COLORADO
Department of Health Care Policy & Financing

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

January 1, 2017

The Honorable Joann Ginal, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Ginal:

Enclosed please find a legislative report to the House Health, Insurance, and Environment Committee from the Department of Health Care Policy and Financing on Access to and Quality of Care for Children on Medicaid and the Children's Basic Health Plan Plus. Section 25.5-1-113.5, C.R.S., requires the Department to report on health care access and the quality of care for children on Medicaid and the Children's Basic Health Plan.

This report is divided into four sections per the legislative mandate and is organized as follows:

- Data showing that providers for children are participating in the programs and are accepting eligible children as patients on a regular basis;
- Data showing that eligible children are enrolling in programs under this title and are remaining enrolled so that the children have continuity of care;
- Data showing that eligible children are receiving the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services required by federal law, including but not limited to regular preventive care and, when appropriate, timely specialty care, and that providers are accurately reporting the data from these visits; and
- Data showing that providers are using other appropriate measures of access and quality to improve health outcomes and maximize the expenditure of health care resources.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

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

SEB/gr
Enclosure(s): Access to and Quality of Care for Children on Medicaid and CHP+

Cc: Representative Daneya Esgar, Vice Chair, Health, Insurance and Environment Committee
Representative Susan Beckman, Health, Insurance and Environment Committee
Representative Janet Buckner, Health, Insurance and Environment Committee
Representative Phil Covarrubias, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
Representative Dominique Jackson, Health, Insurance and Environment Committee
Representative Chris Kennedy, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
Representative Susan Lontine, Health, Insurance and Environment Committee
Representative Kim Ransom, Health, Insurance and Environment Committee
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Gretchen Hammer, Health Programs Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Jed Ziegenhagen, Community Living Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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1570 Grant Street
Denver, CO 80203

January 1, 2017

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find a legislative report to the House Health, Insurance, and Environment Committee from the Department of Health Care Policy and Financing on Access to and Quality of Care for Children on Medicaid and the Children's Basic Health Plan Plus. Section 25.5-1-113.5, C.R.S., requires the Department to report on health care access and the quality of care for children on Medicaid and the Children's Basic Health Plan.

This report is divided into four sections per the legislative mandate and is organized as follows:

- Data showing that providers for children are participating in the programs and are accepting eligible children as patients on a regular basis;
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- Data showing that providers are using other appropriate measures of access and quality to improve health outcomes and maximize the expenditure of health care resources.

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Sincerely,

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

SEB/gr
Enclosure(s): Access to and Quality of Care for Children on Medicaid and CHP+

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Don Coram, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kimmi Lewis, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
Representative Dan Pabon, Public Health Care and Human Services Committee
Representative Brittany Pettersen, Public Health Care and Human Services Committee
Representative Kim Ransom, Public Health Care and Human Services Committee
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Zach Lynkiewicz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

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

January 1, 2017

The Honorable Jim Smallwood, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Smallwood:

Enclosed please find a legislative report to the House Health, Insurance, and Environment Committee from the Department of Health Care Policy and Financing on Access to and Quality of Care for Children on Medicaid and the Children's Basic Health Plan Plus. Section 25.5-1-113.5, C.R.S., requires the Department to report on health care access and the quality of care for children on Medicaid and the Children's Basic Health Plan.

This report is divided into four sections per the legislative mandate and is organized as follows:

- Data showing that providers for children are participating in the programs and are accepting eligible children as patients on a regular basis;
- Data showing that eligible children are enrolling in programs under this title and are remaining enrolled so that the children have continuity of care;
- Data showing that eligible children are receiving the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services required by federal law, including but not limited to regular preventive care and, when appropriate, timely specialty care, and that providers are accurately reporting the data from these visits; and
- Data showing that providers are using other appropriate measures of access and quality to improve health outcomes and maximize the expenditure of health care resources.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

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

SEB/gr
Enclosure(s): Access to and Quality of Care for Children on Medicaid and CHP+

Cc: Senator Beth Martinez Humenik, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator John Kefalas, Health and Human Services Committee
Legislative Council Library
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Zach Lynkiewicz, Legislative Liaison, HCPF

Report on Access to and Quality of Care for Children on Medicaid and the Children's Basic Health Plan

Section 25.5-1-113.5, C.R.S. requires the Department of Health Care Policy and Financing (the Department) to report on health care access and the quality of care for children on Medicaid and the Children's Basic Health Plan, (Child Health Plan *Plus* (CHP+)). This report is divided into four sections per the legislative mandate - Part A through Part D, and is organized as follows:

A. Data showing that providers for children are participating in the programs and are accepting eligible children as patients on a regular basis.

