# Colorado Department of Health Care Policy and Financing

*The mission of the Department of Health Care Policy and Financing is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.*

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

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## Department Performance Plan

FY 2014-15

July 1, 2014

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# Introduction

The Department of Health Care Policy and Financing is the federally designated Single State Agency to receive Medicaid (Title XIX) funding from the federal government for administration or supervision of the Medicaid program. As such, in order to receive federal financial participation, the Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services that provides roughly 60% of the Department's Medicaid budget and 65% of the funding for the Children's Basic Health Plan. The Department also provides health care policy leadership for the State's Executive Branch.

The Department oversees services and distributes administrative costs through interagency agreements with other departments. Because the Department is the Single State Agency designated to administer or supervise the administration of the Medicaid program, a number of statewide programs and services are financed through the Department's budget each fiscal year. Included in these programs and services are services for mental health institutes and nurse aide certifications.

The Department also receives Child Health Insurance Program (Title XXI) funding from the federal government for the Children's Basic Health Plan, marketed as Child Health Plan *Plus* or CHP+. CHP+ provides basic health insurance coverage for uninsured children and pregnant women of low-income families, and is a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. In addition to the Medicaid program and CHP+, the Department administers the following programs:

- The Old Age Pension State Medical Program provides limited medical care for individuals eligible for Old Age Pension grants.
- The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population.
- The School Health Services Program provides reimbursement to qualified school districts that provide health services to children enrolled in Medicaid.
- The Primary Care Fund, which is funded by taxes on tobacco products, provides an allocation of moneys to health care providers that provide basic health care services in an outpatient setting to residents of Colorado who are considered medically indigent.

The statutory authority for the Department can be found at Title 25.5 of the Colorado Revised Statutes.

25.5-4-104, C.R.S. Program of medical assistance - single state agency

*(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.*

25.5-8-104, C.R.S. Children's basic health plan – rules

*The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.*

25.5-3-104, C.R.S. Program for the medically indigent established - eligibility – rules

*(1) A program for the medically indigent is hereby established, to commence July 1, 1983, which ---shall be administered by the state department, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The state board may promulgate rules as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.*

**SMART Government Act**

The State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act (House Bill 10-1119) established a performance-based budgeting system for Colorado. Section 2-7-201, et seq., C.R.S., requires departments to create performance plans outlining their goals, and describe how those goals will be evaluated through performance measures. Performance plans are to be readily available to legislators and the public, and contain the following components:

- A statement of the department's mission or vision;
- A description of the major functions of the department;
- Performance measures for the major functions of the department;
- Performance goals that correspond to the department's performance measures and that extend to at least three years into the future;
- A narrative description of the strategies necessary to meet the performance goals; and
- A summary of the department's most recent performance evaluation.

House Bills 11-1212 and 13-1299 amended the SMART Government Act requiring incorporation of continuous process improvement systems based on lean government principles. The Department has adopted process improvement as a strategic goal in its Performance Plan, and established a Lean Community to drive innovative changes in work processes, deployment of staff, and organizational policy.

**Strategic Management Process**

In January 2012, the Department initiated a new Strategic Management Process which operates year-round to formulate, implement, and evaluate strategy. Strategy formulation activities in calendar year 2012 centered on development of a Department Strategy Map (see page 5) as the cornerstone of the Department's annual Performance Plan. In developing its Strategy Map, the Department recorded over 500 "touchpoints" or interactions with managers and staff who contributed to the development of goals, strategies and performance measures. External and internal assessments were completed to prioritize and distill themes from a Department analysis of strengths, weaknesses, opportunities and threats (SWOT). Distilled themes were mapped to six "lenses" commonly used across private, public, and non-profit sectors to evaluate business success: Customers; Communication; Technology; People; Process; and Financing. These lenses, paired with Department themes, formed the foundation for the Department's six strategic policy initiatives listed below, designed to ensure customer-focused performance management:

**Customer** – Improve health outcomes, client experience and lower per capita costs

**Communications** – Sustain effective internal and external relationships

**Technology** – Provide exceptional service through technological innovation

**People** – Build and sustain a culture of recruiting and retaining talented employees

**Process** – Enhance efficiency and effectiveness through process improvement

**Financing** – Ensure sound stewardship of financial resources

The Department monitors progress toward its goals and performance measures through a continuous evaluation process. Details about strategy implementation and evaluation, with comparisons of actual results to benchmarks, are provided within this Performance Plan.

