State of Colorado Department of Health Care Policy and Financing 2011 Annual Report

Colorado Department of Health Care Policy and Financing
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Letter from the Executive Director

Dear Partners:

The Department of Health Care Policy and Financing made significant progress in several program areas in 2011. We continued to focus on improving health outcomes, containing health care costs and increasing access to health care across the entire continuum of care.

In addition to the work we performed within the Department, Department staff and executive leadership from the Departments of Human Services, Public Health and Environment and the Governor's Office of Information Technology collaborated in new ways to improve the services we provide to Coloradans. Working together, we are moving towards a more efficient, effective and elegant government by updating technology, streamlining application processes, and improving the experience clients have with the health care system. Together we have laid some important groundwork to prepare Colorado for the opportunities and challenges ahead. This report includes details about this progress.

One critical area of focus is improving the long-term services and supports system. Census figures project that the over age 65 populations in Colorado will increase more than 23 percent by 2015. Colorado's percent increase is more than double the national average. This will add significant pressure to our long-term care systems. The Colorado Choice Transitions Program that focuses on home and community based services is critical to meeting the needs of Coloradans today and in the future. We have made progress and much work remains to be done to ensure aging Coloradans and individuals with disabilities have the choice to stay in their homes or a community-based setting as long as they desire and are qualified.

In 2011, our Accountable Care Collaborative Program, or ACC, continued to enroll clients and primary care medical providers. As this report goes to print, the ACC is serving more than 125,000 Medicaid clients and the Statewide Data and Analytics Contractor is gathering preliminary data about improved outcomes within the program.

This is a transformational time in health care policy and many more changes are ahead of us to meet the requirements of federal health care reform while staying focused on containing costs and improving health at the state level. The Department, its staff, and our county and community partners are working hard to meet these challenges together.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Introduction

DEPARTMENT PROGRAMS served approximately 855,673 clients in FY 2010–11. The FY 2010–11 appropriation was $4.66 billion with less than 3% administrative costs.

The Department of Health Care Policy and Financing is accountable for the administration of Medicaid, Child Health Plan *Plus* (CHP+) and the Colorado Indigent Care Program (CICP). Medicaid enrollment has hit a historic high of 642,649 as of May 2012. CHP+ enrollment, which includes both children and pregnant women, was at 86,521 and the CICP served 225,906 clients in FY 2010–11. Coverage is provided to persons through all stages of life—birth through the end of life.

In 2011 the Department focused on initiatives to achieve our triple aim goals of improving health outcomes, containing health care costs and increasing access to care.

This report summarizes Department accomplishments and highlights the progress made on reforming health care from January–December 2011.

MISSION, GOALS AND PRINCIPLES

The mission of the Department is to improve access to cost-effective, quality health care services for Coloradans.

Goals

- Improve Health Outcomes;
- Improve the Long-Term Services and Supports Delivery System;
- Contain Health Care Costs;
- Increase the Number of Insured Coloradans; and
- Increase Access to Health Care.

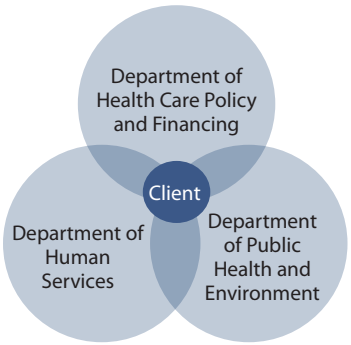
Guiding Principles

The guiding principles for doing business include:

- Empower clients to make good health care choices incorporating prevention and early intervention;
- Purchase and manage appropriate services to achieve value for our clients and the public;
- Treat providers, clients, advocacy groups, counties and other units of government as partners;
- Provide honest and complete information to the public and to each other;
- Focus on accountability and efficiency; and
- Assess, evaluate and continuously improve the quality of our work.

INTERAGENCY COLLABORATION

Interagency collaboration has become a way of doing business for the Department. Collaboration is proven to successfully improve the effectiveness and efficiencies of cross-functional programs. The departments of Public Health and Environment, Human Services and Health Care Policy and Financing formed a team to initially focus on oral health, mental and behavioral health and the redesign of the long-term services and supports delivery system. The three agencies are on track to improve the administration and quality of cross-functional programs—culminating in excellent customer service.



10 WINNABLE BATTLES ROADMAP

The Department is collaborating with the Colorado Department of Public Health and Environment and the Governor's Office to focus on the "10 Winnable Battles" in public health. Many of Colorado's Winnable Battles were identified through current health data measurements and focus on improving the health of all Coloradans. The 10 Winnable Battles serve as a roadmap for improving our clients' health.

