Department of Health Care Policy and Financing

Final Update to FY 2012-13 Strategic Plan
Report on FY 2011-12 Performance Measures
FY 2013-14 Budget Request

November 1, 2012

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OBJECTIVE 1: INCREASE THE NUMBER OF INSURED COLORADANS

The Department aims to increase the number of insured Coloradans by increasing enrollment of individuals eligible for its Medicaid and Children's Basic Health Plan (CHP+) programs. Widening eligibility guidelines from the Colorado Health Care Affordability Act coincides with the federal Affordable Care Act and has allowed the Department to proactively prepare for these newly optional eligibility increases. With each fiscal year, the Department's goal is to have a higher percentage of the eligible population enrolled, which will improve health outcomes for an increasing number of Colorado's population.

Performance Measure 1A[1]:
Percent of Eligible Children Who Are Enrolled in Medicaid

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	85%	87%	87%	~~89%~~	N/A	~~91%~~	N/A	~~93%~~	N/A	~~95%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to minimal Department control and infrequency of data.*

Performance Measure 1B[1]:
Percent of Eligible Children Who Are Enrolled in CHP+

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	62%	64%	63%	~~67%~~	N/A	~~70%~~	N/A	~~73%~~	N/A	~~75%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to minimal Department control and infrequency of data.*

Performance Measure 1C[1]:
Percent of Eligible Parents Who Are Enrolled in Medicaid

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	76%	76%	75%	~~79%~~	N/A	~~81%~~	N/A	~~83%~~	N/A	~~85%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to minimal Department control and infrequency of data.*

Strategy:

The Department plans to discontinue all three of these measures effective FY 2012-13 for the following reasons:

- These enrollment measures were based on objectives from the Health Resources and Services Administration-State Health Access Program (HRSA-SHAP) grant, and, since this federal funding has been discontinued, the Department no longer has resources for an outreach team to perform enrollment functions.
- Due to the two-year lag required to report data, the relevance of these measures is relatively low. These estimates are calculated from data provided by the Colorado Health Institute based on analysis of data regarding health insurance status from the American Community Survey. Due to the lag in data available from the American Community Survey, the Department uses data from the most recent year available as a proxy for the evaluation of the performance measures. This, however, may understate the number of individuals with access to health insurance in the measurement year, as the survey cannot account for increases in enrollment in Medicaid or CHP+ during the year.
- The Department has minimal control over clients entering and exiting its programs, and once the individual mandate to have health insurance is effective in 2014, targeted efforts to enroll eligible individuals will no longer be relevant.
- Using HRSA-SHAP grant funding, the Department initiated a multi-pronged approach to achieve these benchmarks in FY 2011-12. The multi-pronged approach included:
  - improvements to the Colorado Benefits Management System (CBMS), eligibility system processing speed through CITRIX upgrades, and moving the entire system to a web-based format;
  - heightened awareness of the timeliness, processing standards, and corrective action plan benchmarks through communication and outreach. This was conducted through individual eligibility site visits, Director's letters, regular community meetings, and trainings. Additionally, eligibility sites were provided with monthly reports outlining processing times;
  - reviews of conflicting policies and clarification offered to eligibility sites;
  - research and identification of the top reasons applications are pending, and communicating this to eligibility sites that work the cases, as well as working with the CBMS vendor if the pending applications are related to system issues;
  - focused technical assistance to eligibility sites not meeting percentage goals through weekly progress reports on the timeliness percentages so the Department can contact each site below the processing requirement to offer technical assistance and support;
  - the development of additional reports on pending cases or cases identified within exceptions reports needing prioritized and worked by individual eligibility sites to assist in their workload management;
  - providing, through grant funding, additional processing assistance through the Integrated Document Solutions as the Overflow Unit to process family Medicaid and CHP+ applications and redeterminations for eligibility sites that requested assistance. The Department also funded staffing hours for county eligibility staff to perform overtime to assist with processing time frames;
  - the introduction of business process improvements strategies through the Colorado Eligibility Process Improvement Collaborative (CEPIC). County departments implemented new processing strategies that encompassed business process

improvements, staggered work hours to alleviate some of the system activity during peak hours, and overtime for eligibility technicians to decrease the backlog. Further, the Department trained eligibility sites on business process improvements and LEAN to provide ongoing support to those sites as they initiated changes;

- research and data fixes to clean up administratively incorrect data or issues with interfaces that adversely impacted the processing time performance statistics; and
- implementing the web-based PEAK online application, which was reported to have assisted with decreasing the eligibility sites' average processing of cases due to the upload process.

Several program automations and system changes were implemented to decrease workload and increase efficiency. These program changes included:

- administrative renewal, which eliminates the need for worker intervention on many redeterminations and aligns redetermination dates across multiple programs in order to eliminate multiple redetermination dates on one case;
- automation of the ex-parte process;
- implementing the Income and Eligibility Verification System interface that verifies client income for clients through the Colorado Department of Labor and Employment. This initiative allows clients to self-declare their verifiable work income for Medicaid and CHP+, which decreases paperwork delays in processing complete applications and redeterminations;
- implementing the Social Security Administration interface that verifies citizenship and identity for U.S. citizens. This initiative allows clients to self-declare their U.S. citizenship status for Medicaid and CHP+, which decreases paperwork delays in processing complete applications and redeterminations; and
- completing a case assignment system fix, which assigned Family Medicaid and CHP+ applications to the user or user's office/county taking the application and added an authorization trigger to prevent these applications from remaining in a pending status. This change also created two new detail reports to assist the eligibility sites with their new applications and redeterminations.

