COLORADO
Department of Health Care Policy & Financing

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

February 23, 2021

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, which requires:

Section 25.5-4-422, C.R.S. requires that "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 the cost-control measures authorized pursuant to this section of the recipients health outcomes.

The program has achieved no less than $8.7 million in savings, which is above what was promised, but far below the savings potential that the Department is working towards. This savings is despite the fact that our Inpatient Hospital Review program was placed in a dormancy state as part of our Public Health Emergency waivers, along with other Medicaid prior authorization program features early in 2020.

The cost control capabilities and potential of the tools and programs enabled by SB18-266 are critical to the efficient administration of our Medicaid program. As the state and the Department deal with the pandemic, resulting recession, membership surge and budget crisis, all of the systems and programs we have built as the result of SB18-266 are critical to driving down cost trend in order to preserve Medicaid programs during a time of rising demand. We also want to highlight an added benefit of SB18-266: the finite data and insights created through this bill have enabled the Department to manage budget cut recommendations through the state's fiscal crisis in a way that delivers budget results while protecting member health and the programs we offer to the benefit of the JBC, our state budget and the Coloradans we serve.

More importantly, SB18-266 has provided the foundational work that has enabled additional programs which are producing savings or trend deflection while improving the savings of other programs, like our Accountable Care Collaborative (ACC). New programs and projects in progress that we are certain will also produce cost savings are described in more detail in the attached report.

We apologize for the delay in the report submission. Thank you again for your unanimous approval of SB18-266. If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us.

Sincerely,

Kim Bimestefer
Executive Director

KB/AS

Enclosure(s): HCPF 2020 Controlling Medicaid Costs Report

CC: Representative Julie McCluskie, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Chris Hansen, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
Edmond Toy, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Tracy Johnson, Medicaid Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF

Anne Saumur, Cost Control Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

CCQI Controlling Medicaid Costs Annual Report

As required by SB 18-266

February 23, 2021

Submitted to: Joint Budget Committee

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I. Executive Summary

Senate Bill (SB) 18-266 passed the House and the Senate of the Colorado General Assembly with unanimous support and was signed into law on July 1, 2018. The legislation directs the Department of Health Care Policy & Financing (Department) to control costs more effectively within Health First Colorado and its other programs. This report fulfills the legislation's requirement for a report to the Joint Budget Committee detailing the impact of the cost-control measures implemented and associated cost savings as a result of SB18-266. Specifically, SB18-266 directs these programmatic requirements.

- THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **PURSUES STRATEGIES TO CONTROL COSTS IN THE MEDICAID PROGRAM** AUTHORIZED IN THE "COLORADO MEDICAL ASSISTANCE ACT";

- THE STATE DEPARTMENT **DEDICATES PERMANENT STAFF** AND RESOURCES TO PURSUE COST-CONTROL STRATEGIES, VALUE-BASED PAYMENTS, AND OTHER APPROACHES TO REDUCE THE RATE OF EXPENDITURE GROWTH IN THE MEDICAID PROGRAM;

- THE STATE DEPARTMENT SHALL UTILIZE THE MEDICAID MANAGEMENT INFORMATION SYSTEM TO ENSURE THAT CLAIMS ARE AUTOMATICALLY REVIEWED **PRIOR TO PAYMENT TO IDENTIFY AND CORRECT IMPROPER CODING** THAT LEADS TO INAPPROPRIATE PAYMENT IN MEDICAID CLAIMS.

- THE STATE DEPARTMENT SHALL PURSUE **COST-CONTROL STRATEGIES, VALUE-BASED PAYMENTS, AND OTHER APPROACHES TO REDUCE THE RATE OF EXPENDITURE GROWTH IN THE MEDICAID PROGRAM.**

- THE STATE DEPARTMENT SHALL **DESIGN AND IMPLEMENT AN EVIDENCE-BASED HOSPITAL REVIEW PROGRAM** TO ENSURE APPROPRIATE UTILIZATION OF HOSPITAL SERVICES. THE HOSPITAL REVIEW PROGRAM MAY INCLUDE THE FOLLOWING: (I) PREADMISSION REVIEW; (II) CONTINUED STAY REVIEW; (III) TRANSFER PLANNING; (IV) DISCHARGE PLANNING; (V) **CARE COORDINATION; AND (VI) RETROSPECTIVE CLAIMS REVIEW.**

- 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 TIMPACT OF THE COST-CONTROL MEASURES AUTHORIZED PURSUANT TO THIS SECTION ON THE RECIPIENTS HEALTH OUTCOMES.**

The program has achieved no less than $8.7 million in savings, above what was promised, but far below the savings potential that the Department is working towards. These savings were largely driven by the claim edit portion as well as the complex claim review component of the Hospital Review program

components of SB18-266. Savings to date have been impacted by COVID-19 resource shifting; a suspension of the hospital review program due to the COVID-19 pandemic's prior authorization federal waiver; a poorly performing hospital review contractor up to that point that has been terminated and will be replaced in calendar year Q2; and the lack of a savings reporting system (which is in the works) to calculate and report on Regional Accountable Entity *care coordination* savings. Still, each of the initiatives associated with SB18-266 is being managed well and has very high potential for both health improvement and savings to the Medicaid program, as noted below.

The cost control capabilities and potential of the tools and programs enabled by SB18-266 are critical to the efficient administration of our Medicaid program. As the state and the Department deal with the pandemic, resulting recession, membership surge and budget crisis, all of the systems and programs we have built as the result of SB18-266 are critical to driving down cost trend in order to preserve Medicaid programs during a time of rising demand. We also want to highlight an added benefit of SB18-266: the finite data and insights created through this bill have enabled the Department to manage budget cut recommendations through the state's fiscal crisis in a way that delivers budget results while protecting member health and the programs we offer to the benefit of the JBC, our state budget and the Coloradans we serve.

Request of the Legislature

Managing rising health care cost is an ongoing battle – *for the Department and the nation.* The Department will continue to request resources to battle rising trend, to operate our programs efficiently, and to ensure that we control costs in a member-friendly way. It is important that the JBC and General Assembly recognize that the Department's administrative budget is quite low – less than 4% compared to the commercial carrier industry administrative budget allocation of more than 13%. In other words, only 4 cents of every Medicaid dollar is spent on administration versus 13 cents for the private, commercial industry. Investing in the evolving Medicaid analytics and programs modernizations that better improve quality and control our claim cost trends are wise investments, especially in very challenging areas like specialty drug or long-term services and supports and during a fiscal downturn that is projected

to last several years. The JBC should be prepared for the Department's requests to improve our quality improvement and cost control capabilities – thereby increasing the administration component of each health care dollar - in order to reduce the larger component of our spend – *our claim cost spend*. The analytics investments will also help us identify health care disparities and measure the progress we are making to address them. Last, the Department respectfully asks that the Legislature allow the rollover to the next fiscal year, the approximately $2.5 million budgeted for the Prescriber Tool. This work is key to our cost savings initiatives but has been delayed due to a procurement issue. A contract on the affordability component of the prescriber tool is expected to be signed by June 1, enabling the FY2021-2022 implementation.