Winnable Battles

- Clean Air
- Clean Water
- Infectious Disease Prevention
- Injury Prevention
- Mental Health and Substance Abuse
- Obesity
- Oral Health
- Safe Food
- Tobacco
- Unintended Pregnancy

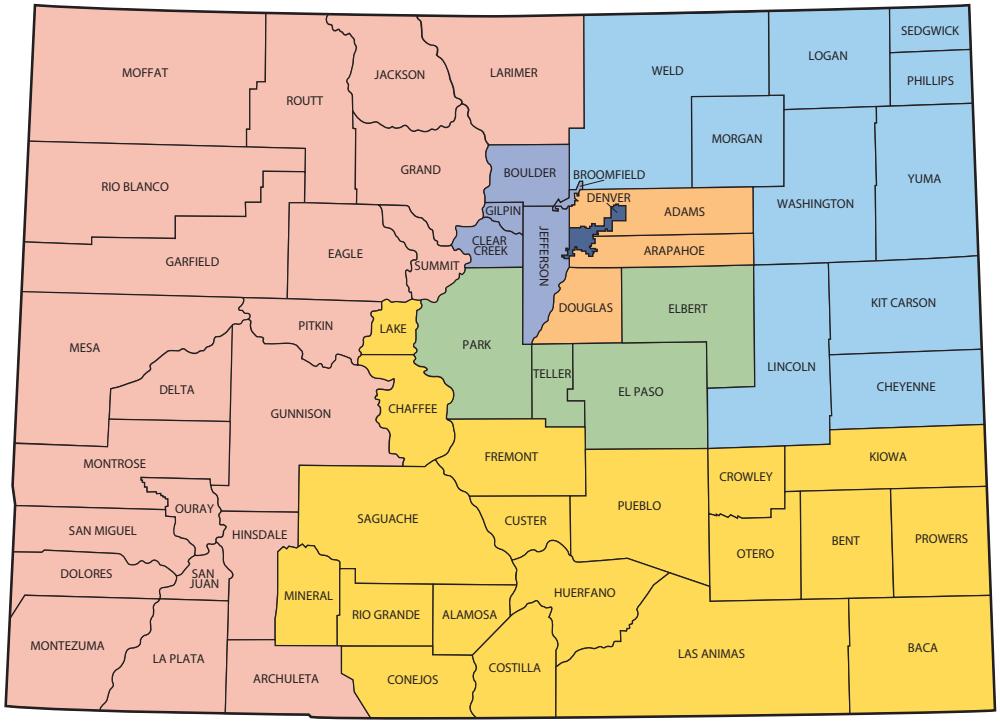
Improve Health Outcomes

IN DECEMBER 2011, 74,413 clients were enrolled in the ACC. By spring 2012, enrollment escalated to 123,000—an increase of 48,587 clients.

ACCOUNTABLE CARE COLLABORATIVE

The Accountable Care Collaborative (ACC) was our first effort at a multi-faceted reform process. It began with improved health outcomes and cost-containment through service delivery refinements.

Colorado's Accountable Care Collaborative
Regional Care Collaborative Organization Map



Region 1 Rocky Mountain Health Plans
Region 2 Colorado Access
Region 3 Colorado Access
Region 4 Integrated Community Health Partners
Region 5 Colorado Access
Region 6 Colorado Community Health Alliance
Region 7 Community Care of Central Colorado

The ACC will change the incentives and health care delivery processes for providers from one that rewards high volume, to one that focuses on the health of our clients. The ACC will control costs by reducing avoidable, duplicative, variable and inappropriate use of health care services.

The ACC has three components: Regional Care Collaborative Organizations, or RCCOs, a Statewide Data and Analytics Contractor, or SDAC, and Primary Care Medical Providers, or PCMPs. The Department awarded RCCO contracts to Rocky Mountain Health Plans, Colorado Access, Integrated Community Health Partners, Colorado Community Health Alliance and Community Care of Central Colorado. The SDAC contract was awarded to Treo Solutions in early 2011.

Enrollment into the ACC began in May 2011 with a Department goal of reaching 123,000 in the first year. As of December 2011, there were over 74,000 clients enrolled in the ACC. Although clients may choose to opt out of the ACC Program, fewer than five percent of clients have done so.

In preparation for alignment between the ACC and medical homes, providers have been encouraged to contact the RCCO in their region to become a Primary Care Medical Provider in the ACC Program and to participate in ACC Advisory Committee discussions about integration.

CHILDREN'S MEDICAL HOMES

Medical homes connect clients with a provider that ensures access to, and coordination of, all medically related services. Medical homes have 24 hour a day, seven days per week coverage, quality improvement projects and must conduct satisfaction surveys to measure the client's experience.

AS OF DECEMBER 2011, 299,000 children in Medicaid and CHP+ were in medical homes. There are 239 practices representing 947 physicians certified as medical homes.

HEALTHY LIVING INITIATIVES

The Department is committed to improving the health of our clients and communities. This focus on healthy living extends from prenatal care to healthy development during infancy and childhood through the life span to healthy aging.

Health promotion priorities:

- Oral Health: Improve dental outcomes in children on Medicaid and CHP+ by promoting evidence-based strategies;
- Behavioral Health: Advance the diagnosis and treatment of depression for clients on Medicaid and CHP+;
- Nutrition and Fitness: Reduce overweight and obesity rates among clients on Medicaid and CHP+; and
- Tobacco Cessation: Reduce tobacco use and secondhand smoke exposure for clients on Medicaid and CHP+.

Improve the Long-Term Services and Supports Delivery System

The Department, in concert with a broad array of partners and other state agencies, is redesigning its long-term services and supports delivery systems to transform long-term care services from institutional-based care to person-centered, community-based care.

COLORADO CHOICE TRANSITIONS

The Colorado Choice Transitions, or CCT, grant program will provide enhanced transition services to clients living in nursing facilities to transition to the community. The Department anticipates enrolling 100 clients per year. We received a five-year grant of $22 million in February 2011 to design and implement the CCT Program and the system changes required.