Evaluation of Prior-Year Performance:

The Department met the 87% benchmark for eligible children enrolled in Medicaid for FY 2011-12 with an additional 32,223 Medicaid children enrolled. The Department came close to meeting the 64% benchmark for eligible children enrolled in CHP+ and the 76% benchmark for eligible parents enrolled in Medicaid. An additional 6,999 CHP+ children were enrolled in CHP+ (for an estimated 63% of all eligible children) and an additional 20,404 Medicaid parents were enrolled in Medicaid (for an estimated 75% of eligible parents) in FY 2011-12.

These estimates are calculated from data provided by the Colorado Health Institute based on analysis of data regarding health insurance status in 2009 from the American Community Survey. Due to the lag in data available from the American Community Survey, the Department uses data from the most recent year available as a proxy for the evaluation of the performance measures.

This, however, may understate the number of individuals with access to health insurance in the measurement year, as the survey cannot account for increases in enrollment in Medicaid or CHP+ during the year.

Performance Measure 1D: Determine Annual Benchmarks to Measure Enrollment of Newly Eligible Populations Under HB 09-1293 Expansions											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
Benchmarks for the population expansions under the Colorado Health Care Affordability Act (HB 09-1293) are established through the Department's Budget Request to the General Assembly. Based on that forecast, the Hospital Provider Fee is adjusted so revenue is sufficient to cover the costs of the expansions. For the Adults without Dependent Children expansion, an enrollment limit of 10,000 was established and approved through the Medical Services Board and the Department's Section 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services. The Department's Eligibility Division has established a monthly process to review the enrollment levels, authorize new enrollments up to the enrollment limit from an established waitlist, and created limits within the Colorado Benefits Management System to prevent enrollment from exceeding the established limit.

Evaluation of Prior-Year Performance:
In accordance with its Section 1115 Demonstration Waiver for the Adults without Dependent Children expansion, the Department implemented the program with an enrollment limit of 10,000 in May 2012. The Hospital Provider Fee model included sufficient revenue and the Department's budget had sufficient spending authority to support the costs of all HB 09-1293 expansion populations implemented to date.

At this time, the Department cannot accurately measure the percent of eligible individuals who are enrolled pursuant to HB 09-1293 due to the timeliness of necessary data from the American Community Survey.

OBJECTIVE 2: IMPROVE HEALTH OUTCOMES

The Department intends to improve health outcomes for clients in the Medicaid and CHP+ programs. This effort will include reducing the percentage of children with dental caries, which is the disease that causes tooth decay and can lead to cavities in teeth and has been shown to be linked to other physical health issues. This effort also includes increasing the number of depression screenings in adolescents and reducing the obesity weight among both adults and children. As a measure to maintain cost-effective care, the Department plans to link an increasing percentage of Medicaid provider payments to value-based outcomes. These efforts should collectively improve health outcomes for Coloradans while combating cost increases.

Performance Measure 2A[1]: Percent of Medicaid Children with Dental Caries Experience											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	57%	55%	55%	~~<55%~~	N/A	~~<55%~~	N/A	~~<55%~~	N/A	~~<55%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to infrequency of data.*

Strategy:
To increase the number of Medicaid children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan with guidance from the Centers for Medicare and Medicaid Services and the Colorado Oral Health stakeholder community. The Action Plan will implement four Medicaid oral health care goals, including one to decrease the number of Medicaid children with dental caries experience by ten percentage points in a four-year period. The Department expects to complete and implement parts of the Action Plan starting January l, 2013.

The Department continues to work with external partners, particularly the Cavity Free at Three (CF3) initiative, to reduce early childhood caries. The CF3 initiative is a grant-funded, statewide consortium of dentists, physicians, public health professionals, foundations, and child-health advocates working to improve oral health outcomes for children in Colorado by educating health professionals about the consequences of early-childhood caries and their role in preventing this disease. The vision is that all children in Colorado, regardless of where they live or their health insurance status, have access to preventive oral care and a dental home starting at age one.

This performance measure will be discontinued effective FY 2012-13 due to infrequency of data, as described in the "Evaluation of Prior Year Performance" section below.

Evaluation of Prior-Year Performance:

The Department is using the nationally recognized Basic Screening Survey (BSS) as a proxy for the percentage of Medicaid children in the third grade with cavities. The BSS is conducted by the Colorado Department of Public Health and Environment and its Oral Health Unit contractors. The survey is conducted every three to five years, represents a single point in time, and is funded by the Centers for Disease Control and Prevention and the Maternal and Child Health Bureau. The most recent survey was conducted in 2011 and showed a 55% caries experience for predominately low-income Colorado children in the third grade. The Department met its goal of a 2% decrease in caries as determined by this survey. The previous survey was completed in 2009 and showed a 57% caries experience for predominately low-income children in the third grade. Unlike medical treatment, diagnosis codes do not exist for dental treatment, necessitating the use of oral examinations rather than claims data to report on this performance measure.

