expected to begin work in July, 2010. The newly contracted QIO would be responsible for prior authorization and retrospective reviews of acute care utilization. Additionally, the new QIO would be required to have the capacity to interface with technology upgrades in future years, when and if the Department incorporates technology and systems changes in later phases of this reform. A single QIO would allow for all reviews to be conducted by appropriate medical professionals, ensuring reviews adhere to the principles of medical necessity and improvement of health outcomes. Additionally, by contracting with a single QIO, any future systems enhancements would not be complicated by the need to integrate multiple technologies from multiple vendors. Finally, any QIO activity would also receive the enhanced 75% federal match rate.

Upon execution of the new contract, the Department and its QIO contractor will begin a two-fold process: 1) performing the required utilization review practices, and 2) develop the technical requirements for implementing a comprehensive utilization management system, positioning the Department to request additional funds for utilization review and systems changes that would allow the Department to more efficiently target a larger number of claims for utilization review and thereby generate additional savings across the Medicaid program. Procurement of a new, single contractor will position the Department to later request additional funding in support of evidence guided utilization review.³

³ 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.

Evidence Guided Utilization Review

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. 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. 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.

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.

The Department's movement towards evidence guided utilization review reform builds upon 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

After consolidation of utilization review functions, the Department may request additional funds for its Utilization and Quality Review Contracts, Professional Services Contracts line item to implement the evidence guided utilization review concept. Any request will be offset by demonstrated savings to the Medical Services Premiums line item resulting from increased utilization review; further, as a result of the utilization review contract consolidation, any General Fund investment will receive an enhanced federal matching percentage of 75%. The additional federal funds and resulting total funds increase will increase the savings return on utilization spending.

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.⁴ An aggregated review of available studies suggests a return of approximately three-and-a-half times cost on prior authorization and utilization review.⁵ 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.⁶

⁴ 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>.

⁵ 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.

⁶ Becher EC and Chassin MR. "Improving The Quality of Health Care: Who Will Lead?," *Health Affairs*, 20(5), 164-179, 2001.

Understanding the current fiscal environment, the Department may propose instituting 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.

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. Evidence guided utilization review would also allow for concurrent review selected activities such as inpatient outlier days.

Furthermore, the Department believes evidence guided utilization review reform would 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.

Moreover, evidence guided utilization review would involve continuing the work of the Accountable Care Collaborative and the Benefits Collaborative, described above, to review policies, to encourage the development of community-wide standards, and to confirming local best practices while shaping medical review policy around best research evidence. As provider panels and client and stakeholder sessions yield newly documented best practices and community standards, and upon request of additional funding, the Department may 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 a new technology system.

Technological Enhancements for Utilization Review

Through the request for proposals process, the Department aims to implement a key technological initiative that would allow for more effective evidence guided utilization

review. 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 new QIO vendor, procured through the consolidated contract for utilization review, would be required to have the capacity to work with these technological advancements upon the Department's option should funding be requested and received.

Due to the current fiscal situation, the Department is not requesting funding to implement the web-based PAR system at this time. The Department is investigating the potential savings from implemented such a system, and may request a change in funding at a future date.

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 have the capacity 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 ultimate 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 may request funding for 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; and,
- 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 and has the ability to expand its use of these and similar technologies should additional funding be requested and become available.

Future Evidence Guided Utilization Review Initiatives

The Department believes that the transition to the evidence guided utilization review program will generate Medicaid program savings, which can be reinvested to expand utilization review efforts. The Benefits Collaborative, which is 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. 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 initiatives.

Summary of Consolidation of Acute Care Utilization Review Contracts

Through the consolidation of acute care utilization review functions, the Department is in a position to contract with a new QIO vendor with the ability to not only perform current utilization review activities but also to help develop and use enhanced technologies that can dramatically increase the effectiveness of the Department’s utilization review program. The Department currently requests to consolidate its utilization review contracts as a first step towards a broader movement to provide appropriate and efficient care while controlling Medicaid program costs.

Expanded Procedures for Dental Hygienists

The Department requests a reduction of \$67,541 total funds, \$29,383 General Fund, in FY 2010-11, as well as a reduction of \$72,562 total funds, \$31,567 General Fund in FY 2011-12, for allowing dental hygienists to provide an expanded menu of services to clients. This request is in alignment with both the Blue Ribbon Commission for Health Care Reform and the intent of the Colorado General Assembly. As part of its findings, the Commission recommended that the State “explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists, and others from practicing

to the fullest extent of their licensure and training.”⁷ The Colorado General Assembly recently passed Senate Bill 09-129, which allowed hygienists to perform unsupervised diagnoses and treatment planning, radiographs, and take impressions for use for study models, whether employed by a dentist or working as an unsupervised hygienist. See Table B.1 and B.2 for additional calculations.