The CCT is a partner-driven program. Members of the disability community, service agencies, health professionals, housing authorities and the Long-Term Care Advisory Committee have come together to ensure a comprehensive, seamless system. It is an opportunity to build and improve on the infrastructure supporting home and community-based services (HCBS) for people of all ages with long-term care needs.

The vision for CCT is to support the Department's goal of redesigning long-term services and supports from institutional-based and provider-driven to person-centered, seamless, consumer-directed and community-based care.

IT IS ESTIMATED THAT CLIENTS in CCT will use roughly $34,000 for a year on the program compared to the average annual cost of a nursing home stay of approximately $60,000.

Goals of CCT

- Facilitate the transition of 490 clients enrolled in Medicaid from nursing facilities back into the community with the appropriate amount of supports and services;
- Enhance and improve quality of life;
- Support nursing facilities in the implementation requirements to assist clients in exploring their long-term services and supports choices;
- Improve access to an array of HCBS services;
- Increase housing options for people with all types of disabilities; and
- Streamline and improve the navigation of the long-term services and supports system for easier access.

INTEGRATED CARE FOR CLIENTS ELIGIBLE FOR BOTH MEDICAID AND MEDICARE, OR DUAL ELIGIBLES

There are 63,000 clients on Medicaid who also receive benefits from Medicare. They represent 11 percent of the total Medicaid enrollment. Expenditures for dual eligible clients totaled $1.1 billion—23 percent of the Medicaid budget. Integrating care for these clients will result in quality care at a better price.

The Department was awarded a contract by the Centers for Medicare & Medicaid Services Innovation Center to develop a proposal to integrate care for clients who are enrolled in both Medicare and Medicaid. The goals of the proposal are to improve care for our clients, improve health outcomes and client experience of care and reduce unnecessary costs.

Since the summer of 2011, the Department has been conducting stakeholder meetings to help draft the proposal. It was submitted to CMS in late May 2012 for funding consideration. If funded, the proposed plan will be implemented in early 2013.

Contain Health Care Costs

The Department continued to run one of the leanest Medicaid programs in the nation. Although enrollment has increased over time, per capita costs have remained flat. Enrollment has increased by eight percent while General Fund appropriations increased by approximately six percent annually.

PAYMENT REFORM

Delivery system and payment reform are imperative to control costs. The Department has implemented multiple payment reform initiatives that will directly impact expenditures and improve care.

Accountable Care Collaborative Payments

In the ACC Program, each RCCO receives a per-member–per-month, or PMPM, fee, for managing the care of the clients in their region and supporting their PCMPs to be medical homes. Each PCMP receives a per-member–per-month fee for being a medical home to our clients.

A portion of the PMPM is withheld in an incentive pool—RCCOs and PCMPs have the opportunity to earn an additional PMPM incentive payment for reaching specific outcome targets, such as reducing hospital readmissions for the clients in their region.

The Hospital Quality Incentive Payment—HQIP

In 2011 various stakeholders met to develop quality measures, payment methodology and to ensure alignment with the Hospital Provider Fee model. Payments under this newly created HQIP program are scheduled to begin in October 2012, conditional upon approval from the CMS. For the first performance period, four measures have been selected for use:

1. Central line—associated blood stream infections;
2. Postoperative pulmonary embolism or deep vein thrombosis;
3. Elective delivery between 37 and 39 weeks gestation; and
4. Structured efforts to improve care transitions and reduce readmissions.

Benefits Collaborative

The Benefits Collaborative's charge is to develop coverage policies for Medicaid services based on clinical evidence and cost-effectiveness. The process is stakeholder-driven. The results of the process include 1) more transparency about coverage 2) better billing practices and 3) reasonable limits on services. Exceptions are allowed to prevent people from not receiving needed services.

Forty-six benefits have been evaluated for duration and scope, clinical efficacy and cost-effectiveness. A recent survey of Benefits Collaborative participants found that 81 percent of stakeholders and Medicaid providers have an increased understanding of policy and 86 percent got value out of participating in the Benefits Collaborative.

Avoidable Hospital Readmissions

In 2011 hospitals were required to bill one claim instead of two for readmissions if it occurred within 24 hours of the initial admission. The goal is to incentivize care and promote effective discharge planning to prevent readmissions.

The Department is researching how readmissions are tracked and measured, identifying top 10 diagnoses and identifying hospitals and nursing facilities for readmissions.

Reduce Unintended Pregnancies

The unintended pregnancy rate of those on Medicaid is approximately double the rate of those not covered by insurance. The Department's goal is to reduce the number of unintended pregnancies among women on Medicaid. In collaboration with the Department of Public Health and Environment, evidence-based methods will be used to help decrease unintended pregnancies.

Expansion of the Preferred Drug List (PDL)

The selection of preferred drugs for the PDL is based on safety, clinical efficacy and cost-effectiveness. Four new drug classes were added to the PDL in 2011.

THE TOTAL ESTIMATED SAVINGS from additions to the PDL drug classes during FY 2010–11 was $3.5 million.

State Maximum Allowable Cost

The State Maximum Allowable Cost list, or SMAC, is used to determine reimbursement rates paid to pharmacies by Medicaid. The Department is currently expanding the pricing methodology to allow for a more accurate reimbursement, and limiting overpayment or underpayment. The SMAC list pricing encourages prudent purchasing of pharmaceuticals because the price is based on an average of available, similar pharmaceuticals, rather than a reported list price.