**Department Performance Plan**

*Department Description*

The Department Description contains the Department's mission, vision, organizational chart and major program descriptions. This section is designed to give the reader a basic understanding of the Department, its divisions, organizational structure, and major programs.

*Strategic Policy Initiatives*

The Strategic Policy Initiatives section describes the Department's six long term strategies. These strategies are supported by goals and performance measures, representing department-wide efforts to bring about strategic changes at an organizational level. The corresponding narratives for each strategy explain the steps taken to achieve the Department's goals and fulfill its mission and vision.

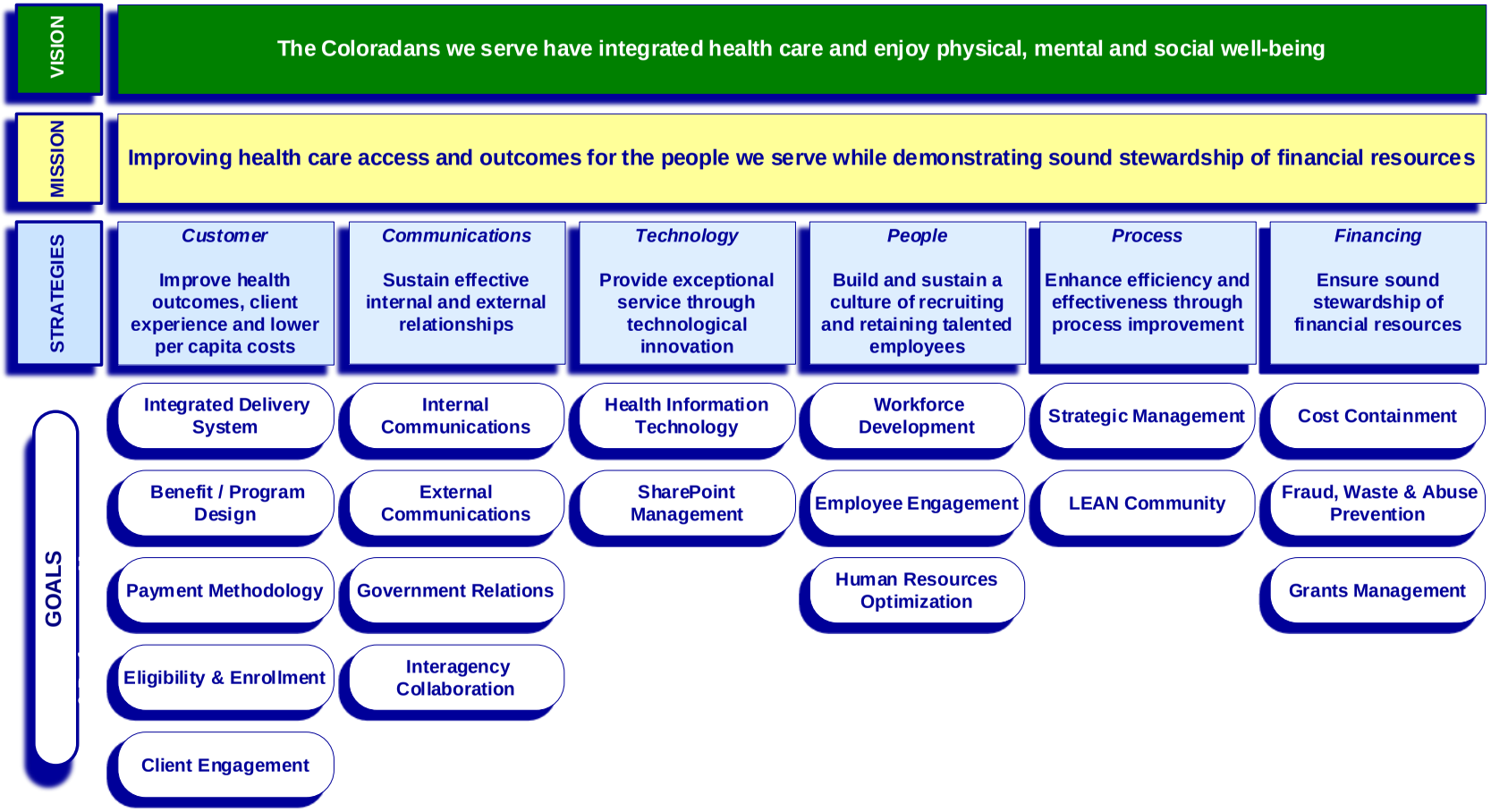
*Performance Measures*

The Performance Measures section contains tables of all the Department's performance measures. These tables include current-year and three-year projections, as well as available historical data for the preceding three years. Each measure is a key performance indicator that shows process flow from input to output.

*Strategy Map*

Due to the cross-functional nature of teamwork within the Department, its FY 2014-15 Performance Plan follows the strategy-based organization of its Strategy Map (see page 5). The Department's major functions are carried out by six major offices, which are described in the Department Description. These offices are responsible for achieving the goals and performance measures supporting the Department's six Strategic Policy Initiatives (SPIs). The first SPI has an external customer focus, while the remaining SPIs are designed to make the Department more efficient, customer-focused, and operationally effective.

# Department of Health Care Policy & Financing Strategy Map



**Strategic Policy Initiative: Customer**

*"Improve health outcomes, client experience and lower per capita costs"*

The Department continues to prioritize a customer-focused Medicaid program to achieve improved health outcomes and client experience delivered in a cost-effective manner. The Patient Protection and Affordable Care Act of 2010 (ACA) fundamentally reshaped the Medicaid landscape. By expanding access to health insurance coverage, instituting reforms to streamline service delivery and alter the nation's health care cost trajectory, the law seeks to address these issues in a way that improves the health, health care outcomes and client experience of people served by Medicaid. To this end, the Department's strategic policy initiative with regard to Customers is focused on achieving five goals, each having its own set of performance measures:

- Integrated Delivery System
- Benefit/Program Design
- Payment Methodology
- Eligibility & Enrollment
- Client Engagement

**Integrated Delivery System**

The Department's Goal for an Integrated Delivery System includes the establishment of the Accountable Care Collaborative (ACC). Additionally, Integrated Delivery also reduces emergency department visits by Medicaid clients seeking non-emergency care, reduces hospital readmissions, and expands provider choice among clients by recruiting new providers.

***Accountable Care Collaborative*:** The Accountable Care Collaborative (ACC) is one of the Department's primary reform efforts. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The ACC focuses on the needs of its members and leverages local resources to best meet those needs. Medicaid clients in the ACC receive the regular Medicaid benefit package and belong to a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP) as a medical home. The PCMP coordinates

STATE OF HEALTH GOAL:

Nearly 760,000 Coloradans lacked health insurance in 2011. Access to health insurance disproportionately affects rural populations and racial and ethnic minorities. The State of Colorado aims to significantly reduce the uninsured population by providing access to public and private insurance to at least 520,000 more Coloradans. This represents 250,000 additional Coloradans covered through Connect for Health Colorado and 271,000 covered by expansions made to the Medicaid program by the 2009 Colorado Health Care Affordability Act and the Affordable Care Act of 2010[1].

[1]*American Community Survey*, 2011, U.S. Census Bureau

and manages a client's health needs across specialties and along the continuum of care.

The four main goals of the ACC are to:
1) Ensure access to a focal point of care or medical home;
2) Coordinate medical and non-medical care and services;
3) Improve member and provider experiences; and
4) Provide the necessary data to support these goals and move them forward

*Goal targeted in State of Health: Colorado's Commitment to Become the Healthiest State.* As of May 2014, 524,984 individuals were enrolled in the ACC program. The Department's goal is to expand the ACC to reach 555,000 Coloradans by 2016 and connect them to a patient-centered medical home.