II. Program Focus and Results

Each component of the bill requirements as noted above is addressed in this section.

STATE DEPARTMENT DEDICATES PERMANENT STAFF AND RESOURCES TO PURSUE COST-CONTROL STRATEGIES, VALUE-BASED PAYMENTS, AND OTHER APPROACHES TO REDUCE THE RATE OF EXPENDITURE GROWTH IN THE MEDICAID PROGRAM

The Department responded to the legislation's first requirement by establishing the Cost Control and Quality Improvement (CCQI) Office. This Office oversees all data analytics, quality insights, clinical leadership, and cost control program development. To perform these functions, the Department reorganized staff with the following skills sets into this new office:

- Data Analytics and Reporting (trends and utilization by benefit, program, eligibility class, etc.)
- Quality Outcomes and Reporting (Federal quality metrics reporting on member quality outcomes)
- Clinical Support (Chief Medical Officer, Chief Nursing Officer, other clinical staff, but not including Pharmacists, who remain in the Pharmacy Office)

This Department staff was aggregated into the newly created CCQI Office. The philosophy behind aggregating these specific skill sets was to ensure that

Medicaid cost control programs would always be crafted with a lens towards quality outcomes through direct input and oversight from clinical experts including the Department's Chief Medical Officer (CMO) and Chief Nursing Officer. More recently, our CMO has also accepted accountability for our health equity strategy, which addresses health disparities. This inclusive structure in CCQI will also ensure that the Departments cost control and quality improvement programs strategy is culturally sensitive and promotes health equity.

The data and insights – *both cost control trend and quality* - serve as the foundation for the development of Department's cost savings programs within CCQI and in collaboration with other Offices across the Department, such as the Health Policy Office, Finance Office, Pharmacy Office, and Executive Director's Office.

Reviewing the savings below, it is estimated that the programs enabled by SB18-266 have saved no less than $8.7 million – exceeding our estimates despite the fact that some programs are in their infancy, some do not yet have savings reporting capabilities, and one large component (Hospital Review) is on hold due to the Public Health Emergency waiver (along with most Medicaid prior authorizations). Savings from the newer components of SB18-266 will be available once the programs are more mature and the systems are built to track the savings. Such savings will be reported in future reporting submissions. Savings are outlined below by bill component.

THE STATE DEPARTMENT SHALL DESIGN AND IMPLEMENT AN EVIDENCE-BASED <u>HOSPITAL REVIEW PROGRAM</u> TO ENSURE APPROPRIATE UTILIZATION OF HOSPITAL SERVICES. THE HOSPITAL REVIEW PROGRAM MAY INCLUDE THE FOLLOWING: (I) PREADMISSION REVIEW; (II) CONTINUED STAY REVIEW; (III) TRANSFER PLANNING; (IV) DISCHARGE PLANNING; (V) CARE COORDINATION; AND (VI) RETROSPECTIVE CLAIMS REVIEW

SB 18-266 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 included improving Medicaid members' quality of care; facilitating better care planning and care

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transitions; and ensuring services occur in appropriate care settings with the optimal stay based on members' needs.

The Inpatient Hospital Review Program (IHRP) started reviewing inpatient admissions with a "soft launch", meaning there would be no denials and therefore no savings, in the Spring of 2019. Implementation of the program with denials for lack of an approved authorization began in August 2019. While implementation was slower than originally anticipated, additional time was needed to configure and implement a program that complied with multiple constraints.

Cost savings analysis on the inpatient admissions component of the program performed by the IHRP vendor *reported more than $40 million in savings for the period August 2019 – January 31, 2020*; however, the Department questioned the savings calculation methodologically. Therefore, the Department is not reporting this $40 million as savings. Instead, the Department engaged IBM to conduct an independent analysis. This analysis also questioned the savings reported by the IHRP vendor, reporting *no verifiable savings as the program was administered*. This IBM finding aligned with the Department's view of the hired vendor's poor performance. It also aligned with the impact of the suspension of the program from March 2020 through the end of the COVID-19 Public Health Emergency, meaning the program was only in place during its infancy – for the 7-month period from August 2019 to mid-March 2020. The program remains on hold – along with most other Department prior authorization programs, in compliance with our federal waiver which will be in place through the end of the Public Health Emergency, now projected through the calendar year 2021. More information on the challenges the Department had with the vendor's reported savings and the IBM analysis is available, if desired, below in Section III.

In addition to the IBM and vendor reported savings, it should be noted that the trend for inpatient hospital care is flat, which is not the case for outpatient hospital trend. This aligns with our projections for the program and the industry standard findings – *that once the Inpatient Hospital program is implemented that hospital behavior will change and that behavior change will have a favorable impact on inpatient hospital trend.*

Department staff are currently working to implement a newly hired IHRP vendor effective April 1, 2021. With this new vendor effective date, the Department has also crafted new vendor contract provisions, program design features, and performance requirements to drive better performance and savings from the program; to better meet the intended goals and industry standards associated with the Inpatient Hospital Review program; and to respond to the administrative feedback from our hospital partners.

Stakeholder Input

Stakeholder collaboration was critical to the IHRP process. The Utilization Management (UM) team, part of CCQI, provided transparent, individualized training and communications and diligent follow up with the Colorado Hospital Association (CHA) and individual hospital providers during implementation. The UM team convened biweekly or monthly meetings inviting all hospitals in addition to arranging individual hospital meetings as needed. Their contact at the Colorado Hospital Association described these efforts to Department leadership as "best practices" in stakeholder engagement.

While a strong relationship with CHA and the hospitals is critical to the Department's work, the collaboration lengthened the implementation timeline as the UM team determined how to honor and incorporate existing hospital workflows and processes in the IHRP program. This was particularly true in relation to accepting electronic authorization request transactions to request authorizations. Similarly, as part of this close working relationship with hospital providers, the Department agreed to a request by hospitals to suspend the IHRP on April 1, 2020 in recognition of the extraordinary demands of COVID-19. This was then memorialized in a PHE waiver from CMS, which will continue as communicated by HHS "likely through the end of the year 2021".