USING THE SMAC LIST has a projected savings of $2.8 million for FY 2011–12.

Recoveries

The Department is responsible for being prudent with taxpayer dollars. We do this through aggressively recovering all moneys due to Medicaid from pharmacy drug rebates, trusts, private insurance and torts.

- **Pharmacy Drug Rebates**
  Rebates are collected from drug manufacturers that participate in the Federal Drug Rebate Program.
- **Trust and Estate Recoveries**
  Medicaid can be identified as the beneficiary for trusts in order for the applicant to become eligible for Medicaid. The state collects the trust balance, up to the cost of benefits received, upon death of the client or when the client is no longer eligible for Medicaid and is able to recover the cost of benefits from his or her estate.
- **Third Party Recovery**
  Medicaid is the payer of last resort. The Department conducts a data match of its eligibility files with those of private insurers and Medicare. If there are matches, payments to the providers are recouped, or the recovery is pursued directly from the health insurer or Medicare.
- **Tort and Casualty Recovery**
  When someone causes an accident or causes harm to someone that requires assistance from Medicaid as a result of this tort, Medicaid pursues a recovery against the responsible party for up to the amount of costs incurred by Medicaid.

Fraud, Waste and Abuse

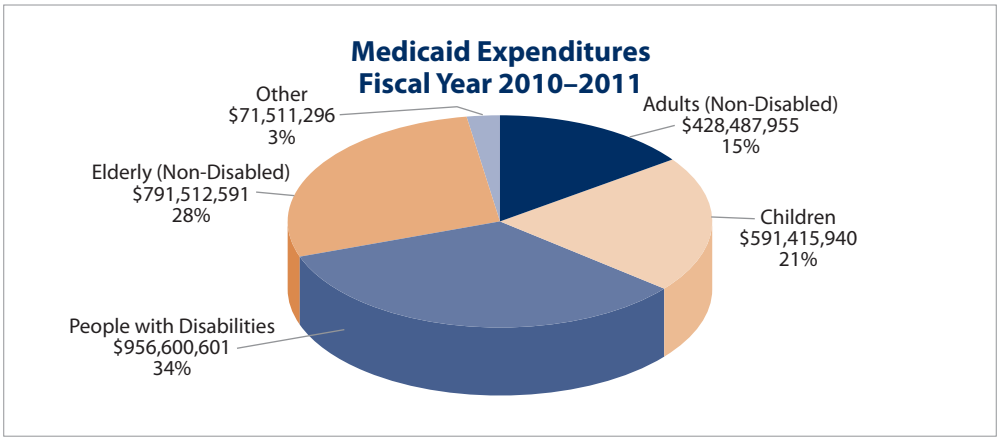
THE DEPARTMENT RECOVERED approximately $91,657,915 in FY 2010–11.

The Department monitors providers for appropriate use of federal and state funds. Along with our contractors, we conduct post-payment reviews to identify fraud, waste and abuse and to recover overpayments. The Department refers suspected fraud or suspected false claims to the Medicaid Fraud Control Unit in the Department of Law for criminal investigation and possible prosecution.

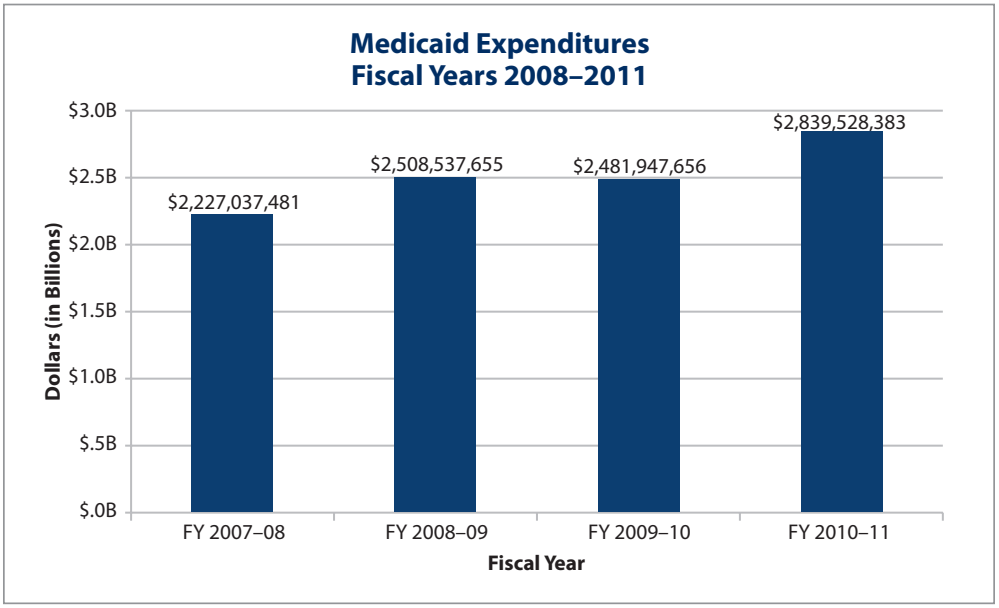
The Department uses data mining and analysis, medical records reviews, contingency based contracts, electronic provider screening checks, and provider education as part of the process for identifying fraud, waste and abuse.