The following tables include the Department's data on ACC processes. The Department monitors five processes with regard to the ACC: the enrollment of individuals into the ACC; the enrollment of Medicaid adults into the ACC; the enrollment of Medicaid children into the ACC; the enrollment of primary care medical providers into the ACC; and the attribution of ACC clients to primary care providers in the RCCO network.

| Process: | Increase Enrollment of Medicaid Recipients into the ACC | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Individuals Served Through Colorado Medicaid | 598,322 | 659,104 | 813,459 | 970,100 | TBD |
| **Output:** | # ACC Enrollees | 78,870 | 226,499 | 485,533 | 726,413 | TBD |
| **Outcome:** | % ACC Enrollees of Total Medicaid Population | 13.2% | 34.4% | 59.7% | 74.9% | TBD |

Counts based upon annual average of monthly enrollment

| Process: | Enroll ACC Eligible Medicaid Adults into the ACC | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # ACC Eligible Medicaid Adults (age 21 and older excluding Duals) | TBD | 125,435 | 379,752 | 440,214 | 576,441 |
| **Output:** | # Adult ACC Enrollees (age 21 and older excluding Duals) | TBD | 82,871 | 201,745 | 402,666 | TBD |
| **Outcome:** | % Adults Enrolled in ACC | TBD | 66.1% | 53.1% | 91.5% | TBD |

Counts based upon annual average of monthly enrollment. Does not include Disabled.

| Process: | Enroll ACC Eligible Medicaid Children into ACC | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # ACC Eligible Medicaid Children (up to age 21) | TBD | 248,599 | 415,380 | 458,182 | 576,340 |
| **Output:** | # Child ACC Enrollees (up to age 21) | TBD | 121,951 | 248,965 | 270,587 | TBD |
| **Outcome:** | % Children Enrolled in ACC | TBD | 49.1% | 59.9% | 59.1% | TBD |

Counts based upon annual average of monthly enrollment. Does not include Disabled.

| Process: | Enroll Primary Care Providers into the ACC Program | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # Medicaid Primary Care Providers eligible for ACC Enrollment | TBD | TBD | TBD | TBD | TBD |
| Output: | # Unique ACC Primary Care Medical Provider Sites | TBD | 135 | 443 | 457 | 513 |
| Outcome: | % ACC Eligible PCPs enrolled as ACC PCMP | 39.0% | 71.0% | 54.0% | 56.0% | 61.0% |

Primary Care Medical Providers (PCMP) are here defined as site locations

| Process: | Attribute ACC Clients to Primary Care Providers in RCCO Network | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # ACC Enrollees | 78,870 | 226,499 | 485,533 | 726,413 | TBD |
| Output: | # ACC Enrollees w PCMP | N/A | 173,126 | 323,254 | 505,829 | TBD |
| Outcome: | % ACC Enrollees w PCMP | N/A | 76.4% | 66.6% | 69.6% | TBD |

Counts based upon annual average of monthly enrollment

***Emergency Department Visits*:** Reduction of the rate of emergency department visits in Colorado to the national Medicaid Health Maintenance Organization average is a Key Performance Indicator (KPI) for organizations within the Accountable Care Collaborative. Clients who access emergency departments for non-urgent care are placed into a Client Overutilization Program, and the Department is evaluating efforts in other states to identify best practices including the possibility of expanding use of urgent care centers.

Emergency Department visits is a new measure included in the Hospital Quality Incentive Payment (HQIP) program this year. Hospital participation in the measure progresses from implementing up to three initiatives designed to reduce Emergency Department visits this year to implementing up to five initiatives in 2015 to decrease the statewide visit rate in 2016.