Performance Measure 2B: Percent of Medicaid Children Who Receive a Dental Service											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	49%	51%	52%	53%	TBD	55%	TBD	57%	TBD	59%	TBD

Strategy:

To increase the number of Medicaid children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan with guidance from the Centers for Medicare and Medicaid Services and the Colorado Oral Health stakeholder community. The Action Plan will implement four Medicaid oral health care goals, including one to increase the number of Medicaid children receiving oral health care services by 10 percentage points in a four-year period. The Department expects to complete and implement parts the Action Plan starting January l, 2013. The Department has also agreed to an external, comprehensive dental benefit review funded by Caring for Colorado. The Department anticipates the reviewer will look at the benefit in its entirety to determine best practices and/or benefit design to maximize Departmental and national strategic goals of increasing access to evidenced-based, preventive services for clients.

Evaluation of Prior-Year Performance:

In federal fiscal year 2010-11, approximately 52% of Medicaid children received a dental service. These estimates are calculated from data provided to the federal Centers for Medicare and Medicaid Services (CMS) and represent the number of children who have been continuously enrolled in Medicaid for at least 90 days and received any dental service between October 1, 2010, and September 30, 2011.

The Department has observed a steady increase of approximately 2.5% per year over the past four years in Medicaid children receiving a dental service. The Department has observed a commensurate increase in dental provider enrollment and outreach, which

increased needed access for clients. In addition, medical providers have been educated to screen and refer children for necessary dental services. Dental staff at the Department will continue to work on internal and external statewide initiatives for continued outreach to both dental providers and clients.

Due to the one-year lag in data available from the federal report the Department uses to evaluate this performance measure ("EPSDT CMS 416 report"), the Department uses data from the most recent year available as a proxy for the number of children receiving dental services in the measurement year. This methodology may, however, understate the actual result, as older data cannot account for progress made during the actual measurement year.

Performance Measure 2C: Percent of CHP+ Children Who Receive a Dental Service											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	44%	46%	41%	45%	TBD	47%	TBD	49%	TBD	51%	TBD

Strategy:
To increase the number of Children's Basic Health Plan (CHP+) children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan in concert with the CHP+ Oral Health Care Contractor and with guidance from the Centers for Medicare and Medicaid Services (CMS) and the Colorado Oral Health stakeholder community. The Action Plan will implement four CHP+ oral health care goals, including one to increase the number of CHP+ children receiving oral health care services by 10 percentage points over a four-year period. The Department expects to complete and implement parts of the Action Plan beginning 2013. In addition, the Department spent the past year drafting a Request for Proposals (RFP) for a new CHP+ Oral Health Care Contract effective July 1, 2013. The goals, strategies, and tactics of the Action Plan are incorporated in this RFP.

Evaluation of Prior-Year Performance:
In federal fiscal year 2010-11, approximately 41% of CHP+ children received a dental service. These estimates are calculated from data provided by the CHP+ Oral Health contractor based on the federal Centers for Medicare and Medicaid Services (CMS) methodology for the Medicaid EPSDT CMS 416 report discussed above and represent the number of children who have been continuously enrolled in CHP+ for at least 90 days and received any dental service between October 1, 2010, and September 30, 2011.

While there was a decrease in CHP+ oral health care utilization from FY 2010-11 to FY 2011-12, the Department believes this is largely due to a change in the methodology used to calculate this measure. Through FY 2010-11, the methodology measured utilization relative to the average CHP+ annual caseload rather than the number of children continuously enrolled in CHP+ for at least

90 days. This change in methodology is consistent with a recent CMS requirement that state CHIP programs adopt the standardized Medicaid methodology for calculating oral health care benefit utilization.

Due to the one-year lag in the data used by the Department to evaluate this performance measure (consistent with the EPSDT CMS 416 report), the Department uses data from the most recent year available as a proxy for the number of children receiving dental services in the measurement year. This methodology may, however, understate the actual result, as older data cannot account for progress made during the actual measurement year.

Performance Measure 2D: Initiate Development of a Data Strategy for Long-Term Integration of Clinical and Claims Data											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

The Department is working with its partner agencies and the Governor's Office of Information Technology (OIT) to implement a Comprehensive State Health Information Management Strategy (C-SHIMS). As the State Medicaid Agency, the Department has a strong and ongoing interest in ensuring efficient and effective collection, management, availability, use, and governance of health information across state health programs, agencies, and non-governmental partners. The overall goal is for the Department to take a lead role in encouraging the adoption and efficient and effective use of Health Information Technology (HIT) by state agencies and the Colorado health care community by providing leadership and funding when possible. The Department assumes the level of financial and technical support needed to achieve this joint goal will be available from the Centers for Medicare and Medicaid Services (CMS).

As a comprehensive health information management strategy, C-SHIMS is expected to be a blueprint to drive strategic thinking and collaboration that will evolve over time with the needs and demands of a transforming health system. C-SHIMS builds upon the Colorado Information Marketplace being championed and implemented by the State Chief Information Officer and Secretary of Technology, and it is built upon a framework of "Capture, Link, Serve and Provide." These principal components of C-SHIMS are essential if health information is to be utilized to achieve outcome, service, programmatic, budgetary, reporting, and other related goals across state agencies and the broader Colorado health community.