B. Data showing that eligible children are enrolling in programs under this title and are remaining enrolled so that the children have continuity of care.

C. Data showing that eligible children are receiving the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services required by federal law, including but not limited to regular preventive care and, when appropriate, timely specialty care, and that providers are accurately reporting the data from these visits.

D. Data showing that providers are using other appropriate measures of access and quality to improve health outcomes and maximize the expenditure of health care resources.

The Department has a number of initiatives in place to improve the access to quality of health care delivered to children on Medicaid and CHP+ as outlined in this report, including:

- Tracking the number of providers serving the Medicaid and CHP+ populations as detailed in Part A of this report.

- Increasing the continuity of primary care providers between Medicaid and CHP+, as detailed in Part B of this report.

- Implementing presumptive eligibility for children in both programs, as detailed in Part B of this report.

- Continuing 12 month eligibility for children in CHP+, as detailed in Part B of this report.

- Providing outreach and case management to children receiving Medicaid benefits through the EPSDT program and the Accountable Care Collaborative, as detailed in Part C of this report.

- Measuring the number of children who receive well-child visits under the CHP+ and Medicaid programs as detailed in Part C of this report.

- Creating other opportunities and pilots that support better health outcomes, improve the access to care and the quality of health care for children receiving Medicaid or CHP+ benefits, as detailed in Part D of this report.

- Adding post-partum care as a Key Performance Indicator (KPI) in the Accountable Care Collaborative to improve care for new mothers and babies.

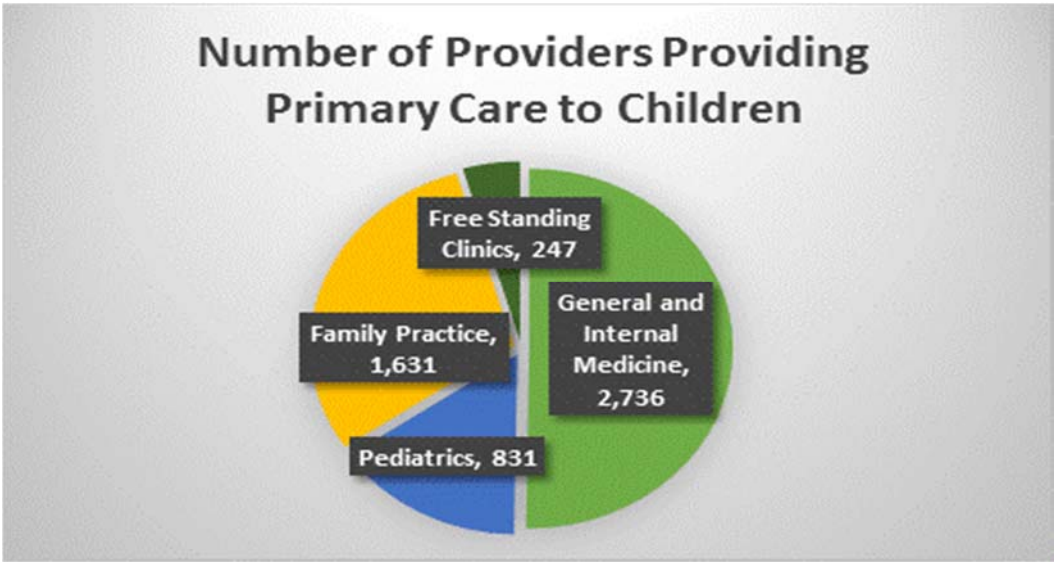
- Aligning state-wide Performance Improvement Projects (PIPs) to focus on care transitions for high-risk populations.

<u>Part A</u> – Providers are participating in the programs and accepting eligible children as clients:

Medicaid is in the process of transitioning our MMIS (Medicaid Management Information System) to a new system. Colorado is required to re-enroll providers by 2016 which will provide us will updated provider information. The new Interchange system will require providers to update their information, allowing the department to obtain more accurate and timely provider enrollment data by 2017.