As the bill was being considered, only the Department of Regulatory Agencies was contacted to provide a note of fiscal impact. After passage of the legislation, the Department, as part of its regular operations to examine the regulatory environment coming out of each legislative session, identified the potential savings made available by the bill’s signing.

Currently Colorado Medicaid allows unsupervised/independent dental hygienists to bill nine procedure codes. SB 09-129 now allows unsupervised/independent hygienists in Colorado to perform an additional seventeen diagnostic, preventive and periodontal procedures related to:

- Dental hygiene assessment;
- Dental hygiene diagnosis;
- Dental hygiene treatment planning for dental hygiene services;
- Identifying dental abnormalities for immediate referral to a dentist (study casts, radiographic and x-ray survey); and,
- Administering fluoride, fluoride varnish, antimicrobial solutions, and antimicrobial agents.

This request is to add the 17 additional procedures to the list of those that hygienists can provide to Medicaid clients. By adding these procedures to the Medicaid reimbursement schedule for independent hygienists to perform, the Department anticipates increased access for an unmet need for some of our clients who are currently not accessing these services from dentists as often as needed.

⁷ Blue Ribbon Commission for Health Care Reform. “Final Report to the Colorado General Assembly.” January 31, 2008, p. 13.

Of the 9 procedure codes currently billable by both dentists and hygienists, approximately 1.93% of expenditure is from hygienist practice. This number represents the possible increase in utilization of the expanded services the Department may witness due to the increased access to providers that hygienists would supply. The Department assumes that only a portion of clients, 50%, will take advantage of the improved access to care. The result would be an estimated increase in total dental expenditure of \$120,414 in FY 2010-11 and \$129,366 in FY 2011-12.

By providing access to routine, and less costly, dental care, the Department anticipates a subsequent decrease in restorative, periodontal, endodontic, surgical, adjunctive, and hospital related dental procedures. The Department estimates those procedures will total \$3,759,102 in expenditure for FY 2010-11 and \$4,038,559 for FY 2011-12. The Department estimates a small offset of 5% of these costs due to improved access to preventive and routine dental procedures. Added to the cost of the program related above, the Department estimates net savings for this initiative of \$67,541 in FY 2010-11 and \$72,562 in FY 2011-12.

Non-Emergency Medical Transportation Policies Reform

The Department requests an increase of \$33,968 total funds, \$14,777 General Fund in FY 2010-11, as well as an increase of \$37,906 total funds, \$16,490 General Fund, in FY 2011-12, through the alteration of non-emergency medical transportation (NEMT) policy in the spirit of the Commission's recommendation that the State "enhance access to needed medical care, especially in rural Colorado where provider shortages are common."⁸ See Appendix Table C for additional calculations.

Many Coloradans, and a proportionally large contingent of rural Coloradans, utilize NEMT services. The Department continually examines this vital program for efficiency and appropriateness of services provided. This request is to expand NEMT services to include client transportation to durable medical equipment (DME) providers for scheduled

⁸ Blue Ribbon Commission for Health Care Reform. "Final Report to the Colorado General Assembly." January 31, 2008, p. 17.

repairs. The Centers for Medicare and Medicaid Services (CMS) informed the Department, through a series of emails in July 2009, that providing this service is necessary in order to remain in compliance with federal regulations. The implementation process only requires notification to the counties and can be accomplished with current Department resources.

Rural clients who have difficulty getting to their doctors are at increased risk for a variety of adverse health outcomes that can lead to expensive emergency room visits and ambulance trips. NEMT was designed to mitigate that risk. However, that risk is not properly dealt with if the DME a client needs in order to follow her doctor's orders cannot be repaired. Currently, NEMT does not reimburse trips to DME repair appointments.

Historically, 0.70% of all DME expenses are for DME repairs. Using that percentage, and applying it to the projected \$2,469,468 in DME expenditure for clients who also use NEMT services for FY 2010-11 and \$2,657,395 for FY 2011-12, the Department anticipates an increase of \$17,163 and \$18,469 in DME repair costs for the respective fiscal years.

Additionally, applying the percentage to the number of trips taken per fiscal year by NEMT clients who also use DME, the Department anticipates an additional 214 NEMT trips in FY 2011-12 at a cost of \$16,805 and an additional 230 trips in FY 2011-12 at a cost of \$19,437.

