

## Schedule 13 Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Primary Care Specialty Collaboration

Priority Number: R-10

Dept. Approval by: Josh Block *JBL* 11/1/13  
Date

OSPB Approval by: *Grant N. ...* 10/29/13

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|--|
| <input checked="" type="checkbox"/> Decision Item FY 2014-15 |
| <input type="checkbox"/> Base Reduction Item FY 2014-15      |
| <input type="checkbox"/> Supplemental FY 2014-15             |
| <input type="checkbox"/> Budget Amendment FY 2014-15         |

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
<b>Total of All Line Items</b>	<b>Total</b>	4,745,317,429	-	5,330,493,347	537,497	(173,987)
	FTE	-	-	-	-	-
	GF	1,038,525,384	-	1,037,369,737	224,061	(52,647)
	GFE	469,842,084	-	469,842,084	-	-
	CF	594,450,563	-	684,103,853	3,479	(2,714)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,639,562,506	-	3,137,177,673	309,957	(118,626)
<b>Executive Director's Office; (A) General Administration, General Professional Services and Special Projects</b>	<b>Total</b>	8,492,552	-	6,660,552	300,000	-
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	150,000	-
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	150,000	-
<b>(2) Medical Services Premiums</b>	<b>Total</b>	4,736,824,877	-	5,323,832,795	237,497	(173,987)
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	74,061	(52,647)
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	3,479	(2,714)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	159,957	(118,626)

Letternote Text Revision Required? Yes:  No:  If yes, describe the Letternote Text Revision:

Medical Services Premiums: Of this amount, ~~\$2,535,659~~ \$2,539,138 shall be from the **Hospital Provider Fee Cash Fund** created in Section 25.5-4-402.3 (4), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund [24A]; FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes:  No:  Not Required:

Schedule 13s from Affected Departments: N/A

Other Information: N/A



# COLORADO

Department of Health Care Policy  
and Financing

Priority: R-10  
Primary Care Specialty Collaboration  
FY 2014-15 Change Request

## ***Cost and FTE***

- The Department requests \$537,497 total funds, \$224,061 General Fund, \$3,479 cash funds, and \$309,957 federal funds.

## ***Link to Operations***

- The Accountable Care Collaborative serves as the Department's platform for ensuring coordinated care and promoting practice transformation in Colorado. To date, efforts in the program have focused on primary care.
- Many Medicaid clients have conditions requiring a level of specialty expertise beyond primary care.

## ***Problem or Opportunity***

- The Department has identified opportunities to improve coordination and access to specialty care services. Currently, there are barriers (geography, reimbursement, coordination, primary care education, client transportation constraints, and technological) to appropriate utilization of specialty services.

## ***Consequences of Problem***

- A lack of appropriate care may result in worsened health outcomes and marked increases in treatment costs from emergency department (ED) visits and hospitalizations. Simultaneously, unnecessary utilization of specialty care inflates costs and further reduces available access for critical needs.

## ***Proposed Solution***

- The Department proposes to leverage the Accountable Care Collaborative infrastructure and technological innovations to address access and utilization issues associated with specialty care.
- The Department requests funds to implement telemedicine technology to allow primary care physicians to exchange patient information with specialist physicians without the need for an in person patient visit with the specialist. The technology would allow specialists to virtually screen clients to see if specialty care is necessary for their case.
- To further address access and reimbursement issues in the long term, the Department requests \$300,000 in contractor funding to facilitate extensive stakeholder engagement, conduct research, and provide evidence based and stakeholder informed recommendations on payment reform options for specialty services through the Accountable Care Collaborative.