As part of the (V) CARE COORDINATION component of the IHRP, the Department has employed the analytics developed in the CCQI Office to focus and direct its Regional Accountable Entity (RAE) partners to approach condition management in a more standardized manner. The goal of this initiative is to ensure that regardless of where a member lives, they have equal access to an evidence-based set of interventions to improve the health of a member based

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on their chronic conditions and to generate savings through the implementation of evidenced based programs.

Through SB18-266, the Department has created analytics to identify the highest utilizers and the conditions that drive that utilization. The Department's data finds that 5.6% of Medicaid members have conditions and utilization that is driving 58.1% of Medicaid spend. More focused care coordination efforts towards these higher utilizers – *who also benefit from increased intervention and support* - leads to better savings and member outcomes. This move to more focused care management also follows the best-practices associated with all larger, sophisticated payers. Our evolving systems provide a monthly release of targeted, high risk members who are appropriate for RAE outreach, condition support and management, creating an efficient use of resources to produce better outcomes for members and savings to the Medicaid program.

Staff worked with RAEs on a gap analysis to identify the current chronic condition management evidence-based approaches for these three areas in order to develop new offerings. Through SB18-266, the Department is able to (a) identify members who would benefit from evidence-based program support as noted above; (b) develop the evidence-based programs to support them to improve their health outcomes to generate savings; (c.) create program components and RAE requirements that will reduce inappropriate utilization to generate savings.

Through the calendar year 2020, the Department adjusted its RAE contracts, crafted evidence-based program requirements, and directed to the RAEs to focus on three specific focus areas of high Medicaid utilization no later than December 31, 2020. These new care coordination and support programs include: (a) diabetes, (b) maternity, and (c) care management for complex members. These focus areas were chosen using the data available through CCQI's evolving data analytics.

To drive best-practice improvements and evolve the programs, the Department holds monthly meetings with RAEs to discuss data related to the three conditions.

Going forward. As the Department's care management and support programming and engagement evolves, the Department will measure patient outcomes and create the respective cost savings reporting. As well, the Department is working with its own systems enabled by SB18-266 and with CIVHC (which manages the state's All-Payer-Claim-Data base under the authority of the Department) to identify higher performing providers based on Medicaid reimbursements as well as commercial reimbursements. Higher performing is defined as "lower cost and better patient outcomes". Accordingly, the next generation of the Medicaid care coordination programs will coordinate member care into these "Centers of Excellence" to further improve patient outcomes and reduce claim costs. The Department is concurrently working on value-based payments: (a) to RAEs and PCMPs for the results associated with managing this coordination; and (b) to care providers that produce cost and quality outcomes that are better than industry norms.

As part of the Hospital Review program, the Department implemented the Claim Review component in January 2020. This program interrupts the claim administration process to review claims above specific thresholds, supply/DME claims over $10,000 for example, or claims that meet particular criteria. This analysis might include verifying proper coding or confirming the appropriate pricing methodology is applied to the claim. Between January 2020 and December 2020, the program saved an estimated $1.7 million.

Therefore, the total savings for the first limited year of the Hospital Review program, including the suspension of the pre-admission certification, continued stay review and discharge planning component, is $1.7 million.

THE STATE DEPARTMENT SHALL UTILIZE THE MEDICAID MANAGEMENT INFORMATION SYSTEM TO ENSURE THAT CLAIMS ARE AUTOMATICALLY REVIEWED PRIOR TO PAYMENT TO IDENTIFY AND CORRECT IMPROPER CODING **THAT LEADS TO INAPPROPRIATE PAYMENT IN MEDICAID CLAIMS**

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 an overpayment. Through the current contract with Gainwell Technology (previously DXC), the Department implemented a commercial technology provided by Change Healthcare called

ClaimsXten that automates and increases the accuracy of claims processing. This is accomplished by augmenting industry-recognized edits based on a robust library of clinical guidelines from the American Medical Association, the Centers for Medicare & Medicaid Services 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.

ClaimsXten was implemented September 26, 2020, after a "soft go-live" that allowed the Department to monitor results and ensure the technology worked as intended. The implementation was originally expected to occur in November 2019, but the contract was not executed until April 2019 thereby delaying implementation. Additionally, the project required significant policy work to configure the ClaimsXten rules with Colorado-specific payment policies. The additional project time ensured the implementation was not only technically successful, but that necessary State policy and rules were appropriately reflected in the tool.

***Savings Status**:* ClaimsXten denied approximately $6.79 million in inappropriate claims in the first four months of the program. When extrapolated over 12 months, this would achieve approximately $20.4 million in inappropriate claims savings. If two thirds or even half of those claims are ultimately denied (providers don't correct, resubmit or win an appeal), the savings of $7-10 million is still greater for just this component of SB18-266 than the originally budgeted savings of $5 million for all SB18-266 program components.

THE STATE DEPARTMENT SHALL PURSUE COST-CONTROL STRATEGIES, VALUE-BASED PAYMENTS…TO REDUCE THE RATE OF EXPENDITURE GROWTH IN THE MEDICAID PROGRAM

The Department has launched initiatives to reward our partners for providing value over volume. The first Alternative Payment Model (APM) for primary care was started in October 2019. In addition, a bundled payment model for maternity care went live on November 1, 2020.

The Department continues to develop value-based payments to reward our partners for providing high quality care and meeting outcome measures. This includes the evolution of our ACC value-based payments to RAEs, behavioral health providers and Primary Care Medical Providers (PCMPs) as well as our bundled payment pilot for maternity. These value-based payments are core to the operational structure of the ACC.

Alternate Payment Methodologies

Alternative Payment Models (APMs) are part of the Department's payment reform initiative to improve health care affordability. APMs are programmatically designed to drive the transition from traditional fee-for-service to payment for value-based care, in other words, from volume to value. The Department launched its first APM program for primary care in October 2019. The APM is mandatory for practices designated as primary care medical providers (PCMPs) under the Accountable Care Collaborative (ACC), including Federally Qualified Health Centers (FQHCs) that care for 200 or more Health First Colorado (Colorado's Medicaid program) members who historically have received at least $30,000 in annual paid claims.

Through the APM, the Department adjusts payments to participating providers based on performance on program metrics during a calendar year. PCMPs are accountable for quality measures — a series of structural measures, claims measures and/or electronic clinical quality measures the providers choose to focus on during the program year. Results are reviewed during the third quarter of the fiscal year and rates are typically adjusted July 1 for the following fiscal year.

