COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

November 1, 2019

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing as directed by SB18-266 – Controlling Medicaid Costs.

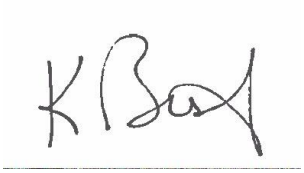
Section 25.5-4-402 (4)(d)(III), C.R.S. requires that "the state department shall provide a report to the joint budget committee by November 1, 2018, on the status of implementation of the hospital review program. The report must include the comments received as part of the stakeholder process described in subsection (4)(d)(I) of this section and a description of, and any available results from, the testing process described in subsection (4)(d)(II) of this section."

Section 25.5-4-422 (5), C.R.S. requires that "by November 1, 2018, the state department shall provide a report to the joint budget committee concerning: the feedback received pursuant to subsection (4)(b) of this section; the timelines for implementation of any cost-control measures enacted pursuant to this section; and a description of the expected impact on recipients and recipients' health outcomes and how the state department plans to measure the effect on recipients."

This year's report highlights the progress made on implementation of SB18- 266, including continued hiring of resources and realignment of staff in the Cost Control and Quality Improvement Office, and status of provider tools, increasing claims efficiency and design of the Inpatient Hospital Review Program.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz, at Nina.Schwartz@state.co.us or 303-866-6912.

Sincerely,



Kim Bimestefer
Executive Director

KB/SZ

Enclosure(s): HCPF 2019 Controlling Medicaid Costs Report

CC: Representative Daneya Esgar, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
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Stephanie Ziegler, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Nina Schwartz, Legislative Liaison, HCPF

Controlling Medicaid Costs Annual Report

As required by SB 18-266

November 1, 2019

Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

Contents

I. Background

Senate Bill 18-266 excerpt:

(6) (a) The State Department shall contract with a third party to perform an independent evaluation of the cost control measures authorized pursuant to this section.

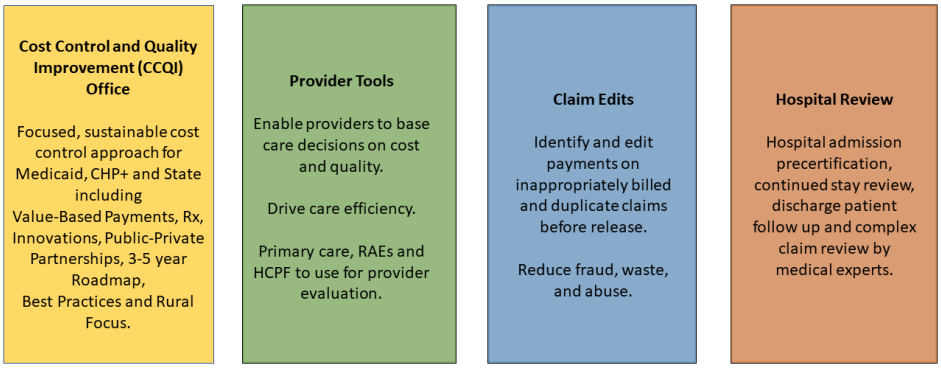
(b) The State Department shall provide a report to the Joint Budget Committee on November 1, 2019 and November 1, 2020, detailing the results of the independent evaluation, including estimates of the cost savings achieved and the impact of cost control measures authorized pursuant to this section on recipients and recipients' health outcomes.

II. Introduction

The Cost Control and Quality Improvement (CCQI) Office in the Department of Health Care Policy and Financing (the Department) was established July 1, 2018 by Senate Bill (SB) 18-266, Controlling Medicaid Costs. This bill passed the House and Senate with unanimous support to enable the Department to control costs more effectively within Health First Colorado, Child Health Plan Plus (CHP+) and its other programs - which make up 33 percent of the State's budget.