# COLORADO

## Department of Health Care Policy and Financing

FY 2014-15 Funding Request | November 1, 2013

John W. Hickenlooper  
Governor

Susan E. Birch  
Executive Director

**Department Priority: R-10**

**Request Detail: Primary Care Specialty Collaboration**

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Primary Care Specialty Collaboration	\$537,497	\$224,061

### **Problem or Opportunity:**

The Department has identified specialty care payment reform as the next pivotal venture in achieving better health and better care for Medicaid clients at lower cost to the State. The role of specialty care providers – often referred to as specialists – is to supplement primary care through the treatment of complex, specialized, or severe conditions. A lack of appropriate care may result in worsened health outcomes and marked increases in treatment costs from emergency department (ED) visits and hospitalizations. Simultaneously, unnecessary utilization of specialty care inflates costs and further reduces available access for critical needs. Access to care is often further complicated by socio-economic challenges, such as transportation difficulties or limited appointment options outside of school and working hours. These challenges are compounded in rural areas of the State, with the added demand of increased travel distance and fewer specialty providers.

By improving coordination between primary and specialty care, and by better managing the appropriate utilization of specialty care, the Department can promote better use of available resources for the benefit of clients' health. Care coordination activities may facilitate solutions to access challenges. In addition, payment reform strategies that incentivize more specialist participation in Medicaid would increase overall access to specialists. The Accountable Care Collaborative (ACC) offers an appropriate venue to implement these new reforms and solutions.

The Department currently spends over \$32 million dollars per year on services provided by obstetricians, oncologists, podiatrists, neurologists, urologists, cardiologists, and dermatologists. Emergency department visits and hospitalizations that may result from the lack of access to specialty care are also very costly to the State. In addition to current efforts through the ACC to support care coordination and collaboration, the Department is developing program and payment reform strategies that promote proper management of care and that promote access to, and coordination with, specialty care providers.

Without proper management of care and coordination between primary care and specialists, the available supply of specialist appointments for Medicaid clients may be poorly allocated for unnecessary care, and

clients truly needing specialist attention must compete for the limited slots. Through payment reform, the Department has an opportunity to both increase total availability of specialty care with program and payment reform incentives, and to decrease inappropriate utilization through care management and coordination between providers. Examples of potential strategies to achieve these aims include developing new payment models for specialty care and providing new technologies to facilitate communication and coordination between primary and specialty providers.

***Proposed Solution:***

The Department requests \$537,497 total funds, including \$224,061 General Fund, \$3,479 cash funds and \$309,957 federal funds, to research and implement a technological solution to exchange patient information with specialists without the need for an in-person visit with the specialist, and hire a contractor to convene with stakeholders in a collaborative process to identify additional opportunities for specialty care reform and to assist in the implementation of a technological based solution to specialty care reform.

Part of these funds will be used for technological solutions to increase appropriate access to specialty care. A collaborative stakeholder process will help develop Colorado's telehealth program. Several programs are available that could inform Colorado's model, including the Doc2Doc model currently used by Oklahoma Medicaid. This model allows primary care physicians (PCPs) and specialty providers to communicate electronically and has proven successful and cost-effective in Oklahoma.

**Doc2Doc Technology**

The Department requests funds to implement technological solutions to specialist reform such as Oklahoma's Doc2Doc program. The Doc2Doc program uses store-and-forward technology to allow PCPs to exchange patient information with specialist physicians without the need for an in-person visit with the specialist.

Doc2Doc is a web-based application created by physicians to enhance communication and collaboration between medical care providers. The application allows PCPs and their office staff to discuss appropriate patient care with specialists asynchronously, securely, and at their convenience. Specialists receive referral requests through the application and advise PCPs on proper care of the patient and the necessity of a referral. PCPs and specialists can share written messages, documents, medical records, and consulting notes on patients. In this way, specialists can respond at a time that is more convenient to them, while still being held to a time window such as 48 hours to respond in order to receive the associated payment.

Oklahoma employed this technology within its Department of Corrections and found that face-to-face specialty visits were reduced by 71% in the first year. This reduction was maintained for over a decade. In over half of the online consultations, specialists could manage the patient's care entirely online. Guidance by specialists allowed PCPs to manage more of the care of the patient and allowed patients to avoid unnecessary travel and lengthy wait times.