Savings Status: For the 2019 program year, the Department planned to review the results in April and determine rate adjustments for fiscal year 2020-21. However, due to the COVID-19 public health emergency, the Department did not adjust payment rates as originally planned. Instead, the enhanced funding for certain primary care procedure codes continues through fiscal year 2020-21. This action supports PCMPs as providers focus on addressing patient care needs and concerns during the pandemic. The Department also offered Primary Care Medical Providers (PCMPs) the opportunity to either report 2019 program year data or request a data submission exemption. If PCMPs were able to report

data, the data was calculated and APM Quality Scores communicated to PCMPs. This gave providers insight into their program year performance so they could identify areas of opportunity.

For the 2020 program year, the Department adjusted the program to reduce the burden placed on practices during the pandemic. Specifically, PCMPs had the opportunity to evaluate and adjust their 2020 program year measure selection. The Department also added two clinically relevant measures - influenza immunization and depression screening and follow-up - to reflect the practices' efforts during the pandemic. This gives PCMPs the opportunity to earn 90 additional points if they achieve the two measures. Finally, the Department adjusted the program design so that providers could simply maintain 2019 calendar year performance rather than improving by a percentage on some of the 2020 program year measures, a process called "closing the gap."

The Department plans to implement the next iteration of its APM in mid-2021. This will be a voluntary program that is budget neutral. Qualified practices will be paid a combination of prospective per-member, per-month and traditional fee-for-service payments tied to quality measures. The program is designed to give providers financial flexibility to develop population-specific care management plans addressing the unique and complex needs of their high-risk patients. The program is currently under federal review for approval and a July 1, 2021 start date.

Maternity Bundle

In addition to the APM, the Department has also pursued a bundled payment model. Bundled payments are designed to align incentives for providers and encourage collaboration to improve the quality and coordination of care across care settings. Under a bundled payment model, participating providers are only responsible for outcomes of a defined episode. The approach aims to reduce silos in a member's care experience and create efficiencies that lower costs. This results in improving the quality of care a member receives throughout the episode and ultimately leads to better health outcomes. These providers hold limited risk for staying within the designated budget threshold and are eligible for shared savings when the threshold is not exceeded. The Department has

worked closely with a diverse group of stakeholders to design its first bundled payment program with the goal of improving health outcomes for mothers and babies throughout Colorado.

Maternal mortality in the United States continues to increase and the issue has gained attention from health care providers, public health officials and policymakers. At the state level, according to the Colorado Department of Public Health and Environment (CDPHE), there were 94 pregnancy-associated deaths between 2014 and 2016 (the most current data available). The leading cause of preventable maternal death within a year of giving birth is accidental overdose followed closely by suicide. CDPHE also reports that Health First Colorado covers approximately 40 - 45 percent of all births in the state, so improving maternal health is a priority. Therefore, the Department is focusing its first bundled payment on maternity care.

The Maternity Bundled Payment Program will cover a full range of services: all prenatal care, care related to labor and delivery, and postpartum care for the mother and her baby. The program's payment structure also encourages participating obstetric care providers to create innovative screening and referral patterns to provide expecting mothers with substance abuse and mental health services as early as possible. The program is voluntary and positions obstetric care providers as the provider accountable for the episode because of their partnership with the patient and their ability to influence outcomes. Upon joining the program, obstetric care providers will have an episode budget calculated based on their historical claims data.

The Maternity Bundled Payment Program went live November 1, 2020. During year one, participating providers will submit FFS claims throughout the performance period (November 1, 2020 - October 31, 2021). Episodes which occur during the performance period will be retrospectively reconciled against the prospective budget. Providers will receive shared savings if the aggregated average cost per episode remains within the prospective budget and quality goals are met. Providers will be liable for partial risk if the episode exceeds the threshold in the second performance period of the program.

Savings Status: Typically, in bundled payment programs, providers who join share in upside and downside risk for the episode. However, the Department

will offer upside-only during the Maternity Bundled Payment Program's first year. This approach allows program participants time to develop clinical pathways to improve a mother's care experience and prepare for the second year when downside risk is introduced. The expectation is that savings will be more evident when downside risk is introduced in the second year.

THE STATE DEPARTMENT SHALL PURSUE COST-CONTROL STRATEGIES AND OTHER APPROACHES TO REDUCE THE RATE OF EXPENDITURE GROWTH IN THE MEDICAID PROGRAM.

Through SB18-266, the Department has begun work on a host of other critical programs designed to tackle emerging claim trend, control costs and improve health outcomes in the Medicaid program. These programs are outlined below.

a. **Provider Services Expenditure and Quality Tool.** This includes the creation of a customized analytic tool called Prometheus that compares quality and cost across populations of patients with the same condition or disease to identify Potentially Avoidable Costs. Specifically, SB18-266 enabled the Department to partner with Altarum on customizing an analytic tool called Prometheus that compares quality and cost across populations of patients with the same condition or disease. Across episodes, services and providers, Prometheus separates the typical costs of care from costs associated with potentially avoidable complications (PACs); for example, inpatient hospital stays for chronic conditions such as diabetes. The goal is to identify and address high cost and high PAC episodes and reduce each over time. Prometheus is used by hospitals in the Department's Hospital Transformation Program (HTP) and by the Regional Accountable Entities (RAEs) as a Key Performance Indicator (KPI) measure.

   The seven RAEs use Prometheus data to develop strategic care interventions for the highest cost PACs. While the overarching goal is to reduce PAC cost over time, RAEs are also looking to improve the overall care and outcomes within populations living with chronic conditions such as diabetes or chronic obstructive pulmonary disease. The Department encourages the RAEs to take creative ownership of their work as they develop actionable, evidence-based plans that fit the needs of their regions and populations. As a result, RAEs are invested in developing comprehensive, results-driven plans. This

past year, several RAEs focused on member outreach. For example, Rocky Mountain Health Plans (RAE 1) expanded telehealth services and provided tablets and phones to members living with diabetes and depression or anxiety. The RAE also created a diabetes toolkit for providers. Other RAEs are flagging admissions or discharges in their electronic health records to follow up with high-risk patients and maintain care continuity.

Savings Status: The PAC work is an iterative process. Initiated in 2018, the Department estimates that it will require a few years of cumulative data to determine PAC cost reduction and clinical outcomes.

b. **Pharmacy Expenditure and Quality Tool.** This includes the establishment of a **prescriber tool** that would improve the affordability of prescription drugs dispensed to Medicaid members and reduce the risk of addiction from the over-prescribing of opioids. Specifically, the Pharmacy Tool will improve quality of care and add another cost control mechanism for Medicaid and payers across Colorado by giving providers insight into a drug's costs. 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 that 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.