Through the Health Information Technology for Economic and Clinical Health (HITECH) Act, CMS can provide enhanced federal funding of 90% to modernize and update the State's HIT infrastructure. This funding can be used for the design, development, and implementation (DDI) of statewide databases that will directly benefit the State's health information exchange or the State Medicaid agency. HITECH funds are meant to support time-limited activities and do not provide funding for maintenance. The Department

intends to update its State Medicaid HIT Plans (SMHP) and HITECH Implementation Advanced Planning Document (IAPD, approved on October 18, 2011) to obtain enhanced federal funding for projects described in this document.

In addition, the Department may also request enhanced federal funding through an IAPD for the reprocurement of the Department's Medicaid Management Information System (MMIS), as HIT is vital to the Department's claims payment processes, efficient program administration, reporting, analytics, and monitoring of quality of care. The Department expects to submit an IAPD to CMS during FY 2012-13 with an effective date of July 1, 2013. The reprocured MMIS is expected to be operational by July 2016.

Evaluation of Prior-Year Performance:
The development of a data strategy for integration of clinical and claims data was initiated via kickoff of the procurement process for the Colorado Medicaid Management Innovation and Transformation (COMMIT) project. Included in the COMMIT project is the Department's data warehouse and analytical capabilities. C-SHIMS outlines a strategic approach to integrate data from a variety of sources into the Department's data warehouse, including clinical and quality data to provide sophisticated analytics to create client risk scores, performance monitoring and benchmarking, evaluating utilization variances, and creating provider profiles. The Department developed a written strategy, which was finalized on August 1, 2012.

Performance Measure 2E[1]: Number of Annual Depression Screenings for Adolescents (Age 11-20) on Medicaid/CHP+ Combined											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[2]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1,500	TBD	~~3,000~~	N/A	~~N/A~~	N/A	~~N/A~~	N/A	~~N/A~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to reporting lag time and low correlation between depression screenings and treatment.*
[2]*FY 2011-12 data not available until January 2013.*

Strategy:
The Department's strategy for increasing the number of adolescent depression screenings is to communicate the availability of this benefit and online depression tool kit. Communications are targeted to fee-for-service primary care providers through the "At A Glance" and "Provider Bulletin" newsletters and other provider sources such as the Colorado Children's Healthcare Access Program.

Evaluation of Prior-Year Performance:
Not applicable. New measure effective FY 2012-13.

OBJECTIVE 3: INCREASE ACCESS TO HEALTH CARE

Enrolling eligible clients is only effective in improving health outcomes if these individuals have access to high quality health care. As one of its goals, the Department intends to increase the percentage of Medicaid clients, both adults and children, who have a medical home or focal point of care. By having a medical home or focal point of care, these clients will receive the health care services they need in a timely manner, effectively preventing more expensive emergency treatment that comes as a result of neglected health conditions.

Performance Measure 3A[1]: Percent of Adult Medicaid Clients Who Have a Medical Home or Focal Point of Care											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[2]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	38%	42%	38.4%	~~52%~~	N/A	~~70%~~	N/A	~~75%~~	N/A	~~80%~~	N/A

[1] *Measure to be replaced effective FY 2012-13 by "Number of Medicaid clients enrolled in the Accountable Care Collaborative."*

[2] *Preliminary result based on 1st half of FY 2011-12. Final result pending data run-out from claims on 2nd half of FY 2011-12 (available January 2013).*

Strategy:

The Department's strategy for this measure in FY 2011-12 was to implement Phase I of the Accountable Care Collaborative (ACC). The goal in the first year of the ACC program was to enroll up to 123,000 Medicaid members, providing them with a focal point of care. Each Regional Care Collaborative Organization (RCCO) in the ACC launched enrollment in designated focus communities in which a contracted provider network of Primary Care Medical Providers (PCMPs) was established, as well as an informal network of specialists, ancillary providers, and community resources. Whenever possible, ACC enrollees were linked to a PCMP based on claims history. RCCOs also used a variety of additional strategies to reach members with no clear pattern of claims history and link them to a PCMP. To assist in this process, a subgroup of the ACC Program Improvement Advisory Committee was formed in February 2012 to develop recommendations for optimizing the linking process. Recommendations that have been, or are being, implemented include: adding the State Seal to Health Colorado letters and envelopes to draw attention to them; developing a statewide provider directory to show new members a wide range of provider options across the state; developing a set of federally approved marketing guidelines to support outreach to ACC members not yet linked with a PCMP; and developing a plan for rechecking the claims history of unlinked ACC Members every six months to link them with a PCMP.

Evaluation of Prior-Year Performance:

The Department implemented Phase I of the Accountable Care Collaborative. New members were enrolled in May 2011, and the program met its initial enrollment benchmark of 123,000 clients for FY 2011-12. Although ACC members may choose to opt out of the program, opt out rates have been consistently very low (approximately 5%) over the fiscal year. The Department and the RCCOs

have worked on ways to identify and contact hard-to-reach populations (e.g., the new Adults without Dependent Children) and ways to address the four main program goals: improved client health, improved client and provider experience, reducing overall cost of care, and providing detailed and actionable data to support program strategies.