The Department could purchase this application, or a similar application, for interested primary care medical providers and specialists in the Accountable Care Collaborative (ACC), though participation would not be mandatory. The Department anticipates that all PCPs in the ACC may not have the desire or the

capacity to use this technology. To encourage the use of this technology for Medicaid clients, the Department could offer an incentive payment to both the PCP and the specialist to collaborate on the necessity of potential referrals. Rather than paying an additional per-member per-month fee to incentivize this behavior, the Department would pay for the collaboration as it occurs, thereby making payment conditional on utilization.

Although the Department is interested in the Doc2Doc model, it serves as one example of how Colorado might implement a similar program. Other programs similar to Doc2Doc may be adopted, including Project ECHO through the University of New Mexico, a model for medical learning and collaborative practice that links primary care clinicians with specialist care teams at university medical centers to manage clients who have chronic conditions requiring complex care. Before any program is fully implemented, comprehensive stakeholder engagement and addressing the variation between Medicaid programs will be necessary.

### **Contractor Funding**

The Department requests \$300,000 to hire contractors for several necessary projects related to implementing this reform. A contractor would be needed to convene stakeholders in a collaborative process to identify additional opportunities for specialty care reform, research reforms from across the nation to identify reform options, formulate policy options related to reform, analyze new payment methodologies and complete data analysis, model the impact of proposed payment reform options in an actuarially sound manner, and seek any federal authorization that may be needed, including promulgating new rules necessary to implement reform. The contractor would make recommendations to the Department based on stakeholder input and evidence based research on the future of specialty care payment reform.

### **Alignment with Other Department Initiatives**

Through the Department's ACC program, clients are each linked with a PCP who is responsible for the client's care, thereby improving health outcomes, reducing costs to the Medicaid program, and bettering the client and provider experience. Applying Doc2Doc technology or a similar application within the framework of the ACC allows the focus to continue to be the relationship between the PCP and the client, and helps the PCP to better understand the clients' needs and manage conditions previously addressed by the specialist or not treated at all.

Through the ACC program, the State hired a Statewide Data Analytics Contractor (SDAC) to provide electronic access to clinically actionable data to the RCCOs and PCPs to help meet the goals of the ACC program. However, the Department does not yet have the ability to collect data on how clients transition from a PCP to a specialist or hospital setting. Acquiring technology such as Doc2Doc will give the Department, RCCOs, and PCPs insight into the referral process and will identify areas of potential improvement and successful processes.

### ***Anticipated Outcomes:***

The Department anticipates significant savings and an opportunity to address care transitions in a meaningful way that will improve access to care, expand relationships between PCPs and specialists, increase the quality of care and reduce costs significantly. Limiting the number of unnecessary specialist visits will quickly offset any payments associated with PCPs and specialists consulting electronically. The

average reimbursement for a visit to a specialist is around \$70, while the costs associated with programs such as Doc2Doc are roughly half that amount.

Alaska Medicaid implemented a program using telecommunication technologies to support long-distance clinical health care, commonly referred to as telehealth, and realized a savings of \$8.5 million in travel costs for the state. Since the program's inception in 2003, Alaska estimates \$38 million in savings. The need for travel was eliminated in 75% of the patients involved in specialty telehealth consultations and in 25% of patients involved in primary care telehealth consultations.

Similarly, through the Doc2Doc program's success reducing unnecessary referrals, Oklahoma was able to realize a savings of approximately \$60 per-member per-month when patients received an online consult. In addition to cost savings, Oklahoma also conducted a study in 2004 with the conclusion that clients involved in an online specialist consultation through their PCP had better health outcomes than those without a specialist consultation.

#### ***Assumptions and Calculations:***

The Department's estimates for costs and savings, shown in the appendix, are based on a proposed implementation of Oklahoma's Doc2Doc program. While this is necessary to provide an estimate for this budget request, the Department notes that its actual implementation of a technological solution may be different. The Department would determine the best implementation strategy in consultation with stakeholders during FY 2014-15, and use the budget process to adjust the estimates for program costs and savings.