The following table includes the Department's data for the reduction of emergency department visits.

| Process: | Reduce Emergency Department Visits | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # Medicaid Fee-for-Service Member Months Per Thousand | 549,615 | 607,241 | 664,293 | 790,509 | 888,216 |
| Output: | # Medicaid Fee-for-Service Emergency Dept Visits | 463,731 | 523,071 | 556,782 | 645,846 | 668,826 |
| Outcome: | # Emergency Dept Visits per Thousand Member Months | 844 | 861 | 838 | 817 | 753 |

***Hospital Readmissions:*** The hospital readmission rate is a Key Performance Indicator for Regional Care Collaborative Organizations. For measuring the hospital readmission rate, readmissions rather than clients are counted for a period of 30 days after the initial hospitalization using data from paid claims. A collaborative effort between the Center for Improving Value in Health Care, Colorado Hospital Association, Colorado Regional Health Information Organization, and the Department resulted in a statewide initiative focused on reducing hospital readmissions.

The HQIP program included the 30-day hospital readmission as a quality measure in 2013 and it will continue for 2014. Hospitals are eligible for incentive payments if the 30-day readmission rates decreased from the previous year. The rate is diagnosis independent and reflects readmissions for any reason.

The following table illustrates the percentage of hospital readmissions within 30 days of discharge.

| Process: | Reduce Hospital Readmissions | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # Acute Care Inpatient Hospital Discharges | 52,172 | 55,266 | 67,977 | 80,893 | 90,891 |
| Output: | # Hospital Readmission Events within 30 Days of Discharge | 5,398 | 6,185 | 7,308 | 8,494 | 9,089 |
| Outcome: | % Hospital Readmissions within 30 Days of Discharge | 10.3% | 11.2% | 10.8% | 10.5% | 10.0% |

***Medicaid Providers:*** During 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 to retain Medicaid providers, assist prospective providers in the enrollment process, and recruit new providers. The Department's Regional Care Collaborative Organizations also encourage providers to enroll in Medicaid and to enroll in the Accountable Care Collaborative program. In addition, the Department's Clinical Services Office networks with providers and professional organizations to recruit new providers on an ongoing basis. Recognizing the need for dedicated resources to address provider recruitment, retention and relations, the Department established a Provider Relations Unit in March 2014. This unit will focus on ensuring that Colorado Medicaid has an adequate and comprehensive network of quality providers that meet high standards for physical, behavioral, dental and long-term services.

The following tables illustrate the number of providers and physicians serving Medicaid in support of efforts to enroll new Medicaid providers, the increase of ACC Primary Care Medical Provider Sites, and the improvement of access to Medicaid Primary Care Providers.

| Process: | Enroll New Medicaid Providers | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | # Colorado Providers Serving Medicaid | 36,537 | 39,821 | 42,800 | 44,996 | 50,845 |

| Process: | Increase the Number of Unique ACC Primary Care Medical Provider Sites | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | # Unique ACC Primary Care Medical Provider Sites | TBD | 135 | 443 | 457 | 513 |

| Process: | Improve Access to Medicaid Primary Care Providers | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | # Colorado Primary Care Providers Serving Medicaid | 14,747 | 16,641 | 18,422 | 20,393 | 24,990 |

***Behavioral Health Services:*** Integrating behavioral health and physical health is a key priority for the Department. Traditionally, mental health and substance use services have been systemically separated from physical health services, worsening a cultural stigma often attached to individuals in need of care. A health system in which physical health is separated from behavioral health — and in which only one condition is treated at a time — results in poor quality and high costs. Integrated care is a proven approach to reduce costs, support better outcomes, and improve the experience of care for individuals who have both physical and behavioral conditions.

The Department's Community Behavioral Health Services program is a statewide managed care program that provides comprehensive behavioral health services to all Coloradans enrolled in Medicaid. Medicaid members are assigned to a Behavioral Health Organization (BHO) based on where they live. BHOs arrange or provide for medically necessary behavioral health services to the clients in their service areas. In November 2013, the Department published a Request for Proposals (RFP) to re-procure the BHO contracts. Among other stipulations, the RFP included requirements for behavioral health integration, trauma informed care and care coordination. The Department also integrated the limited fee-for-service substance use disorder (SUD) benefit into the BHO managed care contract, with the addition of two new services – Medication Assisted

The following tables illustrate the number of Medicaid clients that currently received a Behavioral Health Office service. This process will measure the percentage of BHO clients that utilize at least one Behavioral Health service.

