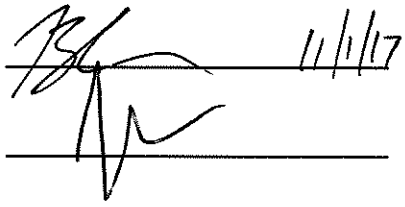
Schedule 13

Funding Request for the FY 2018-19 Budget Cycle

Department of Health Care Policy and Financing

Request Title **R-10 Drug Cost Containment Initiatives**

Dept. Approval By:  11/1/17

OSPB Approval By:

___ **Supplemental FY 2017-18**

X **Change Request FY 2018-19**

___ **Budget Amendment FY 2018-19**

Summary Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,662,782,054**	**$0**	**$7,611,566,065**	**$132,777**	**($1,512,798)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,105,506,778	$0	$2,093,075,442	($24,407)	($390,093)
	CF	$892,523,832	$0	$890,531,810	($39,129)	($102,816)
	RF	$70,714,284	$0	$70,525,230	$0	$0
	FF	$4,594,037,160	$0	$4,557,433,583	$196,313	($1,019,889)

Line Item Information	Fund	FY 2017-18 Initial Appropriation	FY 2017-18 Supplemental Request	FY 2018-19 Base Request	FY 2018-19 Change Request	FY 2019-20 Continuation
01. Executive Director's Office, (A) General Administration -- General Professional Services and Special Projects	**Total**	**$9,412,649**	**$0**	**$14,534,207**	**$300,500**	**$300,500**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,005,615	$0	$5,621,706	$150,250	$150,250
	CF	$1,600,352	$0	$1,545,040	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$4,656,682	$0	$7,217,461	$150,250	$150,250
01. Executive Director's Office, (C) Information Technology Contracts and Projects -- MMIS Maintenance and Projects	**Total**	**$41,646,122**	**$0**	**$41,988,677**	**$630,500**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,955,404	$0	$5,979,906	$63,050	$0
	CF	$4,288,071	$0	$4,445,412	$0	$0
	RF	$11,808	$0	$6,618	$0	$0
	FF	$31,390,839	$0	$31,556,741	$567,450	$0

01. Executive Director's Office, (E) Utilization and Quality Review Contracts - - Professional Service Contracts	**Total**	**$13,824,436**	**$0**	**$16,087,495**	**$282,297**	**$512,599**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,017,493	$0	$4,597,070	$70,574	$128,150
	CF	$470,308	$0	$497,964	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$9,336,635	$0	$10,992,461	$211,723	$384,449

02. Medical Services Premiums -- Medical Services Premiums	**Total**	**$7,597,898,847**	**$0**	**$7,538,955,686**	**($1,080,520)**	**($2,325,897)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,092,528,266	$0	$2,076,876,760	($308,281)	($668,493)
	CF	$886,165,101	$0	$884,043,394	($39,129)	($102,816)
	RF	$70,552,476	$0	$70,368,612	$0	$0
	FF	$4,548,653,004	$0	$4,507,666,920	($733,110)	($1,554,588)

CF Letternote Text Revision Required?	Yes	X	No	**If Yes, see schedule 4 fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X
FF Letternote Text Revision Required?	Yes		No	X
Requires Legislation?	Yes		No	X

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- The Department requests an increase of $132,777 total funds, including a decrease of $24,407 General Fund in FY 2018-19 and a decrease of $1,512,798 total funds, including a decrease of $390,093 General Fund in FY 2019-20 to improve management of the pharmacy and physician administered drug benefits. This funding would be used to procure a utilization management vendor for physician administered drugs, administrative resources to set up alternative payment models for prescription drugs, and to account for anticipated savings from these initiatives.

Current Program

- The total funds spent on pharmacy and physician administered drug benefits totaled $834,402,471 ($425,522,785 net of rebates) and $53,185,751 respectively in FY 2015-16.
- Pharmacy claims are paid through the Pharmacy Benefit Management System (PBMS), while physician administered drugs are considered a medical benefit and are paid through the interChange system.
- Prior authorization is required on some drugs in the pharmacy benefit, including those non-preferred agents on the preferred drug list (PDL). There are currently no prior authorization restrictions on any physician administered drugs. The Department was appropriated an FTE to manage the physician administered drug benefit through the FY 2017-18 R-7 "Oversight of State Resources."
- Oversight of these benefits come from the Drug Utilization Review (DUR) Board, the Pharmacy and Therapeutics (P&T) Committee managing Preferred Drug List, and Medical Services Board.