Current provider numbers for Medicaid Primary Care are listed below:

Table 1



Number of Providers Providing Primary Care to Children	
General and Internal Medicine	2,736
Pediatrics	831
Family Practice	1,631
Free Standing Clinics	247
Total:	5,445

These numbers do not indicate which providers have open panels, the number of practice locations for a provider, and specialty areas.

Prior to FY 2014-15, Children on Medicaid received dental care through Delta Dental. In FY 2014-15, the Department contracted with DentaQuest to provide dental services for all Medicaid members. The following tables summarizes provider information for Medicaid dental providers:

Table 2

Colorado Medicaid Dental Providers	**2015**	**2016**
Active Providers	**1591**	**1646**
Specialty Designation of Active Providers		
Anesthesiologist	6	6
Endodontist	16	16
General Practitioner	1105	1161
Hygienist	167	153
Oral Pathologist	1	0
Oral Radiology	1	1
Oral Surgeon	66	69
Orthodontist	119	125
Pediatric Dentist	87	93
Periodontist	14	13
Prosthodontist	8	8
Public Health	1	1
Total	**1591**	**1646**

CHP+ enrollees receive health care through one or more of the following HMOs: Colorado Access, Colorado Choice Health Plans, Kaiser Permanente, Denver Health Medical Plan and Rocky Mountain Health Plan. Dental Services are provided by Delta Dental.

For children enrolled in CHP+, the Department contracts directly with health care providers to offer coverage during pre-Health Maintenance Organization (HMO) enrollment and in counties where health maintenance organizations are unable to offer coverage. This network of providers is referred to as the State Managed Care Network and is comprised of approximately 15,837 providers including all specialties. Of those providers, 15,456 have open panels. The Department contracts with Colorado Access for administrative services to manage the State Managed Care Network.

Table 4 summarizes the total number of CHP+ providers for each health plan and the Dental plan, the total number of those providers with open panels, and the total number of new providers who have signed contracts with the State Managed Care Network or HMO to serve CHP+ children and pregnant women.

Table 4: Providers Participating in the CHP+ Network

	CHP+ HMO	CHP+ SMCN
Number of Providers Who Accept CHP+ in Colorado	15,265	13,337

Number of Those Providers Who Have Open Panels	11,340	9,842
Number of New CHP+ Providers (Who have open panels)	4,193	3,349
Number of New Providers (prior to 1/1/2015) Regardless of Open Panel	6,128	4,839

<u>Part B</u> - Eligible children are enrolling in programs under Titles 19 and 21 and are remaining enrolled so that children have continuity of care:

Table 5 summarizes the average monthly number of children enrolled in Medicaid and CHP+.

Table 5: FY 2014-15 and FY 2015-16 Children's Caseload: Medicaid and CHP+

	Medicaid		CHP+	
	Client Caseload	Average Length of Enrollment During the Fiscal Year (in months)	Client Caseload	Average Length of Enrollment During the Fiscal Year (in months)
FY 2014-15	558,799	10.25	53,699	7.21
FY 2015-16	597,832	10.32	51,041	6.57

<u>Part C</u> – Medicaid-eligible children are receiving the EPSDT services required by federal law, including but not limited to, regular preventive care and, when appropriate, timely specialty care, and that providers are accurately reporting the data from these visits:

The Centers for Medicare and Medicaid Services (CMS) requires annual reporting for EPSDT screenings. The most recent version of this report, called the CMS EPSDT 416 report, is available for Federal Fiscal Year 2014-2015 This reporting period covers October 1, 2014 through September 30th, 2015. The Department is currently calculating data for FFY 2015-2016. Children are eligible to receive EPSDT services if they are eligible for Medicaid and are 20 years old or under. CHP+ clients are not eligible for EPSDT benefits.

The FFY 2014-15 CMS EPSDT 416 report indicates that 584,277 children were eligible for EPSDT services with 549,047 having at least 90 days of continuous eligibility to be counted on the report. Those children who may have received a well check, but did not remain on Medicaid beyond 90 days are not counted in the report. In 1989, CMS set the benchmark for the percentage of children in each age group receiving recommended EPSDT services at 80%. In FY 2014-15, 64% of eligible Colorado children received any initial and periodic screening services. This is the same as the year prior.