EXPENDITURES

The Department's FY 2010–11 expenditure was $4.66 billion. The following charts and graphs illustrate the disbursement of dollars based on our client population and total expenditure by fiscal year.



Medicaid expenditure data depicted for FY 2009–10 and FY 2010–11 is for Medical Services Premiums only, is not payment-delay adjusted, and excludes all financing, including hospital supplemental payments. Percentages may not sum to 100% due to rounding.



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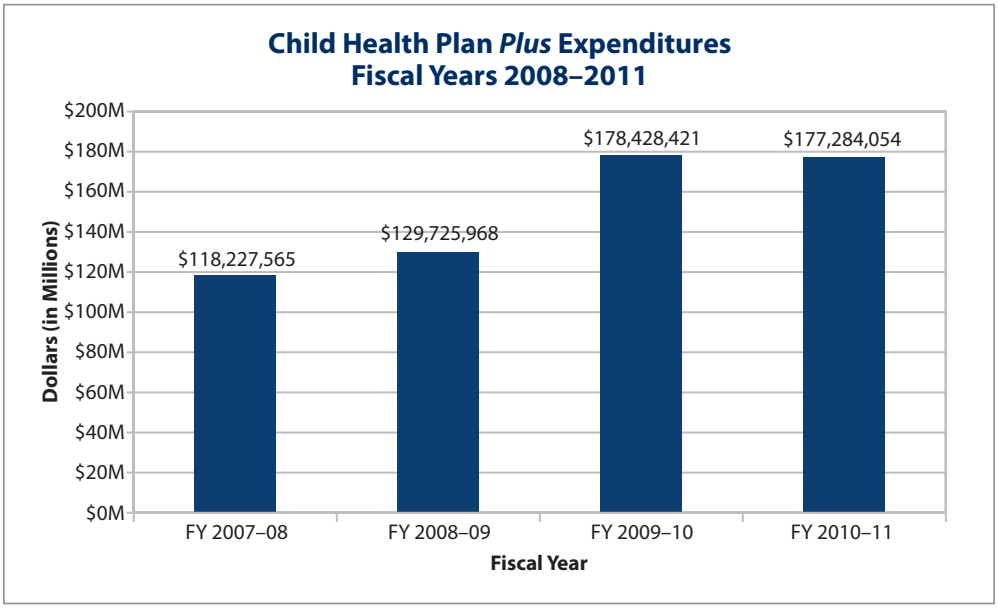


Payment Error Rate Measurement

Payment Error Rate Measurement, or PERM, is an audit program developed and mandated by CMS to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine eligibility determinations and claims payments for the Medicaid and CHP+ programs in an effort to ensure that states only pay for appropriate claims. States are audited once every three years.

COLORADO'S 2011 OVERALL PERM Medicaid error rate was approximately seven percent compared to the overall national Medicaid error rate of eight percent.

CMS computes three error rates of significance to Colorado:

- An individual state error rate;
- An annual error rate that includes only the 17 states audited that year; and
- An overall national error rate that encompasses all states for the three years.

The audit along with the results assist the Department on improving its processes and procedures to streamline provider payments and ensure that only rendered and appropriate services are paid.

Increase the Number of Insured Coloradans

COLORADO HEALTH CARE AFFORDABILITY ACT

The Colorado Health Care Affordability Act, HB 09-1293, authorized the Department to collect a fee from hospital providers to increase Medicaid payments to hospitals and expand coverage under public health insurance programs. The funding includes additional federal matching funds to the state without additional General Fund expenditures.

The additional funding:

- Increases hospital reimbursement for care provided to Medicaid and CICP clients;
- Increases the number of insured Coloradans;
- Improves the quality of health care for clients on Medicaid; and
- Reduces the need to shift the cost of uncompensated care to other payers.

The Department is focused on expanding coverage to the uninsured with the Adults without Dependent Children health insurance program. Implementation up to 10 percent FPL began in 2012. A Medicaid Buy-In Program for Adults with Disabilities was implemented in spring 2012. Twelve month continuous eligibility for children on Medicaid will be implemented depending on full implementation of other expansion programs and available Hospital Provider Fee funding.

In addition to expanding coverage and reducing uncompensated care, the Hospital Provider Fee program provided more than $99.5 million in General Fund relief in FY 2009–10 and FY 2010–11. The General Fund relief was the result of the additional federal funds available through the enhanced Federal Medicaid Assistance Percentage, or FMAP, under the federal American Recovery and Reinvestment Act of 2009, or ARRA.

Increase Hospital Reimbursement

October 2010 through September 2011 the Department collected over $474 million in hospital provider fees. With approved federal matching funds, hospitals received increased payments for inpatient and outpatient hospital services for the CICP.

AS OF DECEMBER 31, 2011, the Department enrolled approximately 35,000 additional parents into Medicaid. Approximately 12,000 additional children and 500 pregnant women were enrolled in CHP+.

FY 2010–11 Hospital Payments	
Inpatient Hospital Reimbursement	$106,240,000
Outpatient Hospital Reimbursement	$121,563,000
CICP Hospital Reimbursement	$293,928,000
Additional Hospital Payments	$275,047,000
Total Supplemental Hospital Payments	**$796,778,000**

Federal Fiscal Year October 2010–September 2011.

The net gain for hospitals from October 2010 through September 2011 was approximately $159 million.