Problem or Opportunity

- Prescription drug expenditures have grown significantly in the last few years due to the increasing number of specialty drugs in the market and increases in drug prices.
- Utilization management of the Physician Administered Drug benefit and participating in alternative payment models (APM) are new tools the Department can use to manage benefits and lessen pressure on the State's financial resources.

Consequences of Problem

- If the request is not approved, the Department would miss two opportunities to mitigate increasing drug costs. The Department would be unable to put prior authorizations on physician administered drugs and could not guarantee that these services are provided in the most cost-effective manner.
- Drug costs would likely increase more rapidly than they would have otherwise under containment policies.

Proposed Solution

- The utilization management vendor would be responsible for working in conjunction with the benefit manager in developing clinical criteria for prior authorization for physician administered drugs and processing prior authorization requests (PARs).
- The Department is in the initial phases of developing APMs to address the rising costs of specialty drugs. The Department expects to start engaging with manufacturers to participate in these APMs in 2018.

Department Priority:	***R-10***
Request Detail:	***Drug Cost Containment Initiatives***

Summary of Incremental Funding Change for FY 2018-19	Total Funds	General Fund
Drug Cost Containment Initiatives	$132,777	($24,407)

Problem or Opportunity:

Drug costs have consistently increased year over year, putting pressure on the State's limited financial resources. In FY 2015-16, the Department spent $834,402,471 on prescription drugs ($425,522,785 net of rebates), and $53,185,751 on physician administered drugs. The Department must come up with new strategies for containing drug costs, reducing inappropriate utilization, and holding manufacturers accountable for the health outcomes that are claimed for the drugs they produce.

A significant driver of this growth is the increase in high-cost specialty drugs[1] in the market. In FY 2015-16, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that high-cost specialty drugs made up 0.9 percent of Medicaid claims in 2014, but accounted for 32 percent of total Medicaid drug expenditures before rebates.[2] The Center for Evidence-based Policy estimates 110 new high-cost specialty drugs in the pipeline awaiting approval from the U.S. Food and Drug Administration (FDA). Medicaid agencies also tend to bear more of these specialty drug costs due to the nature of Medicaid members being on average in poorer health than those on private insurance.[3] Additionally, unlike private payers, Medicaid agencies cannot exclude many of these new drugs from coverage under the prescription drug regulations because they must cover all prescription drugs sold by a manufacturer that has a national rebate agreement with the Centers for Medicare and Medicaid Services (CMS).[4]

The regulatory and economic constraints faced by the Department means it must devise innovative and creative policies to achieve its goals of drug cost containment, while ensuring the health and safety of its members. In previous years, the Department has relied on using prior authorization policies, maintaining a

[1] The definition of a high cost specialty drug varies by organization. Common elements of these drugs include costs greater than $600 per prescription and treatment of a serious or life-threatening disease or condition.
[2] Medicaid and CHIP Payment and Access Commission (MACPAC) (2016). Medicaid spending for prescription drugs: Issue brief https://www.macpac.gov/publication/medicaid-spending-for-prescription-drugs/
[3] Oregon Health & Science University: Center for Evidence-based Policy (2016). State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D) Economic Analysis. http://smart-d.org/wp-content/uploads/2016/09/Pipeline-and-Economic_Final_Sept-9-2016.pdf
[4] 42 CFR § 447.502

preferred drug list (PDL), and using cost-based reimbursement methodologies. The Department is also exploring putting quantity limitations on certain drugs, better managing of unmanaged drug classes, and allowing more prescribed over-the-counter drugs to be reimbursed.

The two new cost containment strategies proposed by the Department in this request involve utilization management of the physician administered drug benefit and engaging in alternative payment models (APMs).

Physician Administered Drugs Benefit Management

The Department is currently in the process of restructuring the physician administered drug benefit[5] and requires additional resources for the next phase of updates. The next step in improved management of the benefit involves using a utilization management[6] vendor to implement and administer a prior authorization system.

As part of the FY 2017-18 R-7 "Oversight of State Resources", the Department requested to set rates of physician administered drugs to an average of 2.5 percent over the average sales price (ASP) by drug class. This structure allowed the Department flexibility to set some drug rates above 2.5 percent over ASP for incentive pricing, while lowering other rates. The Department was also appropriated an administrator FTE to manage the physician administered drugs benefit. The role of this position involves adjusting the Department's drug reimbursement fee schedule, updating pharmacy and procedural codes for new and reformulated drug codes, and developing clinical criteria for utilization.