   Phase I of the tool is being implemented now, as it went live with license applications available effective January 1, 2021. The Department executed a contract in July 2020 with a vendor (OpiSafe) whose tool provides opioid risk metrics and medication monitoring. Five thousand free licenses were made available to providers between January 1-15, 2021. More than 5000 were requested, so the program is off to a good start.

   This application, which will reside in the providers electronic medical record software, will reduce inappropriate prescriptions of potentially addictive medications. While the prescriber tool is primarily a cost control initiative, the potential to improve risk mitigation and improve quality of life are powerful aspects of the tool.

On the broader cost control component of the prescriber tool, contract negotiations continue with vendors for the provision of the core real-time benefit check and drug pricing check tool. An invitation to negotiate has been released. Proposals are in, and a contract amendment is being negotiated through the "invitation to negotiate" process for the desired affordability component of the prescriber tool. The contract should be executed by June 2021.The prescriber tool is expected to be operational in Q3 of 2021.

In phase II, the Pharmacy Tool will enable physicians to prescribe health improvement programs and social determinants of health programs (i.e.: diabetes management supports, SNAP via CDHS, or WIC via CDPHE) to address patients' needs instead of relying solely on medication. This application will also be easy for providers to access and use, as it will be embedded in electronic medical records or available via a web portal. The projected implementation of this component is 2023 but may require additional funding. OeHI is in partnership with the Department and has both **phase I and phase II of this work in their Roadmap.**

Savings Status: Given that the first component of the prescriber tool was implemented on November 1, 2020 and given that the affordability component of the prescriber tool will go live in Q3 of this year, savings are not yet available.

c. Trend Dashboards. Data analysts within CCQI produce data visualization dashboards to track trends in utilization and spending. These dashboards are reviewed regularly by executive leadership as well as the individual policy and program teams to ensure that program design and expert focus is informed by the best available insights, including those areas driving the highest trends (i.e.: specialty drug costs, long term services and supports, etc.). The cost trend dashboards also allow the Department to understand if these trends are being driven by reimbursement rate changes, demographic changes in membership (i.e.: growing seniors population or increasing Medicaid expansion population), benefit changes, or utilization factors. Without the passage of SB18-266, these types of analytics and the resulting cost control strategies – including the strategic direction and focus of the Department's affordability work – would not be possible. These insights

have also enabled the Department to make budget cut recommendations during this fiscal downturn that address trend while protecting our programs and member health.

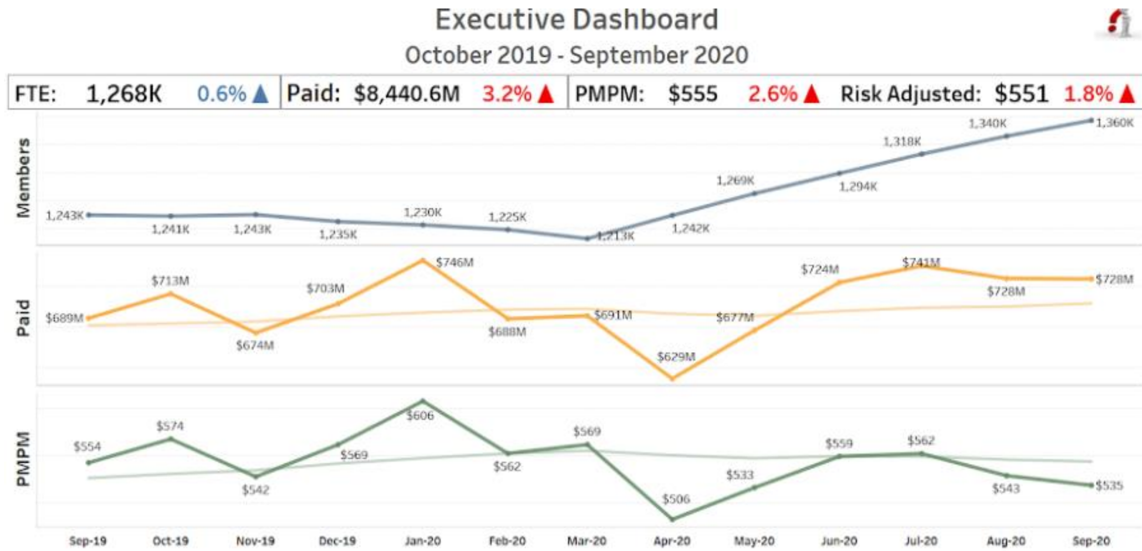
One of the first priorities after the establishment of the CCQI Office was to improve the reporting insights associated with its claim and utilization repository, which houses all claim, encounter, and payment records from Medicaid medical, pharmacy and behavioral benefits. The Department partnered with Truven in 2017 to house the repository and to produce the reports. Truven was subsequently purchased by IBM and integrated into their IBM Watson Health division. All of this had delayed the production of management reports. After much negotiation and review, the Department realized that IBM could merely house the repository but could not create the insights reporting needed to manage the Medicaid program – with an expected 2021-2022 expenditure of more than $12.3 billion. The Department leveraged SB18-266 funding to create the insights necessary to identify trend drivers, building internally all the insight reporting on top of the IBM repository platform.

The impact of this strategy is illustrated in three examples of trend reports and insights that have helped the Department improve its focus on cost control. These data tools, created by SB18-266 funding, allow the Department to better control Medicaid spend and thereby preserve our vital programs during this recession and fiscal crisis when Coloradans need us the most. Though some of the more recent reports are highly impacted by COVID-19, these insights have highlighted key management opportunities such as:

- **Long Term Services and Supports** programs drive more than 40 percent of Medicaid trend, necessitating improved cost control measures where appropriate
- **Provider reimbursements** are a major driver of our trend, and a less controllable factor for the Department
- **Specialty drug** costs are a major driver now and going forward, in line with the commercial health care sector
- **Outpatient hospital** costs are an opportunity while inpatient hospital costs and trends are flat.

Examples of our trend dashboard insights are below.

Medicaid Claims and PMPM Performance Indicators



This data reflects the time period of Oct 2019 – Sept 2020, comparing the twelve-month period of Oct 2019 – Sept 2020 to the twelve-month period of Oct 2018 - Sept 2019. Full time equivalent membership is down 0.6 percent compared with the previous twelve-month period. However, the impacts of new members and the continuous coverage requirement are clear. Membership has been climbing steadily since April 2020.

- Overall spending trend is up 3.2 percent compared with the previous twelve-month period. The latest data points show the impact of COVID on spending.
- The PMPM is a 2.6 percent increase from the previous twelve-month period.
- The risk adjusted PMPM, which considers the health of members, is an increase of 1.8% percent over the previous period.