Table 6 below summarizes the percentage of all EPSDT-eligible children in Colorado receiving at least one well child check per year in the age range identified.

Table 6 – Percent of EPSDT children that receive recommended services, FFY 2014-15

Percentage of all EPSDT-eligible children in Colorado receiving the recommended number of EPSDT screenings						
Age range	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Under 1 year old	52%	100%	100%	100%	100%	100%
1-2 years old	100%	88%	96%	97%	98%	94%
3-5 years old	82%	63%	67%	66%	68%	66%
6-9 years old	48%	36%	40%	39%	42%	42%
10-14 years old	52%	40%	43%	43%	46%	45%
15-18 years old	44%	34%	35%	33%	34%	34%
19-20 years old	44%	26%	24%	21%	16%	14%
Aggregate percentage of all eligible children receiving recommended number of EPSDT services	68%	63%	66%	64%	64%	61%

In FY 2013-14, the ACC added well-child checks as a Key Performance Indicator (KPI) in an attempt to increase these rates. In FY 2014-15, the Department narrowed the focus of the KPI to visits for 3-9 years olds to facilitate more targeted interventions by the RCCOs and PCMPs. Rates for all age groups will continue to be monitored.

The EPSDT Outreach and Administrative Case Management program known as the Healthy Communities Program provides the following services to clients and providers:

- Generate awareness of the existence of the Medicaid and CHP+ programs;
- Offer information on how to apply for Medicaid and CHP+ and the availability of face-to-face application assistance;
- Inform families where to submit their application for processing and eligibility determination;
- Educate families on the value of preventive health care services and how to access their benefits at the appropriate settings;
- Link clients to Medicaid and CHP+ providers that will serve as the client's Medical Home;
- Missed appointment follow-up for providers who request the service;
- Provide clients with information and referrals to other community programs and resources; and
- Explain the re-enrollment process to families that continue to be eligible for Medicaid and CHP+ to eliminate gaps in coverage
- Works with RCCOs and Providers to help them understand the requirements under EPSDT.

As of 2014, the Healthy Communities staff has also moved within the Accountable Care Collaborative Team at the Department to facilitate coordination with RCCOs and Healthy Communities staff. In addition to the CMS EPSDT 416 Report the Department calculates HEDIS (Healthcare Effectiveness and Data Information Set) measures for child health.

Table 7 summarizes the weighted average percentage of children enrolled in Medicaid receiving well care visits. HEDIS is calculated on a calendar year so these rates are reported in 2015 for services received in 2014. HEDIS rates differ from EPSDT 416 rates, in that they require 11 months of continuous eligibility, which is a factor that is more favorable for private insurance than Medicaid, where there is more churn. The EPSDT 416 methodology only uses 90 days of continuous enrollment, criteria that was developed specifically for Medicaid. Well-child visits that happened for clients without the minimum continuous eligibility criteria aren't counted towards the rate.

Table 7

HEDIS® Measure	Colorado Medicaid HEDIS 2012 rate*	Colorado Medicaid HEDIS 2013 rate*	Colorado Medicaid HEDIS 2014 rate*	Colorado Medicaid HEDIS 2015 rate*	Colorado Medicaid HEDIS 2016 rate*
Well Child visits in the 1st 15 months of life (6 or more visits)	25.3%	25.5%	67.41%	45.18%	44.49%
Well child visits in the 3rd, 4th, 5th, and 6th years of life	64.2%	61.3%	66.29%	61.59%	56.96%
Adolescent well-care visits	44.8%	42.1%	44.00%	40.38%	32.13%

* *Average is weighted by number of enrollees in each HMO*

CHP+ clients are not eligible for EPSDT benefits. However, there are Healthcare Effectiveness Data and Information Set (HEDIS®) data available related to the number of children in CHP+ that receive the appropriate number of well-child visits by age group.

Table 8 summarizes the weighted average percentage of children enrolled in CHP+ receiving well care visits[1]

Table 8

HEDIS® Measure	Colorado CHP+ HEDIS 2012 rate*	Colorado CHP+ HEDIS 2013 rate*	Colorado CHP+ HEDIS 2014 rate*	Colorado CHP+ HEDIS 2015 rate*	Colorado CHP+ HEDIS 2016 rate*
Well Child visits in the 1st 15 months of life (6 or more visits)	25.3%	61.41%	67.41%	45.18%	47.76%

[1] HEDIS Aggregate Report for Child Health Plan *Plus*, October 2015-2016, Health Services Advisory Group, Inc.