Without a utilization management system, new or costlier drugs that are of similar clinical effectiveness to an existing drug can be billed to the Department without prior authorization. The Department would continue to spend funds on drugs that do not necessarily represent the best, nor most cost-effective treatment for a member.

Additionally, the Department does not currently have a way of tracking if a member has accessed duplicate or similar services through both the medical and pharmacy benefits. Pharmacy claims are paid through the Pharmacy Benefit Management System (PBMS), while physician administered drugs are considered a medical benefit and are paid through the interChange system. Because the two systems do not compare utilization, it is possible for a member to receive treatment for the same diagnosis through both the outpatient pharmacy and physician settings. A utilization management system would prevent duplication of treatment.

Alternative Payment Models (APMs)

The Department seeks to expand its use of value-based purchasing methods by tying more payments to quality or value within the pharmacy benefit. For pharmacy, these models are typically voluntary collaborations between a drug manufacturer and a Medicaid program, intended to hold manufacturers accountable for the outcomes they claim for their drugs, and help Medicaid programs control exorbitant drug costs. An alternative payment model (APM) is based on financial outcomes or health outcomes of the covered population. Financial-based APMs use financial caps or discounts through programs such as

[5] Injectable drugs, allergen extracts, infusion drugs and immunizations administered in a physician's office are considered physician administered drugs.

[6] Utilization Management is the evaluation of the appropriateness and medical need of health care services and procedures according to evidence-based criteria or guidelines.

supplemental rebates to ensure spending predictability, while health outcomes-based APMs tie the clinical outcomes of the patient population to drug payment.[7] APMs have been used in European markets for years with various levels of success in different countries. The most common APM used is the price-volume model. In this model, prices are attached to the utilization volume of a drug and the price per unit gradually decreases as there is more patient utilization. The second most common APM involves data collection requirements so that health outcomes can be measured at a later point in time or cost-savings expectations can be validated.[8]

The Department is investigating whether it would need to pursue a section 1115 Medicaid demonstration waiver in developing some of the APMs. An 1115 waiver would allow the Department to waive certain provisions of the Social Security Act, such as covering all drugs that have entered into the national rebate program with CMS. For a health-outcome based APM that might rely on exemption from covering Fast Track drugs or drugs with limited proven clinical efficacy, an 1115 waiver would likely be necessary. With these drugs, the Department would spend additional time in its reviews before allowing the drugs to be covered.

Proposed Solution:

The Department requests an increase of $132,777 total funds, including a decrease of $24,407 General Fund in FY 2018-19 and a decrease of $1,512,798 total funds, including a decrease of $390,093 General Fund in FY 2019-20 to procure a utilization management vendor for the physician administered drug benefit and for administrative resources to set up alternative payment models. This request also takes into account anticipated savings from a more robust utilization management program for physician administered drugs. These two initiatives represent new tools the Department can use to contain drug costs. The resources requested would provide additional mechanisms for more efficient administration of the pharmacy and physician administered drug benefits through utilization management and value-based purchasing initiatives.

If the request is not approved, the Department would miss an opportunity to mitigate increasing drug costs. The Department would be unable to put prior authorizations on physician administered drugs and could not guarantee that these services are provided in the most cost-effective manner. Drug costs would likely increase more rapidly than they would have otherwise under containment policies.

Procure Utilization Management Vendor for Physician Administered Drugs

The benefit manager appropriated under the FY 2017-18 R-7 "Oversight of State Resources" would work in conjunction with the utilization management vendor in developing clinical criteria for prior authorization for physician administered drugs. The vendor would process prior authorization requests (PARs) and send authorizations to the interChange to pay the claim.

In developing these prior authorization policies, the Department may use existing prior authorization processes in place for the pharmacy benefit to ensure the health and safety of its members. These processes include working with the Medical Services Board, the Pharmacy and Therapeutics (P&T) Committee to put drugs on the Preferred Drug List (PDL), and the Drug Utilization Review (DUR) Board to determine prior

[7] Please refer to footnote 3 for citation.

[8] Oregon Health & Science University: Center for Evidence-based Policy (2016). State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D) Alternate Payment Model Brief. http://smart-d.org/wp-content/uploads/2016/10/SMARTD_APM_Report_Final_Oct-21-2016.pdf

authorization criteria for nonpreferred drugs and drugs with special prescribing guidelines. Before requiring prior authorization on a drug, the Department would carefully evaluate with its stakeholders whether there were appropriate substitutes in place, particularly for drugs used by more vulnerable patients, such as those receiving specialty drugs for cancer treatment.