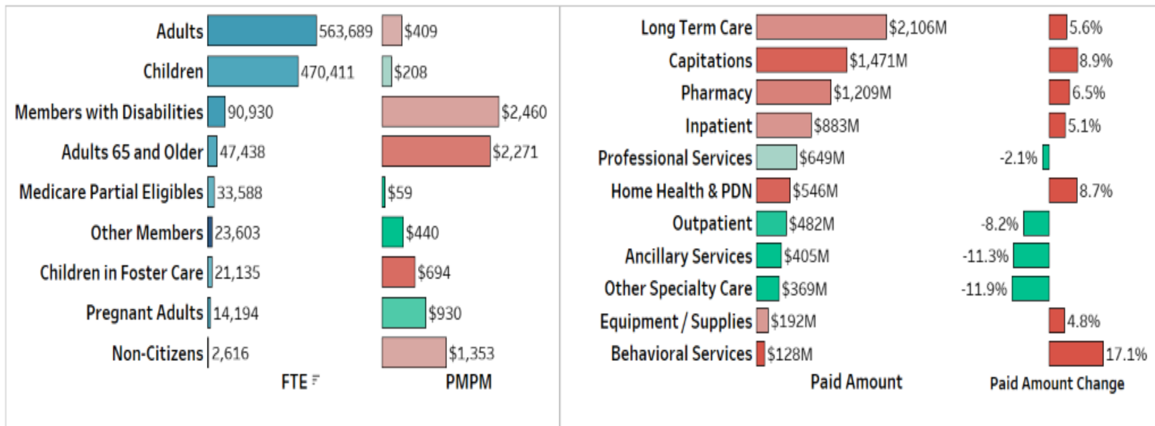
Medicaid Cost Drivers

The Medicaid cost drivers dashboard allows the Department to observe and analyze changes to spending for each of our benefit areas. Four benefit areas have seen a negative trend in spending compared to this time period last year: professional services (physician services, Federally Qualified Health Centers), outpatient services (outpatient hospital, emergency department), ancillary services (imaging, independent lab, transportation), and other specialty care (vision, dental, outpatient speech, occupational and physical therapy). These services were all heavily impacted during the COVID-19 stay-at-home order period. Other analyses conducted by the Department show that some of these services have increased since their low point in April, but only inpatient hospitalizations are at pre-COVID levels of utilization.

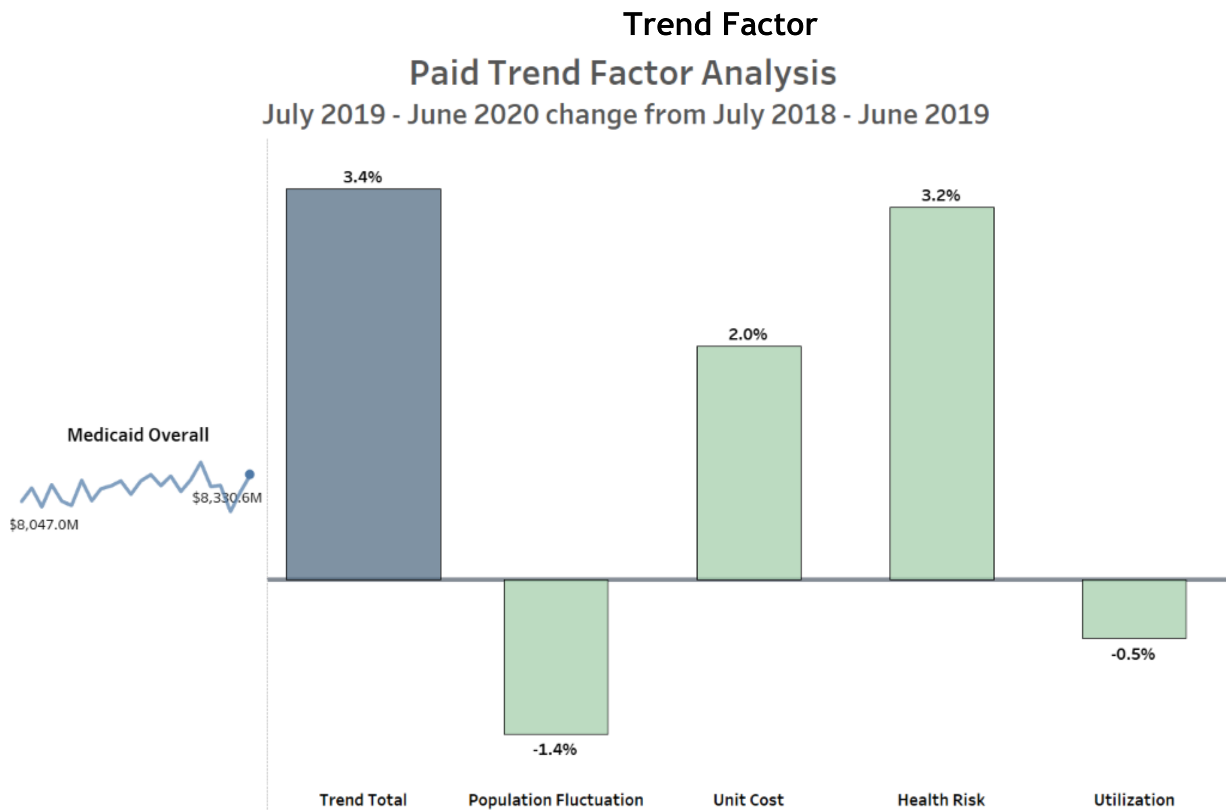
Population and Benefit Trends

October 2019 - September 2020

FTE: 1,268K 0.6% ▲	Paid: $8,440.6M 3.2% ▲	PMPM: $555 2.6% ▲ Risk Adjusted: $551 1.8% ▲



Trend Factor



In addition to tracking monthly changes in service utilization and paid amounts, the Department also monitors the individual factors that make up the total trend – enabling us to differentiate between controllable and less controllable trend drivers. This analysis allows us to understand how these different factors impact the overall trend. The trend can be understood in terms of four components: population fluctuation, unit cost, health risk, and utilization. At a high level, the analysis of this period's data finds that the health risk of members is driving the largest portion of our trend. It is critical to point out that the utilization portion of this graph is typically the largest driver. However, because this data reflects the COVID period, utilization is a much lower contributor than in a typical period. Population fluctuation is becoming less of a downward pressure in our trend. We are in the middle of a transition period with COVID-19.

- **Population fluctuation refers** to changes in the mix of different population groups (children, members with disabilities, adults without dependent children, etc.) that make up our caseload. This change is calculated by multiplying the per member per month cost by the number of member months in each of the groups. Changes in

the number of members within each of these groups matter because service utilization varies greatly depending on the type of member.