Areas of focus, based on SB 18-266, are illustrated in Figure 1, below:

Figure 1: Claims Control Budget Request Areas of Focus



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The CCQI Office Director was hired August 1, 2018. A year later, the Office includes the Department's analytics, reporting and insights staff, quality analytics staff, clinical leadership, cost control programming and Regional Accountable Entity (RAE) partnership. The Office has driven the Department's analytics, insights and cost control strategy, working with the Executive Director to review affordability and quality measurement, providing clinical staff expertise on services, programs, policy and performance. The CCQI team will continue to identify opportunities for savings based on best-in-class programs, approaches, innovations and payment structures. This aligns with the bill's mandate to pursue cost-control strategies and value-based approaches beyond the activities specifically required in the bill.

III. Results of Independent Evaluation

Five Vines Consulting LLC, a consulting firm with expertise in health care reform, value-based payment and policy evaluation, was contracted to perform the Independent Evaluation on August 26, 2019. The report is included as Appendix I.

The Five Vines Independent Evaluation concluded that the Cost Control and Quality Improvement Office has been properly established and competently staffed, with disciplined use of evidence-based evaluation of initiatives and a strong performance culture.

IV. Impact of Cost Control Strategies

A. Cost Control Strategies Specified in SB 18-266

SB 18-266 directs the Department to provide information to providers participating in the Accountable Care Collaborative (ACC) regarding the cost and quality of medical services provided by hospitals and Medicaid providers, as well as the cost and quality of available pharmaceuticals prescribed by Medicaid providers. The Department is in the process of:

- Rolling out a suite of powerful cost and quality assessment capabilities to the seven Regional Accountable Entities (RAEs), hospitals and primary care providers
- Purchasing tools for pharmacy cost and quality information

- Leveraging internal work products to provide cost and quality tools for medical services.

Together, these resources will allow providers to make cost-conscious decisions without sacrificing member safety or clinical efficacy. The Department has also created usable information from multiple data sources that providers can use to connect Medicaid members to primary care providers, specialists, hospitals and other providers. The Department is working with and will train RAEs, hospitals, physicians, and their staffs to use the tools to create maximum value.

1) Provider Services Expenditure and Quality Tool

The Provider Services Expenditure and Quality Tool separates typical costs from costs related to Potentially Avoidable Complications (PACs). PACs are deficiencies in care that cause harm to patients and account for a significant percentage of spending on chronic conditions, acute hospitalizations and procedures. The Department has shared reports to identify areas to potentially reduce spending and improve care. RAEs have been evaluating impactable populations and developing care management interventions with a positive ROI to reduce PACs. The savings and outcomes improvements are expected over a range from one to three years.

2) Pharmaceutical Expenditure and Quality Tool

The Pharmacy Tool will improve quality of care and add another cost control mechanism for the Department and payers across Colorado by giving providers insight into a drug's costs to members and payors. The Department is currently in the procurement process and plans to implement the Pharmacy Tool in 2020, in order to be operational by mid-2020. The tool will provide physicians and other prescribers with information to compare costs associated with prescription therapy alternatives specific to each patient's benefits, so providers can be part of the cost control solution. In addition, the tool will provide insights to assess the patient's risk of addiction before prescribing an opioid. In phase II, the tool will enable physicians to prescribe disease management and health improvement programs to address patients' needs instead of relying solely on medication. The application will be easy for providers to access and use, as it will be embedded in electronic medical records or available via a web portal.

This initiative (Prescriber Tool) is included in the Governor's Dashboard under the Wildly Important Priority, "to save Coloradoans money on health care."

3) Increased Claims Efficiency

SB 18-266 funded additional technology and resources to enhance the Department's ability to identify and deny overbilling or combinations of claims codes that would otherwise create overpayment. Through the current contract with DXC Technology, the Department will implement a commercial technology provided by Change Healthcare called Claims Xten to fulfill this requirement. Claims Xten will automate and increase the accuracy of claims processing by augmenting industry-recognized edits based on a robust library of clinical guidelines from the American Medical Association, the Centers for Medicare & Medicaid Services (CMS) and various medical specialty societies. The technology is widely accepted in the commercial market and is growing in the Medicaid market to reduce inefficiencies and generate associated savings. Claims Xten is projected to be implemented in November 2019.