CO-CHAMP

The Department received funding from the Health Resources and Services Administration, or HRSA, for seven comprehensive and interrelated projects totaling $42,773,029 over five years. Colorado's program is titled Colorado's Comprehensive Health Access Modernization Program, or CO-CHAMP.

Due to federal budget balancing in 2011, HRSA SHAP grant funding in years three to five was cut. The Department was one of the few states to receive a "no-cost extension" allowing us to fund CO-CHAMP activities through August 2013.

The Department conducted a needs assessment at the beginning of the grant award. This assessment gave the Department a baseline for the number and type of outreach and enrollment activities statewide.

Maximizing Outreach, Retention and Enrollment Program

The MORE Program is an outreach and enrollment initiative that provides funding for community grants, known as MORE grants.

The focus of MORE grants in Round 1 and Round 2 was to provide outreach, enrollment and application assistance to enroll newly eligible populations including:

- Children and pregnant women qualifying for CHP+ up to 250 percent FPL and
- Low-income parents with a dependent child on Medicaid and making up to 100 percent FPL.

Round	Number of Grant Recipients	Amount of Funding
Round 1	14	$628,789
Round 2	11	$459,349
Round 3	14	$608,370

The Round 3 grant period concluded on June 30, 2012.

Regional Conferences

Regional Conferences are another benefit of MORE funding. Statewide eligibility workers were invited to learn about new policies and procedures, Department updates and to learn best practices.

PEAK

A toolkit educating workers on the use of the Program Eligibility Application Kit, or PEAK, was developed as part of the MORE Program. Extensive education assists workers in being as efficient and effective as possible with their clients.

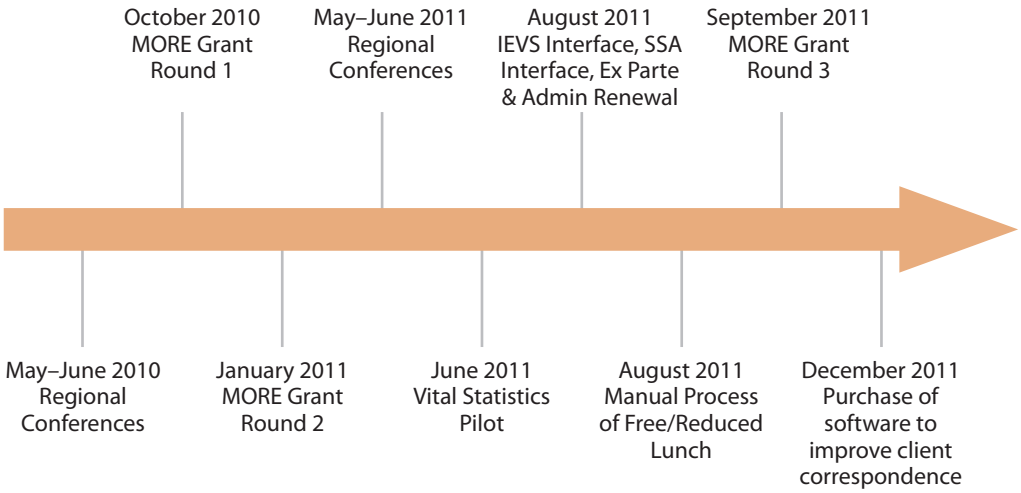
Benefit and Program Design

In 2011 the Department held statewide stakeholder meetings to discuss potential benefit design options and premium structures for the Adults without Dependent Children Program.

Multi-Share Community Projects

A multi-share health insurance plan is a basic plan that brings together employers, workers without coverage and outside funding. Grant funds are supporting two multi-share projects including Health Access Pueblo, or HAP, and San Luis Valley multi-share, or CarePoint.

CO-CHAMP Implementation Timeline



"The MORE grant has allowed our initiative to focus on the newly eligible Medicaid populations thereby increasing access to health coverage and nutrition assistance throughout the Rocky Mountain state."

—Dawn Joyce, Project Director, Statewide PEAK Outreach Initiative

MODERNIZING THE ELIGIBILITY AND ENROLLMENT PROCESS

Electronic System Interfaces

The Department implemented interfaces with other state and federal databases to streamline the enrollment process for applicants and reduce the need for paper documentation. Interfaces with the Colorado Department of Labor and Employment for income documentation and the federal Social Security Administration systems allows for the verification of identity and citizenship electronically. This increases the speed of eligibility determination, reduces costs for the applicant and reduces administrative burden for eligibility workers.

Express Lane Eligibility—School Lunch

In the fall of 2011 a new process called Express Lane Eligibility—School Lunch was available to school districts. Express Lane Eligibility provides a simplified eligibility process for Medicaid and CHP+ using Free/Reduced School Lunch information. The process begins when a family applies for Free/Reduced Lunch benefits at a participating school district. If the school determines the child is eligible for Free/Reduced Lunch using the Free/Reduced Lunch application, the school will send the application information to an eligibility site. The program is voluntary for schools to participate.

Ex-Parte and Auto Reenrollment

Ex-Parte and Auto Reenrollment are processes that automatically use other programs' redetermination data for determining eligibility for public health insurance. Redetermination may occur without filling out a new application if the information is received within three months of the due date for redetermination.

The Auto Reenrollment process automatically starts the redetermination for specific public health insurance programs on the 15th of every month.