Well child visits in the 3rd, 4th, 5th, and 6th years of life	64.2%	66.29%	66.29%	61.59%	67.25%
Adolescent well-care visits	44.8%	44.0%	44.00%	40.38%	46.65%

* Average is weighted by number of enrollees in each HMO

<u>Part D</u> - Providers are using other appropriate measures of access and quality to improve health outcomes and maximize the expenditure of health care resources:

The Department has several initiatives that support better health outcomes; improve access to care and the quality of health care for children receiving Medicaid or CHP+ benefits as highlighted below:

Initiated in FY 2014-15, each plan was required to complete a Performance Improvement Project (PIP) related to care transitions. These projects are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. Year one of these PIPs was focused on planning and data collection. Year two of the PIPs included baseline data, which was submitted in October 2015. This year, plans will begin implementing their interventions and the first re-measurement period will be reported October 31, 2016. The Department has started considering PIP topics for the next round of PIPs, in order to satisfy the new CMS regulation that each plan complete at least two PIPs.

The care transition topics for each plan are included below:

- Managed Care:
  - **Denver Health Managed Care** – Increasing the number of members, aged 5-17, with a persistent asthma diagnosis who complete a follow up visit with a PCP within 30 days following an asthma related ED, Urgent or IP visit.
  - **Rocky Mountain Health Plans** – Improving Transitions of Care for Individuals Recently Discharged from a Correctional Facility.
- CHP+:
  - **Colorado Access -** Improving Transitions for Children Aging Out of the CHP+ HMO Plan.
  - **Colorado Choice -** Improving the Transition Process for Children Aging out of the CHP+ HMO Plan.
  - **Denver Health -** Increasing the number of members, aged 5-17, with a persistent asthma diagnosis who complete a follow up visit with a PCP within 30 days following an asthma related ED, Urgent or IP visit.
  - **Kaiser Permanente –** Improving Access and Transition to Behavioral Health Services.

- **Rocky Mountain Health Plans –** Transitions of Care for CHP+ Members with Special Health Care Needs as they transition from CHP+ Coverage.

- Regional Care Collaborative Organizations:

  - **Region 1 – Rocky Mountain Health Plans** – Improving Transitions of Care for Individuals Recently Discharged from a Correctional Facilities.

  - **Region 2 – Colorado Access –** Adolescent Depression Screening in Primary Care and Transition of Care to a Behavioral Health Provider.

  - **Region 3 – Colorado Access** – Adolescent Depression Screening in Primary Care and Transition of Care to a Behavioral Health Provider.

  - **Region 4 – Integrated Community Health Partners** – Improving the Rate of Completed Behavioral Health Services within 30 Days after Jail Release.

  - **Region 5 – Colorado Access –** Adolescent Depression Screening in Primary Care and Transition of Care to a Behavioral Health Provider.

  - **Region 6 – Colorado Community Health Alliance** – Depression Screening in Primary Care and Transition to Behavioral Health Services.

  - **Region 7 – Community Health Partnership** – Decreasing All-Cause Readmissions for Members who are Homeless.

- Behavioral Health Organizations:

  Access Behavioral Care – Northeast – Adolescent Depression Screening in Primary Care with Transition of Care to Behavioral Health Provider

  Access Behavioral Care – Denver – Adolescent Depression Screening in Primary Care with Transition of Care to Behavioral Health Provider.

  Behavioral Healthcare, Inc. – Adolescent Depression Screening in Primary Care with a Transition of Care to Behavioral Health Provider.

  Colorado Health Partnerships, LLC – Improving the Rate of Completed Behavioral Health Services within 30 Days after Jail Release.

  Foothills Behavioral Health Partners – Improving Transition from Jail to Community Based Behavioral Health Treatment.

Quality Measurement:
The Department has continued efforts to monitor and improve health outcomes for the CHP+ and Medicaid through collection of Quality Measures. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided to and health outcomes of children in Medicaid and CHIP. CHIPRA required HHS to identify and publish a core measure set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs.