The Department assumes in the calculation of this request that only some PCPs will have the capacity or interest to use this technology. Acquiring, learning, and using the product would need to be worth the time of the PCPs, particularly those with a small number of attributed clients. Therefore, the Department assumes that only a quarter of PCPs will begin utilization of the application in the first year. The Department anticipates that 30% of PCPs will be interested in acquiring the technology in FY 2015-16.

Oklahoma's Doc2Doc program experienced a 20-35% reduction in the number of specialist visits. Therefore, the Department believes that a large number of specialist visits would be avoided when a technological system has been fully deployed. However, because the Department's proposed deployment cannot be fully defined until consulting with stakeholders, the Department estimates that 30% of specialist visits can initially be avoided. The Department assumes that the ratio of PCPs participating in the ACC to specialists is approximately 4:1. This is due to the fact that there will likely be several PCPs consulting with the same specialist.

Savings are realized in future years through deferred specialist visits as the initial costs of acquiring the technology are absorbed. Further savings may be realized through averted transportation cost in out years. Colorado spends approximately \$4.9 million on non-emergency medical transportation per year for clients outside of the metro area and over \$5.6 million per year on non-emergent medical transportation for clients within the metro area. This cost to the State and burden on the client could be minimized by reducing unnecessary travel for Medicaid clients. However, these savings are not yet included in the model, as the

time frame on which savings would occur, particularly because a large portion of the Department's transportation contract is currently based on a fixed price, is uncertain. The Department would use the regular budget process to account for any savings achieved.

<b>Table 1.A Summary of Request FY 2014-15</b>						
	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>FTE</b>
<b>Total Request</b>	<b>\$537,497</b>	<b>\$224,061</b>	<b>\$3,479</b>	<b>\$0</b>	<b>\$309,957</b>	<b>0.0</b>
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	\$300,000	\$150,000	\$0	\$0	\$150,000	0.0
(2) Medical Services Premiums	\$237,497	\$74,061	\$3,479	\$0	\$159,957	0.0

<b>Table 1.B Summary of Request FY 2015-16</b>						
	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>FTE</b>
<b>Total Request</b>	<b>(\$173,987)</b>	<b>(\$52,647)</b>	<b>(\$2,714)</b>	<b>\$0</b>	<b>(\$118,626)</b>	<b>0.0</b>
(2) Medical Services Premiums	(\$173,987)	(\$52,647)	(\$2,714)	\$0	(\$118,626)	0.0

R-10 Primary Care Specialty Collaboration  
Appendix A: Calculations and Assumptions

<b>Table 2.A - Summary of Program Expenditure</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2014-15</b>	<b>FY 2015-16</b>	<b>Source</b>
A	Estimated Program Costs	\$441,330	\$2,275,723	Table 2.B Row O
B	Estimated Savings	(\$203,833)	(\$2,449,710)	Table 2.C Row D
<b>C</b>	<b>Net Program Costs</b>	<b>\$237,497</b>	<b>(\$173,987)</b>	<b>Row A + Row B</b>