4) Hospital Review Program

SB 18-266 also charged the Department with implementing a hospital review program to ensure that utilization of hospital services is based on a recipient's need for care. The goals of the hospital review program include:

- Improving Medicaid members' quality of care
- Facilitating better care planning and care transitions
- Ensuring services occur in appropriate care settings with the optimal stay based on members' needs

The Inpatient Hospital Review Program (IHRP) started reviewing inpatient claims in June 2019. Regular stakeholder input has been critical to our progress and will be ongoing.

B. Additional Cost Control Strategies

Through Phase II of the Accountable Care Collaborative and SB 18-266 Controlling Medicaid Costs, the Department has generated broad delivery system reform to support and expand its focus on affordability. In FY 2018-19, the Department conducted a clinical and data-driven analysis of the Medicaid population and a

review of the RAEs' existing care management and coordination efforts to develop a statewide approach for Medicaid members with the most complex needs. The analysis narrowed in on a population with over $25,000 in annual per member expenditure and highlighted it for RAEs to target their evidence-informed allocation of care coordination resources. This initial impactable population is composed of 37,067 members with an overall spend of $2.5 billion in CY 2018, representing 2.8 percent of members and 32.4 percent of expenditures. The population includes:

- Neonates
- Children and adults with complex medical and behavioral health conditions
- Members with disabilities
- Children in foster care
- Members experiencing homelessness or in transition from the Department of Corrections

RAEs created complex care management plans specific to their regions to improve the cost and quality of care for this targeted population in FY 2019-2020. The top chronic conditions by spend included chronic pain, anxiety, depression, hypertension, substance use disorder (SUD), cardiovascular disease and chronic obstructive pulmonary disease. Using existing resources, the Department has developed cost trend and quality outcome metrics and is leveraging staff oversight to support and monitor the performance of the RAEs in reducing related costs.

In addition, through the ACC Cost Collaborative, the Department's cost and best practices forum, consensus was reached that programs for certain conditions would have better cost and quality outcomes if a centralized offering was implemented. These include chronic pain, anxiety and depression.

The Department is requesting funding through FY 2020-21 R-14 "Enhanced Care and Condition Management" to further address these conditions and comorbidities. The requested funding would be for 1.0 FTE to coordinate the ongoing efforts of the Department and the RAEs to improve care and condition management for the highest-risk, highest-cost members. The request also includes funding for contractor costs to provide members with interactive, user-

friendly software that gives members on-demand, clinically-based guidance and techniques for managing chronic pain, anxiety, and depression. The Department anticipates that improved clinical care management of targeted high-cost members and improved condition management of members with targeted chronic conditions would result in improved health outcomes and lower utilization of high-cost medical services over time.

This initiative, under the title, "Identify the members who would benefit the most from Regional Accountable Entity support and identify the areas where Medicaid health care costs are rising," is also included in the Governor's Dashboard under the Wildly Important Priority, "to save Coloradoans money on health care."

V. Value-Based Payments and Other Approaches

A. Alternate Payment Methodologies (APM)

The Department implemented an Alternative Payment Model (APM) for primary care services on October 1, 2019. Qualifying Primary Care Medical Providers (PCMPs) selected certain quality measures to focus on through the year. The Department will evaluate their performance to determine their fee-for-service payment rates for select codes in FY 2020-21. Providers with low performance will be paid at 96 percent of the fee schedule rates, and higher performing providers will be paid more, up to a maximum of 100 percent of the fee schedule rates. Providers can also earn additional enhanced performance payments, which will directly offset the reduction to PCMPs that are paid less than 100 percent of the fee schedule rates, ensuring overall budget neutrality. The APM is intended to reward performance and introduce accountability for outcomes and access to care, while granting flexibility of choice to PCMPs.