In 2016, the following HEDIS measures were calculated for Medicaid and CHP+ Plans:

- Pediatric Care
  - Childhood Immunization Status;
  - Immunizations for Adolescents
  - Well-Child Visits in the First 15 Months of Life;
  - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;
  - Adolescent Well-Care Visits;
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents; and
  - Appropriate Testing for Children with Pharyngitis

- Access to care and Preventative Screening
  - Percent of Children and Adolescents' Accessing Primary Care Practitioner
  - Chlamydia Screening in Women
  - Non-Recommended Cervical Cancer Screening in Adolescent Females

- Mental/Behavioral Health
  - Antidepressant Medication Management
  - Follow-up Care for Children Prescribed ADHD Medication
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents

- Respiratory-Related
  - Appropriate Treatment for Children with URI
  - Medication Management for People with Asthma
  - Asthma Medication Ratio

- Use of Services
  - Ambulatory Care Visits
  - Inpatient Utilization – General Hospital /Acute Care
  - Antibiotic Utilization

These measures are collected and shared in a variety of settings including an annual report of measures and which will be published, with the most recent data, in the summer of 2017 and contained in a separate legislative report due in June. These measures are also shared with health plans in quality meetings, and through our quarterly population health reports. https://www.colorado.gov/pacific/hcpf/hedis-reports

Population Health

Recognizing that Colorado has a multitude of initiatives focusing on improving the health of Coloradans, the Department of Public Health and Environment (CDPHE), Human Services (CDHS), and Health Care Policy and Financing (HCPF) created the Colorado Cross-Agency Collaborative to establish a data strategy, identifying metrics that are pertinent to Colorado as well as identifying gaps where further work is needed.

The Collaborative recognizes that each agency strives to positively impact Coloradans and seeks to leverage points of intersection. The Collaborative intends to foster alignment across the agencies, and establish priority efforts and targeted interventions in order to more effectively improve Coloradans' health.

The Collaborative's goals are to:

- Identify, track and trend metrics collected by CDPHE, CDHS, and HCPF
- Develop aligned initiatives that impact Coloradans' health
- Set targets and benchmarks for performance

Through this collaborative, state health departments will have a shared vision of population health indicators that they can be collectively impact, ultimately reducing duplicative efforts and focusing resources on populations with disparate health needs. Furthermore, Colorado's State Innovation Model (SIM) aims to integrate behavioral health and primary care. Through this integration opportunity exists to improve population health by addressing behavioral factors that often impede the management of chronic health problems, especially obesity, smoking and diabetes. The Collaborative already collects data on most metrics outlined in the SIM population health plan and plans to provide data to the work group to further the improvement of health throughout Colorado.

The collaborative published the Child Health report August 2015. New data will be provided by the end of 2016 that will allow for trending, benchmarking and discussions of appropriate performance targets of child population health outcomes. The Child Health report can be found here:
https://www.colorado.gov/pacific/sites/default/files/Child%20Health%20Final%20Report%20CCAC%206.12.2015.pdf

Another collaborative is the Colorado Opportunity Project. The Project is a cross agency collaborative among the Colorado Departments of Health Care Policy and Financing (HCPF), Public Health and Environment (CDPHE), Human Services (DHS) and Labor and Employment (CDLE). It establishes a common set of indicators so government agencies and private initiatives can work toward the same goals with the same understanding of what needs to be done. Key components are:

- Evidence-based programs
- Maximum Resource return on investment

- Payment reform

Other population health initiatives that are currently in progress include a data match between Medicaid and child welfare. The child welfare population usually has greater health care needs due to violence, abuse, neglect or other factors that have an impact on their health. Because of separate data systems between state agencies, silos are created that lead to difficulty in identifying the utilization of health services of children in child welfare. By matching Medicaid's physical and behavioral health data with the child welfare population, their utilization can by analyzed, identifying gaps and opportunities for improvement. A complete analysis of the data will be available in spring 2017.

Conclusion

The Department is committed to improving the health outcomes, access to and quality of health care to the pediatric population served by the Medicaid and CHP+ programs. The Department is using a combination of strategies to achieve this goal, including: performance measurement that includes health outcomes, increasing provider participation, increasing the continuity of care between Medicaid and CHP+, working with our state partners in achieving health outcomes and partnering on aligned initiatives. The Department is dedicated to building a culture of outcomes-driven policy to better serve clients and providers as well as to be a responsible steward of public funds.