Colorado made the decision to reform Medicaid with or without federal health reform. Federal health care reform supports Colorado efforts and requires that the interfaces work on a real-time basis. More than 20 more interfaces will be implemented in the future to comply with federal law.

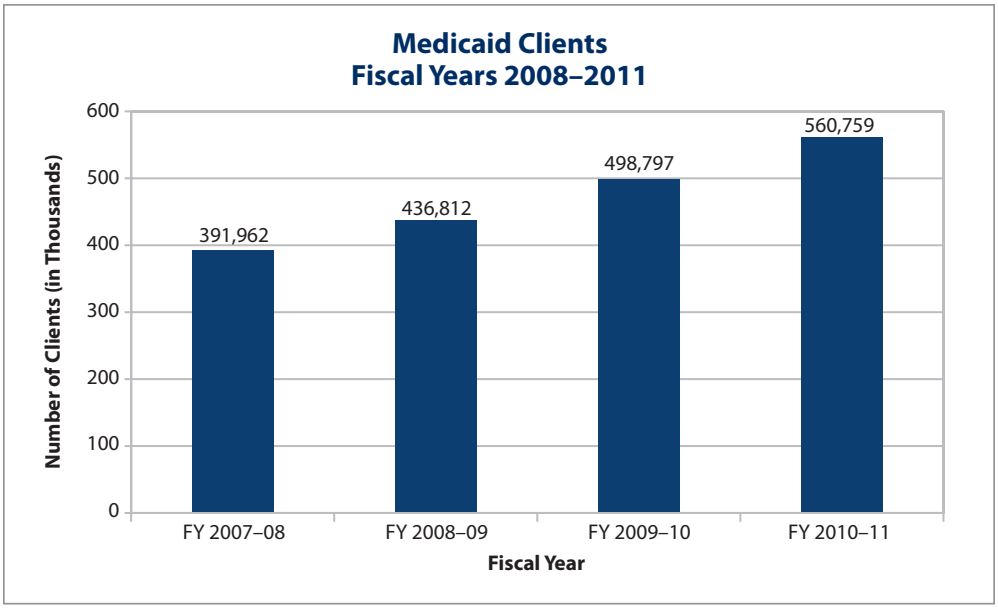
Program Eligibility Application Kit

PEAK is a web-based tool that allows Coloradans to learn about and apply for health, food and cash assistance programs. By visiting Colorado.gov/PEAK, visitors can conveniently check for program eligibility, apply for benefits and if they are a current client, update contact information 24 hours a day seven days per week.

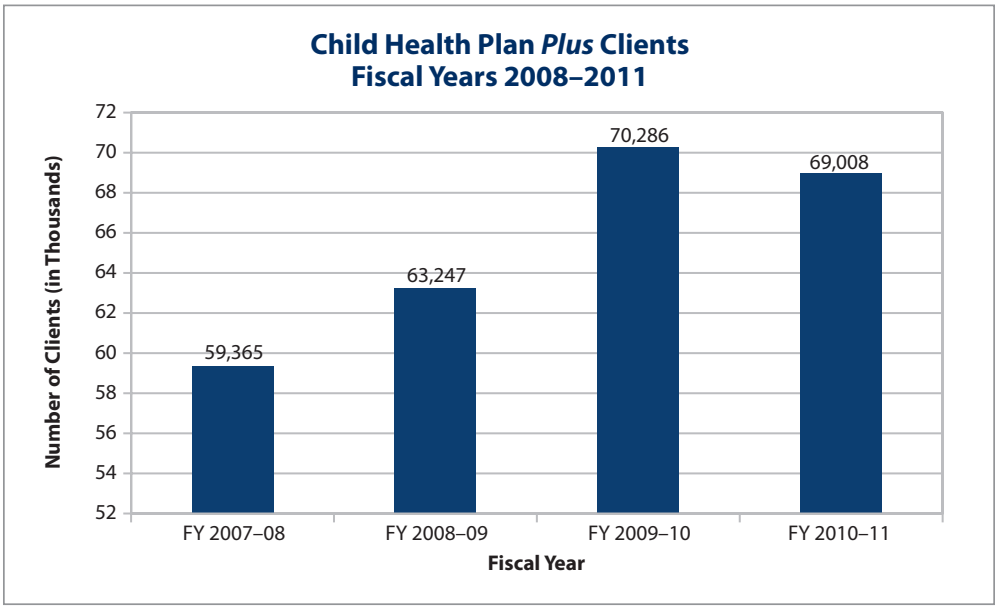
From January 1–December, 31 2011, 22,531 medical assistance applications were completed through the PEAK Web site and 12,636 clients reported changes or checked benefits.

ENROLLMENT

Following are charts depicting Medicaid and CHP+ enrollment from FY 2007–08 to FY 2010–11.



MEDICAID ENROLLMENT increased from 498,797 to 560,759, a 12% increase, from FY 2009–10 to FY 2010–11.