The Department received resources through FY 2019-20 R-7, "Primary Care Alternative Payment Models," to implement the next iteration of its primary care APMs through a voluntary model in which primary care practices would be paid a budget-neutral combination of prospective per member per month and traditional fee-for-service payments. The Department is in the early stages developing a model to be submitted for federal approval.

B. Bundled Payment

The Department is requesting resources for FY 2020-21 to implement bundled payments for certain episodes of care. If approved, the Department would initially target maternity episodes for the bundled payments. A bundled payment methodology incentivizes providers to serve clients in a more cohesive manner through a treatment episode and to reduce expenditure on potentially avoidable complications during that episode. The Department would continue to pay providers based on submitted claims, but after the episode is naturally completed, such as after the postpartum period for maternity, the Department would reconcile actual expenditures for each service to the budget.

The Department plans to implement maternity bundles in FY 2020-21. In FY 2021-22, the Department would reconcile expenditure on actual services incurred during the episode for those providers that participated. In that year, the Department would only include upside risk – i.e., there would be shared savings but no penalty if providers spent over the budget. Over time, the Department would incorporate more downside risk in the bundles. The Department will continue to investigate other episodes to target in future years.

VI. Stakeholder Input

SB 18-266 specifically requires the Department to provide an opportunity for affected recipients, providers and stakeholders to provide feedback and make recommendations on proposed cost control measures.

The Department is utilizing a webpage dedicated specifically to Controlling Medicaid Costs, SB 18-266 and another specific to the Inpatient Hospital Review Program to post updates, stakeholder engagement opportunities, trainings and education materials.

Additional stakeholder communications have included a variety of methods such as:

A. Recipients

- The Department has convened forums **with partners in the disability** community and maternal and child health stakeholders to discuss

identification of cost control options. The stakeholders have been engaged and offered suggested opportunities that the Department is pursuing.

- The **Member Experience Advisory Council (MEAC)** has provided direct member feedback on work related to access and quality.

B. Providers

- **Emails** regarding Inpatient Hospital Review Program implementation were sent biweekly from December 2018 through May 2019.

- **Hospital Bulletins** in February 2019, June 2019 and July 2019 provided Inpatient Hospital Review Program information.

- **An Informational Memo** was published on December 21, 2018 regarding Inpatient Hospital Review, providing the description and goals of the program, implementation plans, methodology, training resources and links to the Department's provider website which also provided links for registration, trainings and additional support.

- **Inpatient Hospital Review Program Training webinars**, live and recorded, were offered at least biweekly from December 2018 through May 2019. In-person training was also provided as needed.

- **Joint Operating Committee meetings** with Department Utilization Management staff, the Colorado Hospital Association and participating hospitals started in October 2018. Recently the meetings have switched to a biweekly cadence.

- Bimonthly ACC **Cost Collaborative Meetings with Regional Accountable Entities** starting in October 2018 have discussed best practices in addressing Potentially Avoidable Complications, Care Coordination and Chronic Disease.

C. Stakeholders

- The July 2019 edition of **At A Glance**, the Department's publication on major initiatives and policy and program changes, included an update on the Inpatient Hospital Review Program.

- **CHASE Board Updates** regarding the IHRP were provided in January, February and March 2019.

- **Legislator Newsletter** updates on the IHRP were provided in January, February and March 2019 editions.