Performance Measure 3B[1]: Percent of Medicaid Children Who Have a Medical Home or Focal Point of Care											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	78%	80%	79%	~~86%~~	N/A	~~92%~~	N/A	~~97%~~	N/A	~~100%~~	N/A

[1]*Measure to be replaced effective FY 2012-13 by "Number of Medicaid clients enrolled in the Accountable Care Collaborative."*

Strategy:

To meet the goals of SB 07-130, the Department, the Colorado Department of Public Health and Environment, providers, advocates, and other community stakeholders are participating in the Colorado Medical Home Initiative (CMHI) so that every child enrolled in Medicaid and CHP+ receive access to health care in a medical home. In FY 2011-12 the Department changed its methodology to include federally qualified health centers (FQHC) and school-based health centers, as well as the new Accountable Care Collaborative providers as medical homes in this program. The program included a Triple Aim for Families: increase quality and accessibility of services; increase capacities for families to change their own trajectories; and transform systems and services.

Evaluation of Prior-Year Performance:

In FY 2011-12, the distinct count of children who could be attributed to a medical home was 263,679; this number excludes 43,438 children who had two or more visits to a federally qualified health center or rural health clinic (FQHC/RHC). The total number of Medicaid children is 334,633, which is the average number of Foster Care and Eligible Children in FY 2011-12. If the 43,438 children with two or more visits to a FQHC/RHC had been factored in, the percent of Medicaid children who had a medical home in FY 2011-12 would be 92%. For a comparable result to the pre-Accountable Care Collaborative methodology used in prior years for this performance measure, FQHC/RHC visits were excluded from the calculation. This results in 79% of children being attributed to a medical home, almost meeting the 80% benchmark.

Performance Measure 3C: Number of Providers Participating in Medicaid											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	24,669	25,902	26,283	27,597	TBD	5% increase from FY 2012-13 Actual	TBD	5% increase from FY 2013-14 Actual	TBD	5% increase from FY 2014-15 Actual	TBD

Strategy:
In FY 2011-12, the Department implemented provisions of the Health Resources and Services Administration-State Health Access Program (HRSA-SHAP) grant to create a Provider Relations team, consisting of two full-time staff, for the purpose of retaining existing Medicaid providers, assisting prospective providers in the enrollment process, and initiating a provider-recruitment strategy. In coming years, the Department's Regional Care Collaborative Organizations will encourage providers to join the Accountable Care Collaborative and become a Medicaid provider. The Clinical Services Office will also network with providers and provider organizations to recruit new providers.

Evaluation of Prior-Year Performance:
By the end of FY 2010-11, there were 24,669 Medicaid providers in Colorado. This represents a correction to the number of FY 2010-11 providers originally reported (27,336) in the Department's FY 2012-13 Budget Request. The corrected number reflects "active" providers with at least one claim per calendar year. As a result, the benchmark for FY 2011-12 has been adjusted to reflect a 5% increase over the FY 2010-11 actual number. The Department exceeded the corrected FY 2011-12 benchmark with a total of 26,283 Medicaid providers. This represents a 6.5% increase over the 24,669 Medicaid providers in FY 2010-11.

Performance Measure 3D: Determine Appropriate Benchmarks to Measure Increases in Provider Participation to Serve Future Expansion Populations											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
The Department estimates a 5% annual increase in provider participation over the next five years will be sufficient to meet the needs of Medicaid clients. This is based on conclusions and methodology of the Colorado Health Institute (CHI) December 2011 report "A Half Million Newly Insured: An Analysis of Primary Care Workforce Needs After Health Care Reform," and supported by Oregon's ongoing Health Study, which cites an initial increase in participant medical utilization. The Department has adapted these findings to its Medicaid-specific populations and incorporated the need to add specialty care providers.

Evaluation of Prior Year Performance:
The Department determined a 5% annual increase in provider participation over the next five years will be sufficient to serve expansion populations under HB 09-1293 and future needs of Medicaid clients.

OBJECTIVE 4: CONTAIN HEALTH CARE COSTS

Increasing caseload is understood to carry an additional financial burden to the State, which is particularly concerning during an economic downturn. The Department has identified a number of areas where it can contain health care costs while still providing health care services to its Medicaid and CHP+ clients. These cost-containment opportunities are made possible by an assortment of efforts to consolidate and streamline the delivery process, thus maximizing a number of potential efficiencies. The Department aims to assure delivery of appropriate, high-quality health care and expand and preserve health care services in the most cost-effective manner possible, as well as design programs that result in improved health status for clients served and improve health outcomes.

Performance Measure 4A: Complete Phase I of the Accountable Care Collaborative											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
By completing Phase I of the Accountable Care Collaborative (ACC), the Department built a solid framework for coordinated care to achieve improved health outcomes, client experience, and lower per-capita costs. The ACC works to improve health outcomes through a coordinated, client-centered system and controls costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources. The three key performance indicators for FY 2011-12 were: 1) reduction in emergency department utilization, 2) reduction in hospital readmissions within 30 days, and 3) reduction in utilization of high-cost imaging (e.g., computerized tomography scans and magnetic resonance imaging). As the ACC program continues to evolve, the Department is developing ways to use data to identify regional and provider-based cost variations and inform additional cost-containment strategies.

Evaluation of Prior-Year Performance:
Phase I of the ACC was completed on June 30, 2012, and the ACC program moved into Expansion Phase in July 2012. As of September 2012, the ACC has approximately 135,000 enrollees, including the new Adults without Dependent Children population. The Department expects to increase enrollment by approximately 30,000 per month beginning October 2012.