The time horizon for the savings could be as long as a lifetime. Determining what proportion of those will remain Medicaid clients, controlling for other behaviors over that time that may impact their health, and anticipating the severity of their future health issues complicate any savings calculation. Because of the complications, the Department does not assume any immediate savings. However, the requested funds would allow the Department to remain in compliance with federal regulation and provide the best access to health care providers and the resources needed to carry out their treatment plans. The Department should realize a savings in future years through the avoided cost of acute and

emergency room treatment that would result from clients being denied the medical equipment they need.

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					
Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$118,359	(\$11,201)	(\$1,672)	\$0	\$131,232
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	(\$384,276)	(\$134,052)	\$0	\$0	(\$250,224)
Consolidate Utilization Review Contract	(\$384,276)	(\$134,052)	\$0	\$0	(\$250,224)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$536,208	\$134,052	\$0	\$0	\$402,156
Consolidate Utilization Review Contract	\$536,208	\$134,052	\$0	\$0	\$402,156
(2) Medical Services Premiums	(\$33,573)	(\$14,606)	(\$2,181)	\$0	(\$16,786)
Dental Hygienists Procedure Expansion	(\$67,541)	(\$29,383)	(\$4,388)	\$0	(\$33,770)
Non-Emergency Medical Transportation Policies Reform	\$33,968	\$14,777	\$2,207	\$0	\$16,984
(2) Medical Services Premiums Long Bill Group Total (ARRA Adjustment)	\$0	\$3,405	\$509		(\$3,914)

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

Summary of Request FY 2011-12					
Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	\$117,276	(\$15,077)	(\$2,251)	\$0	\$134,604
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	(\$384,276)	(\$134,052)	\$0	\$0	(\$250,224)
Consolidate Utilization Review Contract	(\$384,276)	(\$134,052)	\$0	\$0	(\$250,224)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$536,208	\$134,052	\$0	\$0	\$402,156
Consolidate Utilization Review Contract	\$536,208	\$134,052	\$0	\$0	\$402,156
(2) Medical Services Premiums	(\$34,656)	(\$15,077)	(\$2,251)	\$0	(\$17,328)
Dental Hygienists Procedure Expansion	(\$72,562)	(\$31,567)	(\$4,714)	\$0	(\$36,281)
Non-Emergency Medical Transportation Policies Reform	\$37,906	\$16,490	\$2,463	\$0	\$18,953

Cash Funds Projections:

The Department used its FY 2009-10 appropriation as the basis to estimate the proportion of total funding to be dedicated to the Health Care Expansion Fund. The Department estimates reduction of \$1,672 in FY 2010-11 and \$2,251 in FY 2011-12 to the fund.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Health Care Expansion Fund	18K	\$94,003,143	\$119,601,623	\$81,320,908	\$34,980,659	(\$22,674,568)

Assumptions for Calculations:

Where applicable, assumptions are noted in the relevant locations in each table in the appendix, and in the narrative above. 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:

This request includes total net savings of \$11,201 General Fund in FY 2010-11 and a net savings of \$15,077 General Fund in FY 2011-12 due to program efficiencies. However, the proposal includes an increase in federal funds of \$131,232 in FY 2010-11 and an increase of federal funds of \$134,604 in FY 2011-12. While a quantitative cost-benefit analysis is not applicable to this request, the Department believes that there are significant benefits to this proposal, including:

- 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.

Coupled with the savings figures, for these reasons the Department believes that the short- and long-term benefits of these initiatives outweigh the costs.

Implementation Schedule:

To achieve the savings as indicated in this request, the Department is able to implement immediately within the resources requested.

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.

**Base Reduction Item - 1: Prevention and Benefits for Enhanced Value
Appendix**

Table A.1 Requested Shift in Utilization Review Funding						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
A	Current ACS Contract	(\$384,276)	(\$134,052)	\$0	(\$250,224)	Table A.2, Row E
B	QIO Contract	\$536,208	\$134,052	\$0	\$402,156	Would receive 75% federal match
C	Incremental Change	\$151,932	\$0	\$0	\$151,932	Row A - Row B