Designing Alternative Payment Models (APMs)

The Department is committed to tying health outcomes to reimbursement across the Medicaid program through alternative payment models (APMs) and is currently in the initial phases of developing alternative payment models for its pharmacy program. The Department expects to work on an APM implementation plan and target a preliminary selection of drugs and drug classes in fall of 2017 and start reaching out to manufacturers in spring of 2018. There is still uncertainty on which manufacturers the Department would work with, which drugs would be targeted, and the structure of the APM.

The Department is requesting administrative funding for an actuarial contractor and consultant to help develop and implement the APMs and 1115 Medicaid demonstration waiver. An actuary would assist with determining measurable health and financial outcomes for contracts with manufacturers, including compiling other data sources outside of Medicaid claims. It would model the impact of the proposed payment projects on expenditure and health outcomes in the design phase and analyze the actual impact of the APM contract once it is implemented. The actuary would also validate the selected payment methodologies, ensuring that they meet federal regulations. A consultant would provide support with determining whether an 1115 Medicaid demonstration waiver is needed to implement the APMs and guide the Department through the planning process of developing the waiver, performing stakeholder outreach, and working with CMS to ensure any preliminary concepts are defensible. The consultant would need to be experienced in the necessary steps for submitting an 1115 demonstration waiver, including negotiations with CMS, public outreach, and budget neutrality calculations.

Any corresponding savings from implementing the APMs would be accounted for in the Medical Services Premiums line item through the regular budget process once specific drugs are targeted and APM contracts are in place. Pursuant to HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives," the Department would also submit to the Joint Budget Committee its APM plans, including demonstrating the new payment methodology is designed to achieve budget savings and an overview of the stakeholder engagement process used to develop the APM.

Anticipated Outcomes:

Funding this request would allow the Department to better manage the pharmacy and physician administered drug benefits through utilization management and alternative payment methodologies (APMs). These two new cost containment techniques represent the Department's commitment to its performance plan goals of maximizing the use of value-based payment reforms, including tying provider payments to quality and value and implementing cost containment initiatives; and operational excellence through improving the efficiency of business processes.

Through utilization management of physician administered drugs, the Department expects less inappropriate drug usage and better promotion of high-value drugs. Prior authorization and the PDL have historically been

successful tools in managing the pharmacy benefit. In the FY 2014-15 Pharmacy Utilization Plan[9], the Department estimated a cost avoidance of $10,434,380 in FY 2013-14 as a result of these two utilization control mechanisms.

Through developing APMs, the Department anticipates better health outcomes for clients and a better way of controlling drug costs for the State. If a drug's performance falls below expectations, the Department assumes it would collect more in supplemental rebates to offset the drug's cost.

Assumptions and Calculations:

Utilization Management Vendor

The Department would incur costs related to implementing a utilization management vendor, including costs to adapt the interChange to connect to vendor systems, and also savings from changes in utilization associated with increased prior authorizations. The Department based its cost calculations on the presumption that these changes could be implemented using vendors with existing contracts with the Department and a request for proposal (RFP) would not need to be issued. The Department anticipates vendors would be able to start on the project as soon as funding is received on July 1, 2018 and complete the systems changes by January 1, 2019.

Systems Costs Associated with Utilization Management Vendor and interChange

The utilization management vendor would be responsible for approving prior authorizations of physician administered drugs. Based on the preliminary list of drugs identified for prior authorization, the Department anticipates processing approximately 5,000 prior authorization requests per year. The Department also included an estimate for additional funding as prior authorization policies are developed. This flexible funding accounts for a 25% variation in PAR quantities from the estimate based on the preliminary targeted drug list.

The prior authorization costs estimates are based on one vendor's program where the cost per PAR varies based on the processing system the Department chooses. Under a standard prior authorization system with this vendor, every PAR transaction costs $42 to process; this means for a PAR that is denied and then appealed, two transactions would be counted. The standard type of prior authorization system would be used in the proposed PARs reflected in the FY 2018-19 R-8 "Assorted Medicaid Saving Initiatives" request with each PAR transaction costing $22.75. A complex PAR costs $83 to process, but under this system, no additional fees would be assessed regardless of the number of transactions associated with the PAR.[10] The complex PAR system is expected to save both time and financial resources because of the more thorough initial review. The Department would also have the option of using a blended system with both standard and complex PAR processing. The calculations in Table 4.1 assume the Department would use a blended system and correspondingly, a weighted average of $77.95 per PAR. These calculations also assume drugs that

[9] The Pharmacy Utilization Plan was an annual legislative report to the House Health and Human Services Committee and the Joint Budget Committee required by 25.5-5-506(3)(b), C.R.S. (2014). This requirement has been since repealed by HB 16-1081.
[10] Approximately 70 physician administered drugs are recommended to be processed under the complex prior authorization system and undergo an initial peer to peer review.

undergo the standard PAR would only be processed once. Drugs with average annual costs per utilizer that are below the cost of processing a PAR would not be targeted.