- **Unit cost reflects how changes in rates** – both rate increases and rate cuts – impacts the overall trend.
- **Health risk measures** changes in the health of our population. We use the risk score for each member to monitor these changes.
- **Utilization captures** the residual that isn't captured in the other factor categories. This would include any changes in trend due to benefit or policy changes as well as actual utilization of services. We are refining this factor going forward

III. Additional Information on the Inpatient Hospital Review Program (IHRP)

The Inpatient Hospital Review Program (IHRP) started reviewing inpatient admissions in March 2019, with claims starting to deny for lack of approved authorizations in August 2019. While implementation was slower than originally anticipated, additional time was needed to configure and implement a program that complied with constraints imposed by:

- The capabilities of the current Utilization Management vendor, which had limited experience with inpatient review used with All Patient Refined DRGs (APR-DRGs), the Department's inpatient hospital payment methodology
- The capabilities of the Department's fiscal agent, the MMIS and Business Intelligence and Data Management (BIDM)
- State and federal regulations, rules and policies which excluded authorizations for:
  - Admissions related to a maternity code on the bypass list
  - Admissions to a facility on the rehabilitation facility bypass list
  - Admissions (behavioral health) covered by the RAEs
  - Admissions for organ transplants (excluding cornea and kidney) that have already been Prior Authorized

Current UM Vendor Analysis

The Department's current UM vendor provided a cost savings analysis of the program to date, indicating more than $40 million in savings associated with the IHRP. However, the Department found that the vendor calculated savings based on

thousands of technical denials, but only a single medical necessity denial, which is incongruent with the program's intentions. As a result, the Department engaged IBM to conduct an independent cost analysis of the program. Results are detailed below.

A quality inpatient hospital review program cannot exist on technical denials alone as they do not meet the dual goals of cost savings and improved patient care. Technical denials occur when there is non-compliance with program rules and regulations as defined by the Department. Some technical denials, such as lack of information, can be resolved once supporting information is submitted for review. Some technical denials are valid to include in cost savings analysis; after all, when clinical justification is not present, sometimes the information required is not submitted by the provider. However, the Department's UM vendor included technical denials for reasons such as "item or service requested is not a Medicaid benefit" or "services are duplicative of care reimbursed under another benefit or funding source" or "service previously authorized to this or another provider". In other words, routine denials for services that would not have been paid by the Department were included in the vendor's reported savings, which was inappropriate. This resulted in concerns from Department staff regarding the validity of the overall $40 million savings analysis. The Department chose therefore not to include the vendor's reported $40 million savings as part of this report. Instead, the Department sought additional cost savings review for IHRP results.

IBM Analysis

The Department engaged IBM to evaluate the relationship between the pre-admission certification authorization (PAR) requirement and inpatient costs. IBM conducted an analysis using a method that allows for the study of program effectiveness called regression discontinuity. A regression discontinuity analysis is a robust statistical method which establishes a cutoff point and evaluates the impact of a program before and after the point. For this analysis, the cutoff point was June 17, 2019 – the official launch of the admission PAR program. The outcome variable of interest was the average paid amount per inpatient stay. The potential mechanism through which this policy would reduce cost of inpatient stays is by denying unnecessary inpatient stay and diverting these unnecessary inpatient encounters to outpatient health care settings.

IBM's analysis found no relationship between the start of the admission PAR requirement and inpatient stay costs. This finding indicates that the admission PAR

requirement component of the inpatient hospital review program did not result in savings for the Department during the time when the program was in place; this is a logical finding given the hired vendors poor performance, and the suspension of the program from March 2020 through the end of the COVID PHE. It is also a logical finding given that most of the pre-admission certifications performed by the contracted vendor – now terminated - occurred after the patient left the facility or after the concurrent review process should have been initiated. This is not in accordance with industry standard and is a contributing factor to the poor performance of the programs. Again, this vendor has been terminated and a new vendor has been hired, with new provisions and contractual requirements that will address the poor vendor performance to date.

Complex Case Review

Complex Case Review is required on a subset of inpatient admissions at day four when the Concurrent Review is required. The purpose of Complex Case Review is to ensure the provision of care and the level of care is appropriate for the member's needs and current status, and to provide additional information to the RAEs. Complex Case Review is currently required on members with a diagnosis of neonate, sepsis, respiratory failure and pneumonia. Those admitted with these conditions are reviewed for the following indicators: Appropriate length of stay; Appropriate level of care; Appropriate initiation of discharge planning (if applicable). Complex Case Reviews also do not result in claims approval or denial decisions.

The program also intended for the RAE to receive advance notice of patient discharge so it could more effectively prepare for and follow-up with the admission on initiatives such as: making sure the member has the appropriate follow-up visits scheduled; ensuring that necessary prescriptions are filled; or, coordinating other follow care such as home health care and support. This discharge notice is an opportunity - in complement with the provision of complex claimant reports to the RAEs - to improve Medicaid outcomes and cost control for high cost, complex claimants. The Department will ensure that a new Inpatient Hospital Review Program vendor includes this discharge notice component to keep the program in line with industry standards.

Moving Forward with the IHRP Post-Pandemic

A new CCQI Office Director was hired in May 2020 and immediately worked with the Department Chief Nursing Officer and assigned staff to review the status of the

hospital review program in terms of cost savings, alignment with state and federal rules and regulations, UM vendor selection and information systems technology restrictions. This work will be ongoing through the remainder of the fiscal year with a goal of a more streamlined, provider friendly and cost-effective inpatient hospital review program to be implemented post-pandemic, with a new vendor selected through the Department's Invitation to Negotiate (ITN) process.

CCQI staff is working with provider stakeholders to balance increased administrative burden with necessary industry standard IHRP features and will be making appropriate changes, accordingly. The UM team has also reviewed how much the RAEs access the available information to assist with discharge planning and transitions of care. Staff is currently reviewing data and analysis to determine better, more cost-effective approaches to use available resources and support the RAEs in their overall care management responsibilities. Next steps include a review of recommendations by Executive Leadership, followed by planning and implementation with a new UM vendor and additional stakeholder engagement.

IV. Results of Independent Evaluation

Collaborative Health Solutions provided the Independent Evaluation of the cost savings for programs named in SB 18-266, as required. However, the evaluator did not review all the programs that have been enabled and created as a direct result of SB18-266, which are described above.

The Independent Evaluation memo is included as a separate document herewith.