Table A.2 Current Review Activities Subject to Contract Consolidation						
Row	Item	Total Funds	General Fund	Cash Funds	Federal Funds	Description
A	Monthly Cost of Reviews with an Enhanced Federal Match	\$19,365	\$4,842	\$0	\$14,523	The current contractor receives 75% federal match.
B	Monthly Cost of Reviews at the Standard 50% Federal Match	\$12,658	\$6,329	\$0	\$6,329	General Fund Only, adjusted for enhanced FMAP.
C	Total Monthly Cost of Reviews	\$32,023	\$11,171	\$0	\$20,852	General Fund Only, adjusted for enhanced FMAP.
D	Months in Effect	12	12	12	12	Row A + Row B + Row C
E	Current Total Yearly Cost of Reviews	\$384,276	\$134,052	\$0	\$250,224	Row C * Row D

**Base Reduction Item - 1: Prevention and Benefits for Enhanced Value
Appendix**

Table B.1 Estimated Savings from Dental Hygienists Procedure Expansion to Adults				
Row	Item	FY 2010-11	FY 2011-12	Description
A	FY 2008-09 Dental Expenditure on Procedures to be Allowed to be Performed by a Hygienist	\$10,797,306	-	Actuals.
B	Estimated Growth Rate of Dental Expenditure	7.43%	-	Average year-to-year growth from last three fiscal years.
C	Projected Dental Expenditure on Procedures Allowed to be Performed by a Hygienist	\$12,462,355	\$13,388,825	FY 2010-11: Row A * (1 + Row B) ² FY 2011-12: Row C * (1 + Row B)
D	Increase in Dental Utilization on Selected Services	0.97%	0.97%	Table H.2, Row H.
E	New Total Dental Expenditure on Selected Services	\$12,582,769	\$13,518,191	Row C * (1 + Row D)
F	Increase in Expenditure	\$120,414	\$129,366	Row E - Row C
G	FY 2008-09 Dental Expenditure for Adults on Acute Procedures	\$3,256,862	-	Actuals of adult expenditures on acute procedures.
H	Estimated Growth Rate of Dental Expenditure	7.43%	-	Average year-to-to year growth from last three fiscal years.
I	Projected Acute and Emergency Dental Expenditures	\$3,759,102	\$4,038,559	FY 2010-11: Row G * (1 + Row H) ² FY 2011-12: Row I * (1 + Row H)
J	Estimated Savings	5.00%	5.00%	Assumption.
K	Total Reduction to Emergency Expenditure	(\$187,955)	(\$201,928)	-(Row I * Row J)
L	Total Estimated Net Savings	(\$67,541)	(\$72,562)	Row F + Row K

Table B.2 Estimated Utilization Increase from Dental Hygienists Procedure Expansion to Adults					
Row	Procedure Description	Hygienist Units Reimbursed	Total Units Reimbursed	Hygienist Percentage of Total Units Reimbursed	Source
A	Prophylaxis Adult	811	24,927	3.25%	Actuals
B	Prophylaxis Child	1,011	92,681	1.09%	Actuals
C	Topical app fluoride child	1,312	92,637	1.42%	Actuals
D	Topical app fluoride adult	707	22,314	3.17%	Actuals
E	Sealant Per Tooth	1,531	45,431	3.37%	Actuals
F	Weighted Average			1.93%	Average weighted by units reimbursed.
G	Percentage of Clients Who Utilize New Access			50.00%	Assumption: 50% of clients utilize the expanded access hygienists supply.
H	Substitution Effect			0.97%	Row F * Row G

**Base Reduction Item - 1: Prevention and Benefits for Enhanced Value
Appendix**

Table C				
Non-Emergency Medical Transportation (NEMT) Policies Reform				
Row	Item	FY 2010-11	FY 2011-12	Description
A	Expenditure on Durable Medical Equipment (DME) by NEMT Clients	\$2,469,468	\$2,657,395	Projected from average growth of actual expenditure.
B	Proportion of All DME that is on Repairs	0.70%	0.70%	Average of the last two years of actual % of DME expenditure that is for repairs.
C	Estimated Additional DME Repair Expenditure	\$17,163	\$18,469	Row A * Row B
D	Estimated Number of NEMT Trips by DME Clients	30,805	33,149	Based on prior year actuals and growth rates
E	Estimated Additional NEMT Trips	214	230	Row B * Row D
F	FY 2008-09 Average Trip Cost	\$67.82	-	Actuals.
G	Year-to-Year Inflationary Rate	7.61%	-	Average year-to-to year growth from last three fiscal years.
H	Average NEMT Trip Cost	\$78.53	\$84.51	Row F trended to the appropriate year using Row G.
I	Increase in NEMT Expenditure	\$16,805	\$19,437	Row E * Row H
K	Total Estimated Savings	\$33,968	\$37,906	Row C + Row I + Row J