Depending on the vendor that is selected for the project, and the PAR processing system, it is possible that an interface would need to be built between the PBMS system and interChange system. This cost of building this interface is estimated to be $630,500 and require 4,850 project hours.

The Department assumes the cost of setting up the interface between the interChange and utilization management system is eligible for a 90 percent federal financial participation (FFP) rate as allowed by 42 CFR § 433.15(b)(3) for design, development, or installation of mechanized claims processing and information retrieval systems. For the components involving processing prior authorizations, the Department anticipates claiming 75 percent FFP under 42 CFR § 433.15(6)(i) for funds expended for the performance of medical and utilization review. In order to claim this enhanced funding, the Department would need to submit an advance planning document (APD) to CMS with implementation details.

Effect of Prior Authorization Policy on Utilization

The Department assumes that implementing a prior authorization system on physician administered drugs would result in a 7.0 percent decrease in utilization of drugs targeted for prior authorization policies. The Department selected this percentage as a conservative estimate based on previous research on the effects of prior authorization on drug utilization.

The findings of prior authorization literature are varied and the results are often only specific to a particular class of drugs or for certain programs.[11] There are frequently other policies taking place at the same time of the research period and this makes it difficult to attribute a change unambiguously to prior authorization policies. The effectiveness of a prior authorization program also depends upon if the class of drugs has other available substitutes. Another limitation is that rebate amounts are confidential and the drug expenditures used in these studies represent expenditure before rebates are applied. As such, the research findings do not necessarily reflect the net effect of a policy change.

The Department assumed that implementing prior authorization on physician administered drugs would result in a 7.0 percent decrease in utilization. This figure is roughly half of the 13.9 percent reduction in market share observed in West Virginia upon putting prior authorization criteria on second-generation antipsychotics (Law et al, 2009). In the West Virginia study, the researchers examined the effect of Medicaid prior authorization policies on utilization of second-generation antipsychotic agents. Specifically they looked at changes in nonpreferred medications in West Virginia and Texas in comparison with other states without similar prior authorization requirements. In West Virginia, implementing prior authorization policies was associated with a 13.9 percent reduction in the market share of nonpreferred drugs over two years.

[11] Maine's prior authorization policy is associated with decreases in the use of nonpreferred drugs and a $3.40 per patient decrease in medication costs for patients with bipolar illness (Zhang et al, 2009). Michigan and Indiana's prior authorization programs on lipid-lowering medications for dual-eligible enrollees is associated with a reduction of $24,548 in prescription expenditures in Michigan and $16,070 in Indiana (Lu et al, 2011). Fischer et al (2004) found prior authorization criteria for cyclooxygenase-2 inhibitors in Medicaid programs was associated with a spending reduction of $185 million annually.

Nonpreferred drug usage in Texas also decreased but this trend was not statistically significant.[12] Phillips (1997) evaluated the effect of prior authorization on drug utilization in Iowa's Medicaid program and found overall 17.1 percent of new and extension prior authorization requests were denied coverage and there was an associated net savings of $2.51 million to $3.83 million for antiarthritics, benzodiazepines, antiulcer, and antihistamines.[13] The Department assumed a lower percentage decrease in utilization than those that can be inferred from Law et al (2009) and Phillips (1997) to remain conservative in its savings estimates. Additionally, the Department assumes a portion of clients would switch to less expensive alternatives, thereby dampening any assumed decrease in drug utilization.

The Department based the cost avoidance calculations on FY 2015-16 claims of a preliminary set of physician administered drugs. The drugs targeted in these calculations do not represent the Department's final decisions on which drugs to prior authorize. The Department would continue to work with stakeholders, such as through the Pharmaceutical and Therapeutics committee, Drug Utilization Review Board, and Medical Services Board before making any determinations. These initiatives would not circumvent existing processes.

The Department assumes there would be no reduction in costs related to visits to the physician's office. Due to the nature of these targeted drugs, the drugs must be administered in a physician's office or another clinical setting. In addition to billing for the drug itself, providers can also bill for an administration fee or an infusion fee depending on how the drug is administered. The Department assumes that the billing for the administration or infusion fee would not change.