<b>Table 2.B - Estimated Costs of Technology for Specialty Care Reform</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2014-15</b>	<b>FY 2015-16</b>	<b>Source</b>
A	Total Primary Care Physicians (PCP) in the Accountable Care Collaborative (ACC)	2,300	2,415	Approximate number of PCPs participating in the ACC as of August 2013 (inflated by 5% for FY 2015-16)
B	Percent of PCP Participation	25%	30%	Assumed, see narrative for additional information
C	Number of PCPs Participating	575	725	Row A * Row B
E	Number of Specialist Utilizers	144	181	Assumes a 4:1 ratio of PCP utilizers to specialist utilizers - see narrative for additional information
F	Estimated Fee to Acquire Technology per Specialist and PCP per Month	\$25	\$25	Doc2Doc fee to acquire technology
G	Number of Applicable Months in Fiscal Year	6	12	Assumes January 2015 Implementation
<b>H</b>	<b>Total cost of acquiring software</b>	<b>\$107,850</b>	<b>\$271,800</b>	<b>(Row C + Row E) * Row F * Row G</b>
I	Number of Specialist Referrals by Participating PCPs	3,970	5,964	Tables 3.1 and 3.2
J	Percentage of Technology Applicable Referrals	40%	80%	Assumed, see narrative for additional information
K	Number of Technology Applicable Referrals	9,528	57,255	Row G * Row I * Row J
L	Cost per Use of Technology	\$5	\$5	Doc2Doc fee per use
M	Provider Reimbursement for Referral	\$30	\$30	\$10 to PCPs, \$20 to RCCOs. Based on Doc2Doc model
<b>N</b>	<b>Total Cost of Consultation</b>	<b>\$333,480</b>	<b>\$2,003,923</b>	<b>Row K * (Row L + Row M)</b>
<b>O</b>	<b>Total Costs</b>	<b>\$441,330</b>	<b>\$2,275,723</b>	<b>Row H + Row N</b>

<sup>1</sup> Includes the following eligibility groups: Adults 65 and Older, Disabled Adults 60-64, Disabled Individuals up to Age 59, Categorically Low-Income Adults, Expansion Adults up to 60% FPL, Expansion Adults up to 100% FPL, Baby Care Adults, Adults without Dependent Children, and Working Adults with Disabilities.

R-10 Primary Care Specialty Collaboration  
Appendix A: Calculations and Assumptions

<b>Table 2.C - Savings</b>				
<b>Row</b>	<b>Item</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>	<b>Source</b>
A	Total Visits Potentially Deferred	9,528	57,255	Table 2.B Row K
B	Percent of Visits Deferred	30%	60%	Assumed, see narrative for additional information
C	Average Expenditure per Specialist Visit Deferred	(\$71.31)	(\$71.31)	Based on FY 2012-13 MMIS Claims Data
<b>D</b>	<b>Estimated Savings</b>	<b>(\$203,833)</b>	<b>(\$2,449,710)</b>	<b>Row A * Row B * Row C</b>

**Table 3.1 - Provider and Visit Estimates FY 2014-15**

Row	Item	Estimate	Source
A	Total Medicaid Clients FY 2014-15	939,581	FY 2014-15 R-1: "Medical Services Premiums Request" page EB.1 (totals exclude "Non Citizens" and "Partial Dual Eligibles")
B	Total Medicaid Clients Enrolled in the ACC FY 2014-15	535,894	FY 2014-15 R-1: "Medical Services Premiums Request" Page EI.9
C	Percent of Medicaid Clients in the ACC FY 2014-15	57.04%	Row B / Row A
D	Total Specialty Visits FY 2012-13	283,934	FY 2012-13 MMIS claims data
E	Estimated Specialty Visits in FY 2014-15	334,069	Assumed 8.47% annual growth rate - the growth rate of physician services expenditure in Medicaid from FY 2011- 12 to FY 2012-13.
F	Estimated Monthly Specialty Visits in FY 2014-15 Referred by Participating Providers	3,970	Row C * Row E * Table 2.B Row C / 12

**Table 3.2 - Provider and Visit Estimates FY 2015-16**

Row	Item	Estimate	Source
A	FY 2015-16 Average Monthly Medicaid Enrollment	998,384	FY 2014-15 R-1: "Medical Services Premiums Request" Exhibit B (totals exclude "Non Citizens" and "Partial Dual Eligibles")
B	FY 2015-16 Average Monthly ACC Enrollment	655,894	FY 2014-15 R-1: "Medical Services Premiums Request" Exhibit I
C	Percentage ACC Enrollment	65.70%	Row A / Row B
D	Estimated Specialty Visits in FY 2015-16	363,133	Table 3.1: Row E * 1.847
E	Estimated Monthly Specialty Visits in FY 2015-16 Referred by Participating Providers	5,964	Row C * Row D * Table 2.B Row C / 12