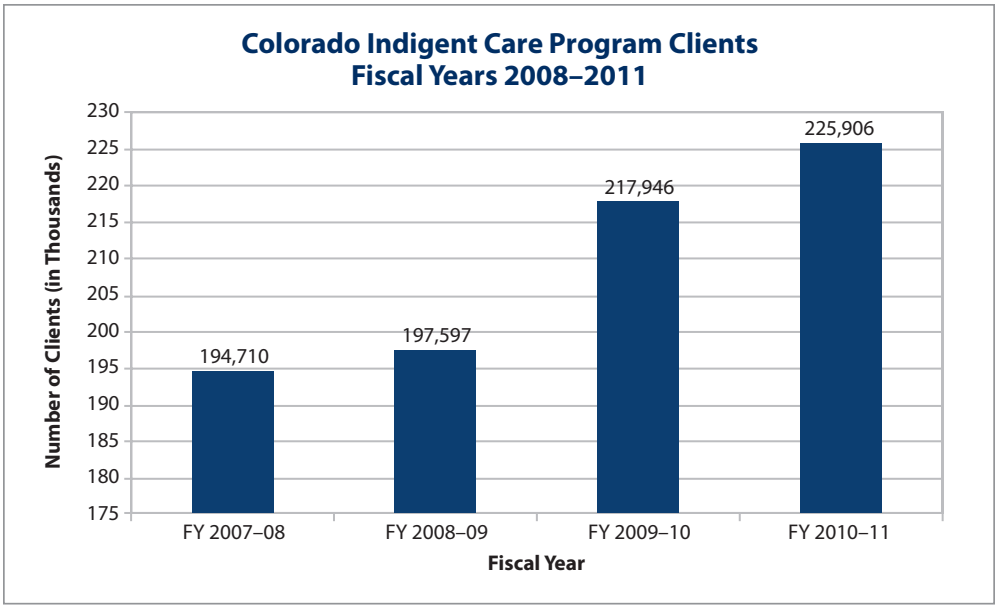


CHP+ ENROLLMENT, which includes both children and pregnant women, decreased from 70,286 to 69,008. The decrease was due to a combination of kids moving from CHP+ to Medicaid and the impacts of the Deficit Reduction Act changes reducing the caseload.

CICP

The Colorado Indigent Care Program, or CICP, provides funding to clinics and hospitals allowing medical services to be provided at a discount to Coloradans that meet the eligibility requirements for the CICP.

CICP CLIENTS SERVED increased from 197,597 to 217,946, a 10 percent increase, from FY 2008–09 to 2009–10.



Increase Access to Care

PRIMARY CARE FUND

The Primary Care Fund provides funding to health care providers that make basic health care services available in an outpatient setting to Coloradans who are considered medically indigent.

HB 10-1378 appropriated $11,940,000 from the Primary Care Fund to draw federal matching funds under the Health Care Services Fund, and $12,800,000 for General Fund relief in the Medical Services Premium Line Item. Remaining Primary Care Funds were appropriated to the Primary Care Funds Special Distribution Fund.

PRIMARY CARE FUND SPECIAL DISTRIBUTION FUND

The Primary Care Grant Program Special Distribution Fund was created during the 2010 legislative session. An appropriation of $3,560,000 total funds in FY 2010–11 was received, all of which were cash funds from the Primary Care Fund.

On the Horizon

The Department has learned many lessons over the past year. We know what we need to do: support better health for Coloradans at a better price. Movement forward includes initiatives that support the goal of improving access and health while being prudent stewards of financial resources.

DELIVERY SYSTEM AND PAYMENT REFORMS

Bending the cost curve by transforming payment systems from volume-based to outcome-based and other payment reform initiatives is an important focus of the Department. The year 2012 will see the first data set from the Accountable Care Collaborative on performance measures such as high-cost imaging, hospital readmissions and emergency room use.

HEALTH CARE REFORM IMPLEMENTATION

The implementation of the Affordable Care Act, or ACA, and the Colorado Health Benefits Exchange, or COHBE, are expected to be a major focus for the Department over the next few years. The Department will continue to work closely with COHBE and county and community partners to streamline application and eligibility determination processes. This will facilitate access and reduce barriers to participation.

Eligibility system redesign is an area with more work to be done in order to effectively and efficiently implement health care legislation and leverage federal funding opportunities.

COLLABORATION—CREATING A CULTURE OF COVERAGE TOGETHER

Interdepartmental collaborations will continue in 2012 and beyond. The Department, along with the departments of Human Services and Public Health and Environment will continue to tackle the "Winnable Battles;" focusing on improving overall population health rather than a focus on sick care.

The departments will work together with partners to move beyond a focus on eligibility and enrollment to creating a culture of coverage and client engagement. We will find new ways of engaging our partners and look for innovative opportunities with the private sector. While much of the groundwork has been laid, realizing Colorado's vision for health care reform will require a collaborative effort by all of us.

Oversight

FEDERAL OVERSIGHT

The Department is federally regulated by the CMS. The Department is the federally designated Single State Agency to receive Medicaid (Title XIX) funding from the federal government and also receives Children's Health Insurance Program (Title XXI) funding from the federal government for Colorado's CHP+. The Medicaid and CHP+ state plans are agreements with CMS as to what services are provided.

STATE OVERSIGHT

The Medical Services Board has the authority to adopt rules that govern Medicaid, CHP+ and the CICP that are in compliance with state and federal regulations.

The Board consists of eleven members appointed by the Governor and confirmed by the Senate. Members have knowledge of public health insurance programs, experience with the delivery of health care and expertise in caring for medically underserved Coloradans.

The Medicaid Services Board serves as yet another opportunity for input from the public, assuring that all populations are served appropriately through all public health insurance programs.

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