Alternative Payment Model (APM)

The Department assumes it would start negotiating APM contracts with manufacturers in spring of 2018 and any agreements would be effective in FY 2018-19. Any associated savings would also be reflected in the FY 2018-19 budget cycle. This timeline is subject to change based on the APMs that the Department chooses to pursue and whether they would need an 1115 demonstration waiver, which can take two years to develop and submit to CMS for approval. The Department would also need to evaluate whether statutory changes are needed to implement the APMs.

The Department estimates it would need $300,500 total funds in contractor funding on an ongoing basis to assist with measuring the health and financial outcomes of the APMs, including compiling any other necessary data outside of Medicaid claims, and planning an 1115 demonstration waiver. This figure is based on an estimate of 500 contract hours for the actuary at an average rate of $250 per hour based on previous actuarial contracts and 1,300 contract hours for the consultant at an average rate of $135 per hour based on contracts of similar scope.

Please see Appendix A for more detailed information on calculations.

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[12] Law, M.R., Ross-Degnan, D., & Soumerai, S.B. (2008). Effect of prior authorization of second-generation antipsychotic agents on pharmacy utilization and reimbursements. Psychiatric Services, 59(5), 540-546.

[13] Phillips, C. (1997). Evaluating the operational performance and financial effects of a drug prior authorization program. Journal of Managed Care Pharmacy, 3(6), 699-706.

Table 1.1: FY 2018-19 Drug Cost Containment Initiatives by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Comments**
A	**Total Request**	**$132,777**	**($24,407)**	**($39,129)**	**$196,313**	**Sum of Rows B through E**
B	(1) Executive Director's Office, (A) General Professional Services and Special Projects	$300,500	$150,250	$0	$150,250	Row F of Table 2.1
C	(1) Executive Director's Office, (C) Medicaid Management Information System Maintenance and Projects	$630,500	$63,050	$0	$567,450	Row C of Table 2.1
D	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$282,297	$70,574	$0	$211,723	Row A + Row B of Table 2.1
E	(2) Medical Services Premiums	($1,080,520)	($308,281)	($39,129)	($733,110)	Row D of Table 2.1
Footnotes: (1) Cash funds include decreases of $72 to the Breast and Cervical Cancer Prevention cash fund and $39,057 to the Healthcare Affordability and Sustainability Fee cash fund.						

Table 1.2: FY 2019-20 Drug Cost Containment Initiatives by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Comments**
A	**Total Request**	**($1,512,798)**	**($390,093)**	**($102,816)**	**($1,019,889)**	**Sum of Rows B through D**
B	(1) Executive Director's Office, (A) General Professional Services and Special Projects	$300,500	$150,250	$0	$150,250	Row D of Table 2.2
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$512,599	$128,150	$0	$384,449	Row A of Table 2.2
D	(2) Medical Services Premiums	($2,325,897)	($668,493)	($102,816)	($1,554,588)	Row B of Table 2.2
Footnotes: (1) Cash funds include decreases of $155 to the Breast and Cervical Cancer Prevention cash fund and $102,661 to the Healthcare Affordability and Sustainability Fee cash fund.						

Table 1.3: FY 2020-21 Drug Cost Containment Initiatives by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Federal Funds**	**Comments**
A	**Total Request**	**($1,671,380)**	**($438,128)**	**($125,656)**	**($1,107,596)**	**Sum of Rows B through D**
B	(1) Executive Director's Office, (A) General Professional Services and Special Projects	$300,500	$150,250	$0	$150,250	Row D of Table 2.3
C	(1) Executive Director's Office, (E) Utilization and Quality Review Contracts, Professional Services Contracts	$531,307	$132,827	$0	$398,480	Row A of Table 2.3
D	(2) Medical Services Premiums	($2,503,187)	($721,205)	($125,656)	($1,656,326)	Row B of Table 2.3
Footnotes: (1) Cash funds include decreases of $167 to the Breast and Cervical Cancer Prevention cash fund and $125,489 to the Colorado Healthcare Affordability and Sustainability Fee cash fund.						