Performance Measure 4B: Implement Payment Reform via the Benefits Collaborative, National Correct Coding Initiative, and Behavioral Health Organization Rate Reform											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
The Benefits Collaborative serves as the Department's formal policy-development process. The Benefits Collaborative is a transparent, stakeholder-driven process for: ensuring benefit coverage policies are based on the best-available clinical evidence and guided by best practices; outlining the appropriate amount, scope, and duration of Medicaid benefits; and promoting the health and functioning of Medicaid clients. The collaborative is intended to provide guidelines for determining coverage criteria for Colorado Medicaid's covered benefits, promoting appropriate utilization and access to care, and minimizing variations in care. The development of the policies were centered around three main goals: 1) defining clinical criteria, 2) reducing inappropriate utilization, and 3) promoting proper billing practices.

The Department will implement National Correct Coding Initiative (NCCI) in accordance with the federal Affordable Care Act (ACA). The NCCI editing methodologies will be implemented in order to prevent coding errors and potential fraud, waste, and abuse. Medicare and most insurance companies already follow NCCI rules, and this will bring the NCCI rules to Medicaid. SB 10-167 allocated funding to the Department for such implementation and future operations. The Department began the development of this project in FY 2010-11 and, in FY 2011-12, finalized the system and policy requirements. Starting February 1, 2013, the Department's NCCI Implementation Project will begin the editing of claims in the Department's Medicaid Management Information System (MMIS). After necessary system changes and approval by the Medical Services Board, claims submitted by providers shall be edited according to the six NCCI methodologies:

- NCCI procedure to procedure edits for practitioner and Ambulatory Surgical Centers (ASC) services
- NCCI procedure to procedure edits for outpatient hospital services
- NCCI procedure to procedure edits for Durable Medical Equipment claims
- Medically Unlikely Edits (MUEs) for practitioner and ASC services
- MUEs for outpatient hospital services
- MUEs for supplier claims for Durable Medical Equipment

In implementing Behavioral Health Organization (BHO) rate reform, the Mental Health Rates group uses the annual case rate based on the Chronic Illness and Disability Payment System (CDPS), a risk-adjustment model that groups diagnoses according to chronic and disabling disease to measure service efficiency by BHOs. With the service mix data, Rates also analyzes the impact of the

prevention/early intervention services on the efficiency change from year to year and among BHOs. When there is any efficiency gain available, the Department will share a portion of the gain for incentives for the prevention/early intervention services.

Evaluation of Prior-Year Performance:

The Department is implementing payment reform through the Benefits Collaborative, NCCI, and BHO rate reform. With respect to the Benefits Collaborative, the Department has worked closely with the Colorado Radiological Society to ensure the radiology benefit coverage standards are based upon generally accepted standards of practice and the American College of Radiology's Appropriateness Criteria. Three of these Benefit Coverage Standards entered the public comment period in August 2012. The Department's stakeholders have capitalized on the opportunity to provide cost-effective ways for Colorado Medicaid to render services. In addition, and as a result of stakeholder feedback, the Department plans to offer tablet computers as a lower-cost option for Medicaid clients requiring Augmentative and Alternative Communication Devices (AACDs). Effective June 1, 2012, the Medical Services Board approved a rule to allow the Department to incorporate by reference any Benefit Coverage Standard developed through the Benefits Collaborative process. The inclusion of the Benefit Coverage Standards into rule will assist in the Department's client appeals defense.

In implementing NCCI, the Department meets weekly to further progress. The estimated implementation date is February 2013. The Department will adjust rates associated with certain procedure codes that have been out-of-balance and would conflict with NCCI coding guidelines. The Department is reaching out to affected providers and is updating rules, billing manuals, and provider bulletins.

The Department has also begun implementing BHO rate reform as described above. When there is any efficiency gain available, the Department will share a portion of the gain for incentives for the prevention/early intervention services.

Performance Measure 4C: Percent of Hospital Readmissions Within 30 Days of Discharge Among Medicaid Clients (Excluding Dual-Eligibiles)											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[1]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	9.95%	9.55%	TBD	9.65%	TBD	9.36%	TBD	9.08%	TBD	8.80%	TBD

[1] *FY 2011-12 data not available until January 2013 (requires six months paid date run-out).*

Strategy:

There were many activities initiated to affect the 30 day hospital readmission rate during FY 2011-12:

- The readmission rate is now a key performance indicator for each Regional Care Collaborative Organization.
- A policy to deny payment for any readmission that occurred within 48 hours of a discharge was implemented July 1, 2011.
- A questionnaire was sent to all hospitals about their current efforts to decrease 30-day hospital readmissions. The intent of this questionnaire was to increase awareness of the importance of decreasing readmissions.
- A work group of Department staff was initiated to focus on activities that could be done to lower readmissions.
- A collaborative effort between the Center for Improving Value in Health Care, Colorado Hospital Association, Colorado Regional Health Information Organization, and the Department began investigating the need for a statewide initiative focused on reducing readmissions.