VII. Appendix 1: Independent Evaluation

State of Colorado

Department of Health Care Policy and Financing

P20-141590

Independent Evaluation of SB 18-266
Controlling Medicaid Annual Report

Five Vine Consulting, LLC

COLORADO
Department of Health Care Policy & Financing

A. Scope

The charter of the review calls for an evaluation of the cost control strategies with respect to potential cost savings and impact on recipients' health outcomes. Due to the recent and ongoing implementation of covered projects, much of the review is qualitative in nature. In various sections I include recommendations for future tests of these initiatives. This review is based on reports provided by the Department, interviews, independent research, and personal experience as Vermont's Chief of Health Reform from 2014 through 2016 and as an independent health transformation advisor since January 2017, including extensive work with the State of Colorado.

B. Review – Key Observations

1) Provider Services Expenditure and Quality Tool

Using Prometheus tools, de Brantes, Rastogi and Painter (Health Services Research, 2010) found that for a specific set of chronic conditions in a national database, 30% of costs were associated with Potentially Avoidable Complications (PACs), and that 4% may be considered a reasonably achievable savings target. They also documented wide variation by region and condition and cite numerous sources.

It is important to recognize that the identification of PACs is only the first step. The focus on the most financially impactful PACs is important, but a prioritization among those that focus on efficient evidence-based interventions is critical to realizing benefits sooner than later. Energy spent on a high cost PAC lacking a proven intervention would be poorly spent compared to implementing several highly impactful interventions on lower cost PACs. It will be important for RAEs to share experiences and information with each other as they implement their regional focus.

PACs are perhaps the greatest example of an improvement in patient health outcomes, because avoided care is also avoided suffering, time lost, cost, and family impact, and occasional loss of life.

I recommend future analysis study performance across RAE's not just system-wide and quantify both financial cost savings and patient benefits of avoided care. Particularly high-performing interventions should be identified and shared among RAEs.

2) Pharmaceutical Expenditure and Quality Tool

Pharmaceuticals are currently the fastest growing cost in health care, prices vary widely between generic and name-brand, and what is covered on an insurer formulary is not easily known to prescribers today. This is an incredibly important focus and has great promise to yield meaningful savings over time, as well as improve recipient experience by improved match with the most efficacious treatments.

Given that the planned implementation timeframe is from January to June 2020, the conservative savings estimated for the next fiscal year are prudent .

Research has found that specific conditions of each implementation can have notable impacts on uptake, for example, how many screens a prescriber has to click through to get to the tool has a significant impact on utilization. Prescribers also need time to adapt to the program and gain trust in the software recommendations. The Department is properly considering the policies that will increase provider utilization.

Given the anticipated launch date and ramping issues, the 2020 report will not likely describe meaningful quantitative results. Future analysis should include prescriber uptake and qualitative experience as well as financial results.

3) Increased Claims Efficiency

Claims XTen was first launched in 2016 and appears to be past the significant complications that often accompany new software. This appears to be a relatively low risk project.

Other implementations of Claims XTen have resulted in approximately 4% improvement in claims processing efficiency, and a very notable reduction of 30% in appeals. These results are a tremendous improvement for both staff and recipients. An overall cost savings of 3-8% is cited across implementations.

Given the anticipated launch date, reasonable data should be available for the 2020 report to quantify initial results and consider trends in budgeting for the following fiscal year. In addition to financial evaluation, a key metric will be claim denials overturned on appeal.

4) Hospital Review Program

A review of the rules and procedures relative to other jurisdictions undertaking similar efforts showed consistency with recommended practices. While the transition to capitated payment models, as in the example of Managed Care Organizations, is expected to eventually decrease the need for prior authorization and the other reviews in the program, for now they are important cost management tools and can greatly improve care. In particular, complex care review and continued stay review help identify recipients with need of particular attention to improve health resolution, and pre-authorizations can help beneficiaries avoid inappropriate or sub-optimal care. These are the primary objectives of this program, with some avoided cost as a result. It is intended to ensure prompt access to medically indicated care, not to restrict access to care.

Unavoidably, some recipients will experience adverse determinations with which they disagree, even in cases that advance through Peer to Peer Consultation. In my opinion, the rules and procedures in place are sound for appropriately managing this process. Given the sensitivity that accompanies any payer evaluating physician decisions, this can be a highly emotional event with lasting and viral concerns. The Department has developed a stakeholder engagement process that is critical to its continued success.