Table 2.1: FY 2018-19 Drug Cost Containment Initiatives							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**	**FFP**	**Comments**
A	Cost of Processing Prior Authorization Requests	$247,297	$61,824	$0	$185,473	75.00%	Table 3.2
B	Implementation Costs of Utilization Management System	$35,000	$8,750	$0	$26,250	75.00%	Table 3.2
C	Developing Interface between interChange and UM System	$630,500	$63,050	$0	$567,450	90.00%	Table 3.2
D	Costs Avoided from Prior Authorization on Physician Administered Drugs (PADs)	($1,080,520)	($308,281)	($39,129)	($733,110)	67.85%	Table 3.1
E	**Utilization Management of Physician Administered Drugs Subtotal**	**($167,723)**	**($174,657)**	**($39,129)**	**$46,063**		**Sum of Rows A through D**
F	Alternative Payment Model (APM) Contractor Resources	$300,500	$150,250	$0	$150,250	50.00%	Table 6.1
G	**Total of Drug Cost Containment Initiatives**	**$132,777**	**($24,407)**	**($39,129)**	**$196,313**		**Row E + Row F**

Footnotes:
(1) Cash funds include decreases of $72 to the Breast and Cervical Cancer Prevention cash fund and $39,057 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 2.2: FY 2019-20 Drug Cost Containment Initiatives							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**	**FFP**	**Comments**
A	Cost of Processing Prior Authorization Requests (PARs)	$512,599	$128,150	$0	$384,449	75.00%	Table 3.2
B	Costs Avoided from Prior Authorization on Physician Administered Drugs (PADs)	($2,325,897)	($668,493)	($102,816)	($1,554,588)	66.84%	Table 3.1
C	**Utilization Management of Physician Administered Drugs Subtotal**	**($1,813,298)**	**($540,343)**	**($102,816)**	**($1,170,139)**		**Row A + Row B**
D	Alternative Payment Model (APM) Contractor Resources	$300,500	$150,250	$0	$150,250	50.00%	Table 6.1
E	**Total of Drug Cost Containment Initiatives**	**($1,512,798)**	**($390,093)**	**($102,816)**	**($1,019,889)**		**Row C + Row D**

Footnotes:
(1) Cash funds include decreases of $155 to the Breast and Cervical Cancer Prevention cash fund and $102,661 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 2.3: FY 2020-21 Drug Cost Containment Initiatives							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**	**FFP**	**Comments**
A	Cost of Processing Prior Authorization Requests (PARs)	$531,307	$132,827	$0	$398,480	75.00%	Table 3.2
B	Costs Avoided from Prior Authorization on Physician Administered Drugs (PADs)	($2,503,187)	($721,205)	($125,656)	($1,656,326)	66.17%	Table 3.1
C	**Utilization Management of Physician Administered Drugs Subtotal**	**($1,971,880)**	**($588,378)**	**($125,656)**	**($1,257,846)**		**Row A + Row B**
D	Alternative Payment Model (APM) Contractor Resources	$300,500	$150,250	$0	$150,250	50.00%	Table 6.1
E	**Total of Drug Cost Containment Initiatives**	**($1,671,380)**	**($438,128)**	**($125,656)**	**($1,107,596)**		**Row C + Row D**

Footnotes:
(1) Cash funds include decreases of $167 to the Breast and Cervical Cancer Prevention cash fund and $125,489 to the Healthcare Affordability and Sustainability Fee cash fund.

Table 3.1: Net Effect of Utilization Management (UM) of Physician Administered Drugs (PADs)					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	Utilization Management Systems Costs	$912,797	$512,599	$531,307	Row D of Table 3.2
B	Decreased Utilization from Prior Authorization Policies	($1,080,520)	($2,325,897)	($2,503,187)	Row K of Table 3.3
C	**Net Effect of PADs Utilization Management**	**($167,723)**	**($1,813,298)**	**($1,971,880)**	**Row A + Row B**

Table 3.2: Utilization Management (UM) Systems Changes					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	Processing Prior Authorization Requests	$247,297	$512,599	$531,307	Row H of Table 4.1
B	Implementation Costs of Utilization Management System	$35,000	$0	$0	Based on contractor estimate
C	Developing Interface between interChange and UM System	$630,500	$0	$0	Row C of Table 4.2
D	**Total**	**$912,797**	**$512,599**	**$531,307**	**Row A + Row B + Row C**