Evaluation of Prior-Year Performance:

In FY 2010-11, the percent of hospital readmissions within 30 days of discharge among Medicaid clients (excluding dual-eligibles) was 9.95%. This represents a correction to the 9.4% hospital readmission rate originally reported in the Department's FY 2012-13 Budget Request. As a result, the benchmark for FY 2011-12 was adjusted to 9.55% to reflect the targeted four-tenths of one percentage point decrease from the actual rate in FY 2010-11. The actual rate is based on an analysis of claims data six months after the close of the reporting period to allow for the completion of provider billing cycles. When compared to a 16-state Medicaid average of 8.3%, Colorado's readmission rate is nearly 1.7% higher than the other states. The Department will be able to gauge the success of the strategies employed in FY 2011-12 in February 2013.

Performance Measure 4D: Initiate Development of a Data Strategy for Long-Term Containment of Health Care Costs											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

A major component of the Department's data strategy in FY 2011-12 was to complete implementation of the Accountable Care Collaborative and, in particular, the Statewide Data and Analytics contractor (SDAC). The SDAC is responsible for providing secure electronic access to clinically actionable data to the Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) to help them meet the goals of the Accountable Care Collaborative (ACC) – to improve client health and reduce costs. The SDAC helps providers by allowing PCMPs to better coordinate Medicaid clients' care by: providing secure access to diagnoses, prescriptions, and other health information; providing reports to PCMPs and RCCOs to help eliminate avoidable and duplicative procedures; and analyzing claims to identify potentially preventable health events (e.g., ER visits and hospital readmissions). The SDAC is contributing to the development of a data strategy for long-term containment of health care costs by:

- building and implementing the ACC data repository;
- creating reports using advanced health care analytics;
- hosting and maintaining a Web Portal;
- fostering accountability and ongoing improvement among RCCOs and providers; and
- identifying data-driven opportunities to improve care and outcomes.

Evaluation of Prior-Year Performance:

The SDAC completed development of the SDAC data warehouse, including the establishment of a regular, weekly data feed from the Department. This data feed contains all physical health and pharmaceutical administrative data captured by the Department's Medicaid Management Information System (MMIS). The data warehouse contains data from January 2008 forward. The SDAC also incorporated behavioral health data from calendar years 2008 to 2010. The SDAC transforms the data warehouse into actionable information. First, the data is run through a series of algorithms that create comparable groups of clients based on diagnoses and co-morbid health conditions, then this information is displayed in the SDAC web portal. The web portal became operational in January 2012.

RCCOs and PCMPs have access to the Web Portal dashboard. The dashboard contains information on RCCO and PCMP performance for the ACC Key Performance Indicators (KPIs). The KPIs include: 30-day all-cause readmissions, ER visits, and high-cost imaging services. By tracking these metrics on a risk-adjusted basis, the Department is able to compare the RCCOs and PCMPs

to each other. RCCOs and PCMPs are using the dashboard Web Portal to help guide their care management priorities. For instance, a RCCO may notice that they are performing poorly on the ER visits KPI metric. They are able to "drill down" into the metric and determine the specific patients who have the highest number of ER visits.

The SDAC hosted a monthly operations meeting for RCCOs and Department staff during FY 2011-12 to demonstrate how the Web Portal can be used to enhance care management practices in a manner that focuses on optimizing practice resources. This monthly meeting facilitated the dissemination of best practices across RCCOs. RCCOs were able to provide feedback to the SDAC that led to the creation of several monthly care-management reports. The development of the Patient Profiler tool began during a monthly SDAC operations meeting. This tool displays a patient history by service category, listing the inpatient hospital stays, ER visits, drugs, and primary/specialty care visits a patient has had in the past year. Both RCCO and PCMP representatives reviewed this tool positively in terms of its impact on care management practices.

During the past year, the SDAC has been discussing how to best incorporate behavioral health data and hospital data on an ongoing basis. The behavioral health information in the State's MMIS is not actionable due to a large number of edits that influence what behavioral health claims are actually paid and how they are priced. The Department sent the SDAC three years of behavioral health claims data and is currently building a system to send this information on an ongoing basis. The SDAC and Department have also been in close contact with the Colorado Regional Health Information Organization on linking admission, discharge, and transfer hospital data into the SDAC in a real-time basis. Incorporating this data set would be an asset for providers. Providers are not currently notified when their patients are admitted to the hospital. As a result, it is difficult to coordinate care with the hospital or to arrange for appropriate care transitions upon discharge. Delivering this information to providers in a timely fashion would be a significant step forward in terms of actionable data for providers. The Department and the SDAC are currently aiming for implementation in March 2013.

Performance Measure 4E[1]: Percent Reduction of Medical Services Premiums Expenditures for Nursing Facilities											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	Total Expenditures for Class I Nursing Facilities: $521,244,769	0.7% (Reduction of $3,648,713 from prior FY expenditure)	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1]*Measure discontinued effective FY 2012-13 due to dependency of nursing facility expenditures on external factors such as growth of aging populations and federal and state rules and regulations.*

Strategy:

One of the Department's strategies for containing Medical Services Premiums expenditures for nursing facilities is to minimize the aggregate census of Class I Nursing Facilities by applying the Minimum Data Set (MDS) 3.0 Section Q assessment process. The MDS Section Q assessment is part of the federally mandated process that assesses nursing facility residents' health conditions, treatment, abilities, and plans for discharge. It is designed to explore nursing facility residents' desire for living in the community through an individualized, person-centered evaluation. Once community placement is expressed by nursing facility residents, community transitions measures are applied using Community Transition Services in the HCBS-EBD waiver and Colorado Choice Transitions program processes. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition.