Over time, as alternative payment models with quality measures further develop, the Department may consider reducing the number of procedures, for some or all practitioners, where the benefits of efficiency may overcome diminished cost savings but there is no indication that such consideration is indicated at this time.

5) Clinical Stratification

In my opinion the methodology for the clinical stratification process was sound. The population of 2.8% of recipients is a realistic target for implementation. As with the PAC initiative, this initiative is highly dependent on the performance of

the RAEs. The Department appears to have effective metrics and monitoring in place. Again, I recommend future analysis study performance across RAEs not just system-wide and quantify both financial cost savings and patient benefits. Reasonable future steps would be to move to 5% of recipients to expand the financial impact if two years of data demonstrate effectiveness and capacity once systems are well exercised. Focus on these cases correctly emphasizes both the most expensive cases and those whose health conditions are having the most severe impact on their lives and the lives of their families.

6) Enhanced Care Management Program (ECMP)/Chronic Condition Management Program (CCMP)

Evaluation of financial impact is premature. This reviewer has extensive experience with the benefit of a similar program in Vermont that has become a core element of cost savings and health improvement. Interrupting development of complexity and deterioration is incredibly helpful for recipients requiring lower levels of intervention required to maintain or improve health status, and thus save significant money. I concur with the approach of selecting best-practice approaches to be implemented statewide, both as a matter of quality improvement and as a matter of health equity. Leveraging the ACC Phase II work is prudent, and continued cycles of learning and sharing are well considered.

7) Alternative Payment Models

The Colorado Model of Care is fundamentally a Primary Care Medical Home Model. Selecting a primary care Alternative Payment Model as the founding initiative in APM's is, accordingly, the best place to start. Current literature indicates that Primary Care may be underfunded relative to specialty, hospital, and pharmaceutical costs for optimized system results. The objective of a budget neutral program is consistent with supporting primary care by allowing practices to yield margin improvement through efficiency associated with these models, while introducing downside risk for those who do not achieve quality target. Importantly, these quality targets are tailored for practices and thus provide an opportunity to drive quality improvement among high and lower performing practices.

As additional APMs are considered, it will be important to align incentives among primary care, specialty care, and hospitals. Particular attention should address alignment on Admission, Discharge and Transfer (ADT) events, with linked incentives for complete referrals and timely and complete repatriation to primary care.

8) Bundled Payments

I strongly encourage the development of bundled payments, and more specifically episodes-of-care that that include a "warrantee" period. Third party providers are active in the market who can use existing claim system data to administer bundled payments with reduced IT system change risk and cost, and adaptive flexibility through learning periods. There is a strong evidence base for which bundles are most successful, and initiating with maternity is well indicated. Importantly, this work can leverage the department's investment in, and experience with Prometheus. Bundles are a form of APM, often applied to specialty care, and the need to align incentives with primary and hospital care is crucial to realize best performance.

C. Conclusions

In my opinion, the Cost Control and Quality Improvement Office has been properly established and competently staffed. The organizational relationship to the Executive Director is tight and the work of the office well considered. My interaction found disciplined use of evidence-based evaluation of initiatives and a strong performance culture.

New programs invariably take time, training, and refinement to realize savings over time. In the course of my work, I have found Department leadership to be thorough and vigorous in seeking cost-savings, and realistic about timing.

Many elements rely on the performance of the RAEs. In my opinion, a good share of initial savings should be re-invested in technical assistance and development to fully realize the long-term opportunity these ambitious initiatives offer. These initiatives enable clinical reform, but this is a complex system and

details in execution are incredibly important. The State cannot assume that sending a price signal alone will manifest the desired change.

Respectfully Submitted,

Lawrence Miller, Principal
Five Vine Consulting, LLC