Table 3.3: Decreased Utilization of Physician Administered Drugs (PADs) as a result of Prior Authorization Policies					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	FY 2015-16 Total Units of Service of Targeted PADs	1,933,169	1,933,169	1,933,169	FY 2015-16 MMIS Claims Data
B	Utilization Trend from FY 2015-16	13.50%	17.64%	21.94%	FY 2017-18 S-1 Medical Services Premiums Exhibit B-1 Caseload Trends
C	Estimated Units of Service of Targeted PADs	2,194,178	2,274,266	2,357,276	Row A * (1 + Row B)
D	Estimated Percentage Decrease in Utilization	-7.00%	-7.00%	-7.00%	Assumption based on research on effects of prior authorization on utilization
E	Estimated Utilization avoided with Policy Change	-153,592	-159,199	-165,009	Row C * Row D
F	FY 2017-18 Weighted Average Price of Targeted PADs	$13.55	$13.55	$13.55	Table 5.1; Weighted Average based on FY 2015-16 units of service
G	Drug Price Inflation Factor from FY 2017-18	3.83%	7.81%	11.94%	Three-year weighted average increase of Average Sales Price rates
H	FY 2017-18 Weighted Average Price of Targeted PADs	$14.07	$14.61	$15.17	Row F * (1 + Row G)
I	Full Year Estimate of Costs Avoided	($2,161,039)	($2,325,897)	($2,503,187)	Row E * Row H
J	Portion of Year Policy is Effective	50.00%	100.00%	100.00%	Assume effective date of January 1, 2019
K	**Estimate of Costs Avoided by Fiscal Year**	**($1,080,520)**	**($2,325,897)**	**($2,503,187)**	**Row I * Row J**

Table 4.1: Cost of Prior Authorization on Physician Administered Drugs					
Row	**Items**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
A	FY 2015-16 Distinct Utilizers	4,472	4,472	4,472	Table 5.1; FY 2015-16 MMIS Claims Data of Preliminarily Targeted PADs
B	Utilization Trend from FY 2015-16	13.50%	17.64%	21.94%	FY 2017-18 S-1 Medical Services Premiums Exhibit B-1 Caseload Trends
C	Estimated Number of Prior Authorization Requests (PARs)	5,076	5,261	5,453	Row A * (1 + Row B)
D	Flexible Prior Authorization Request (PAR) Funding	6,345	6,576	6,816	25% increase in Row C to allow for flexibility in designing PA policies
E	Cost of Processing Complex PAR	$77.95	$77.95	$77.95	Table 5.1; weighted average based on preliminary set of codes targeted for PARs.
F	Full Year Cost Estimate of Prior Authorization	$494,593	$512,599	$531,307	Row D * Row E
G	Portion of Year Policy is Effective	50%	100%	100%	Assume effective date of January 1, 2019
H	**Estimate of Costs Avoided by Fiscal Year**	**$247,297**	**$512,599**	**$531,307**	**Row F * Row G**

Table 4.2: Estimated Cost of Developing Interface between interChange and UM System		
Row	**Items**	**FY 2018-19 Costs**
A	Blended Staff Rate	$130.00
B	Number of Project Hours	4,850
C	**Cost of Developing Interface**	**$630,500**

Table 5.1: Preliminary Set of Physician Administered Drugs (PADs) Targeted for Prior Authorization			
Row	**Item**		**Comments**
A	FY 2015-16 Expenditure of Preliminarily Targeted Drugs	$16,071,108	FY 2015-16 MMIS Claims Data
B	FY 2015-16 Units of Service of Preliminarily Targeted Drugs	1,933,169	FY 2015-16 MMIS Claims Data
C	FY 2015-16 Distinct Utilizers of Preliminarily Targeted Drugs	4,472	FY 2015-16 MMIS Claims Data
D	FY 2015-16 Average Cost Per Utilizer of Preliminarily Targeted Drugs	$3,593.72	Row A / Row C
E	July 2017 Average of ASP Pricing of Preliminarily Targeted Drugs	$13.55	Medicare Part B Drug Average Sales Price
F	Average Suggested Prior Authorization Request (PAR) Cost based on Drug Code	$77.95	Contractor Estimate: $42 for standard PAR and $83 for complex PAR

Table 6.1: Alternative Payment Model Contractor Resources					
Row	**Item**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**Comments**
	Actuarial Analysis				
A	Contractor Rate	$250.00	$250.00	$250.00	Average actuarial contractor rate based on previous contracts
B	Number of Hours	500	500	500	Estimated number of hours based on previous contracts
C	Total Request for Actuarial Analysis	$125,000	$125,000	$125,000	Row A * Row B
	Consultant for 1115 Demonstration Waiver				
D	Contractor Rate	$135.00	$135.00	$135.00	Average consultant rate based on previous contracts
E	Number of Hours	1,300	1,300	1,300	Estimated number of hours based on previous contracts
F	Total Request for Consultant Hours	$175,500	$175,500	$175,500	Row D * Row E
G	**Total Request for Contractor Resources**	**$300,500**	**$300,500**	**$300,500**	**Row C + Row F**