It is not possible, however, to set targeted expenditure reductions for nursing facilities due to dependency on external factors such as growth of aging populations and federal and State rules and regulations for nursing facility reimbursement.

Evaluation of Prior-Year Performance:

Not applicable. New measure effective FY 2012-13.

OBJECTIVE 5: IMPROVE THE LONG-TERM CARE SERVICE DELIVERY SYSTEM

As the population ages and costs increase, long-term care continues to serve as a difficult category in the arena of public health care. Long-term care services are expensive; however, the Department believes there are efficiencies that can yet be attained, thus minimizing and perhaps containing cost increases while continuing to deliver the same level of care. Transitioning clients from facility-based care to community-based care and consolidating waiver programs are efficiency opportunities the Department plans to immediately pursue.

Performance Measure 5A:
Develop a Five-Year Strategy to Increase the Number of Dual-Eligible Long-Term Care Clients Who Have a Health Home

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
The Department's strategy to increase the number of dual-eligible clients who have a health home is to enroll them in the Accountable Care Collaborative (ACC) in 2013. All dual-eligible clients who are not already receiving care in a coordinated setting will be enrolled in the ACC. In the next year, it is likely the Department will pursue a health homes project through section 2703 of the Affordable Care Act (ACA), which may include some dual-eligible clients.

Evaluation of Prior-Year Performance:
The Department has a strategy in place and is in negotiations with the Centers for Medicare and Medicaid Services to finalize a contract and Memorandum of Understanding to implement the Demonstration to Integrate Care for Dual-Eligible Clients. The Department anticipates completing these negotiations in early 2013 and enrolling dual-eligible clients into the ACC later in 2013.

Performance Measure 5B:
Develop a Five-Year Strategy to Improve Long-Term Care Population Outcomes

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Yera FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
To improve outcomes for the long-term care (LTC) population, the Department will develop a strategic plan with input from Long-Term Supports and Services (LTSS) stakeholders. The key sections for developing the plan include the Quality Health Improvement Unit, the Quality Assurance/Audit Unit in the LTSS Division, and the LTC Reform Unit. The plan will identify key outcome measures to track and aggregate over time. A key criterion for selecting measures will be the capacity of the Department to collect data related to specific measures. In the first year of the plan, baseline data will be established for all measures, which key personnel will use to establish goals and develop intervention strategies. A few years from now, the Department may want to consider developing a home- and community-based services (HCBS) scorecard and Nursing Home scorecard as part of this process so clients can see which of the LTSS providers offers the best quality of care linked to the best client outcomes.

Evaluation of Prior-Year Performance:
A five-year strategy to improve long-term care population outcomes has not been completed. Governor Hickenlooper redirected the Department and the Department of Human Services to focus first on cooperating to improve efficiencies in the delivery of services to the developmentally disabled and inform the Joint Budget Committee and General Assembly in writing as efforts progressed. In addition, turnover of a position in the Department's Quality and Health Improvement Unit, as well as delay in filling a manager position in the LTSS Division, caused additional postponement of the development of a plan to improve health outcomes for the LTSS population.

Performance Measure 5C: Develop a Roadmap for Waiver Consolidation											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
To establish a roadmap for waiver consolidation, the Department created a subcommittee of the Long-Term Care Advisory Committee (LTCAC) to work on a plan to consolidate waivers. The first subcommittee meeting was in August of 2012. The Department expects the roadmap will be established no later than March 2013 and will provide a detailed plan that lays out the key recommendations for consolidating the home- and community-based services (HCBS) waivers, key decisions, resource requirements, information technology system changes, stakeholder engagement process, suggested waiver amendments and renewals, and a timeline. The Department is currently working on procuring a contractor to provide technical assistance and develop the roadmap.

Evaluation of Prior-Year Performance:
The Department did not pursue waiver consolidation in FY 2011-12. It was essential to first establish the LTCAC then develop the strategic priorities in collaboration with the LTCAC. The LTCAC identified waiver consolidation as a priority in FY 2011-12.

Performance Measure 5D[1]: Percent of Dual-Eligibles Enrolled in the Accountable Care Collaborative for a Focal Point of Care											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	N/A	~~60%~~	N/A	~~70%~~	N/A	~~70%~~	N/A	~~70%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to dependency on federal funding.*

Strategy:
The Department's strategy for this measure is linked to federal funding via a Memorandum of Understanding (MOU) and contract with the Centers for Medicare and Medicaid Services for the Demonstration to Integrate Care for Dual Eligible Clients (demonstration project). Because of delays in development of the MOU and contract for the demonstration project, it will not be executed and implemented in January 2013 as originally anticipated; the expected implementation date is April 2013 or later. Upon implementation, the Department anticipates approximately 10,000 dual-eligible clients perm month will be enrolled in the demonstration project, resulting in a low percentage of dual-eligible clients being enrolled by the end of FY 2012-13 if the contract is awarded. There is no State budgetary impact because, if implemented, the demonstration project would be funded through a federal grant. This performance measure will be discontinued effective FY 2012-13 due to dependency on federal funding.

Evaluation of Prior Year Performance:
Not applicable. New measure effective FY 2012-13.