Introduction

Collaborative Health Solutions (CHS) is a health care consulting corporation based in Colorado. Its owner and primary consultant, Michele Patarino, has worked with public and private payers, departments of health, divisions of insurance and related organizations since 1990 in a variety of capacities, typically in a role that combines research, project and program management, evaluation and technical writing. Areas of expertise include care management and quality improvement programs, pharmacy benefit management, health promotion and product development. Ms. Patarino has participated in several legislative implementation and healthcare reform projects for the State of Colorado.

Purpose

Senate Bill 18-266 requires a third-party independent evaluation of the cost control measures authorized, in addition to a report to the Joint Budget Committee detailing results of independent evaluation, including estimates of the cost savings achieved and the impact of cost control measures on recipients' health outcomes.

Review Process

Ms. Patarino reviewed the progress and status of the Provider Services Expenditure and Quality Tool (Prometheus), Pharmacy Expenditure and Quality Tool, ClaimsXten, Inpatient Hospital Review Program (IHRP), extended care management programs, Alternate Payment Methodologies and Bundled Payment programs. Estimates of cost savings achieved and the impact on recipients' health outcomes are not yet available for any of the programs due to procurement, staffing, budget and other barriers.

Inpatient Hospital Review: Additional Background

Ms. Patarino collaborated with the Utilization Management (UM) team and gained a greater understanding of the IHRP's implementation challenges and results. While the initial goals of IHRP include significant return on investment and improved health care quality through enhanced care coordination, the UM team was hampered by system and regulatory limitations for both pre-admission reviews (PAR) and concurrent reviews that minimized the program's impact.

The IHRP was officially launched June 17, 2019 and was operational until April 1, 2020, when the program was suspended to decrease the burden to providers while they were providing care to Coloradans in response to the COVID-19 pandemic. The goals of the IHRP were to:

- Ensure members receive medically necessary and appropriate care in the right setting at the right level
- Improve the Regional Accountable Entities' (RAEs') ability to provide care coordination for members following an inpatient admission
- Better control inpatient hospital costs

The program required inpatient hospital facilities to submit admissions for:

- Pre-admission review (PAR) for all inpatient hospital admissions excluding admissions related to maternity (labor and delivery), long term rehabilitation facilities at admission, or within 24 hours of stabilization following admission
- Concurrent review at day four after the admission; a subset of admissions (neonate, sepsis, pneumonia, respiratory failure) required a complex case review when a concurrent review was entered

The Department's analysis of inpatient hospital costs has consistently supported the need for a hospital utilization review program. Ensuring that Health First Colorado members receive medically necessary services in the right setting and for the right duration require an IHRP because of reasons discussed in more detail in the January 2020 Colorado Cost Shift Analysis:

- Colorado hospitals charge some of the highest prices in the county… 14.0% higher than the national average
- Hospital profits increased by more than 280% between 2009 and 2018

- Colorado hospitals' prices went up far more sharply than the growth in patient volume

IHRP is one critical component of the Department's care management approach to contain hospital costs and improve care. It supports RAEs and Primary Care Medical Providers (PCMPs) by providing additional information regarding attributed members' admissions and current medical condition, and prioritizes members needing RAE assistance and care coordination. IHRP brings the Department in line with other Colorado payers, which have required pre-admission review, concurrent review and complex case management for years.

Prior to suspending the IHRP due to COVID-19 on April 1, 2020, the Department was working closely with the Colorado Hospital Association (CHA), and individual providers to identify areas of the program that were working well, and those that were not helping the Department achieve the goals of IHRP. Both CHA and hospital representatives communicated to the Department that IHRP resulted in a significant provider administrative burden. As a result, the Department reviewed IHRP to determine areas to modify, cancel or add to achieve the Department's goals while also reducing provider burden. Many issues associated with the challenges of implementing IHRP are being addressed through the Invitation to Negotiate (ITN) process which has selected a new utilization management (UM) vendor and provided the opportunity to develop a new UM contract. After an 18-month process, in October 2020, the Department selected a new UM vendor to take over the existing program and assist the Department in designing and implementing a new IHRP. The resulting contract with the new vendor and system will be implemented in the first half of 2021.

IHRP Recommendations

Based on PAR data and claims data from the first year of IHRP in addition to industry best-practices, Ms. Patarino agrees with UM and Cost Control and Quality Improvement (CCQI) leadership that improvements to IHRP should include:

1. Complete data analysis to select a subset of admissions that are high cost and/or utilization or have a high rate of waste, fraud and abuse and require review within 24 hours of admission to an inpatient facility for those selected codes.

2. Require hospitals to submit basic patient information (diagnosis, vitals, medications, etc.) for all inpatient admissions to serve as notification to the Department and the member's assigned Regional Accountable Entity (RAE) to supplement the Admit, Discharge, Transfer (ADT) data the RAEs already receive. These notifications would not result in approval or denial but would bolster care coordination and care management activities including discharge planning.
3. As part of concurrent reviews, allow (or require) providers to update basic patient information (including updating diagnosis, medications, estimated or planned discharge date, etc.) at predetermined and regular intervals, regardless of the status of the initial admission review. This data would then be transmitted to the RAEs and CMAs and prioritized based on certain criteria (co-morbidities, certain diagnosis that are identified as complex cases, medications, etc.) to allow (or require) care management interventions.
4. Perform concurrent reviews on longer lengths of stays, before patients reach the outlier payment (unusually high compared to a typical patient) associated with their diagnosis or at specific intervals (for example, every 30 days). This will alert the Department to lengthy and costly stays and help identify members who cannot be discharged from hospitals because there is no adequate alternate placement (frequently referred to as "boarders") or because they need RAE or Case Management Agency (CMA) care coordination services to assist with transitions to home or appropriate long-term care facilities.
5. Focus on post-service prepayment reviews to determine medical necessity of inpatient stays prior to claims payment, rather than attempting to determine medical necessity prior to or at the time of admission.
6. Review the various methods of automated electronic data transfers available to the Department, the new UM vendor and hospital providers to assess the best method for decreasing provider burden while ensuring efficiency and effectiveness for IHRP.

Incorporating these recommendations and additional subject matter expertise from within the Department, the new UM vendor and other external stakeholders (including hospitals) will allow the Department to make significant improvements to

IHRP that will reduce inpatient costs and improve quality of care for Health First Colorado members.

Conclusion

Ms. Patarino concurs that Department staff have responded to the challenges described above in appropriate ways and that cost savings can be expected from the specified programs in the timeframes described within the report. While many of the project barriers were present prior to the pandemic, the Department has done an admirable job handling additional responsibilities with reduced budgets and staffing. As noted, cost control has become a primary concern in every part of the organization over the past six months.