Treatment and Peer Advocate Services.

| Process: | Increase Medicaid Clients Receiving a BHO Service | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # BHO Clients | 598,322 | 659,104 | 813,459 | 970,100 | 1,086,103 |
| **Output:** | # BHO Clients Receiving a BHO Service | 80,681 | 88,829 | TBD | TBD | TBD |
| **Outcome:** | % BHO Clients Receiving a BHO Service | 13.5% | 13.5% | TBD | TBD | TBD |

## Benefit/Program Design

The Department uses the evidence-based Benefits Collaborative process to define benefit coverage standards and incorporate them into rule, ensuring that covered services are limited to those necessary and effective to provide quality health care. The Department is also working through the Community Living Advisory Group, established under Executive Order D 2012-027, to redesign Long Term Services and Supports (LTSS) delivery system, to promote person-centered care wherever a person chooses to reside. The Colorado Choice Transitions (CCT) program, made possible by a five-year $22 million federal grant, is designed to build Home and Community Based Services (HCBS) infrastructure to assist residents of long term care facilities transition to the community with the services and supports to live as independently as possible. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 enrolled in Medicaid. In addition, the Department's Benefits Collaborative process has developed more than a dozen benefit coverage standards, including standards for home health and dental services.

***Benefit Coverage Standards*:** The Department achieves its Benefit Coverage Standards through the Benefits Collaborative, a public process that ensures standards are based on the best available clinical evidence; outline the appropriate amount, duration, and scope of services; set reasonable service limits; and promote the health and functioning of clients. By defining Benefit Coverage Standards through the Benefits Collaborative Process and including amount, scope and duration parameters in rule, the Department ensures appropriate utilization, equity, and consistency in the delivery of Medicaid services. Clearly defined standards help improve guidance for service providers, increase client understanding of their benefits and ensure responsible allocation of taxpayer dollars.

The following table includes data for Medicaid benefits defined by the Benefits Collaborative.

| Process: | Increase Medicaid Benefits Defined by Collaborative | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # of Medicaid Benefits to be Defined by Collaborative | 67 | 70 | 70 | 75 | 80 |
| **Output:** | # Medicaid Benefits Defined by Collaborative | N/A | 1 | 13 | 23 | 47 |
| **Outcome:** | % Medicaid Benefits Defined by Collaborative | N/A | 1.4% | 18.6% | 30.7% | 58.8% |

***Long Term Services & Supports:*** The Long Term Services and Supports Division oversees Medicaid Home and Community Based Services (HCBS) waiver programs, nursing facilities, the Program of All-Inclusive Care for the Elderly (PACE) and hospital back-up. HCBS provides services in clients' homes and communities as an alternative to placement in a nursing facility or other institutional setting. The division is also responsible for managing consumer-directed attendant support services which allow qualifying individual clients to direct their own care.

The following tables include data with regard to long term care and Home and Community Based Services (HCBS). The Department monitors placement of appropriate long term care clients into nursing facilities, provision of waiver and PACE services to appropriate long term care clients, per capita nursing facility costs, and per capita HCBS costs.

| Process: | Place Appropriate Long-Term Care Clients in Nursing Facilities | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # LTSS Clients | 42,965 | 44,979 | 46,226 | 52,016 | 55,623 |
| **Output:** | # LTSS Clients in Nursing Facilities | 9,570 | 9,511 | 9,437 | 9,398 | 9,444 |
| **Outcome:** | % LTSS Clients in Nursing Facilities | 22.3% | 21.1% | 20.4% | 18.1% | 17.0% |

| Process: | Provide Waiver Services to Appropriate Long-Term Care Clients | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # LTSS Clients | 42,965 | 44,979 | 46,226 | 52,016 | 55,623 |
| **Output:** | # LTSS Clients Receiving HCBS | 31,324 | 33,051 | 34,211 | 39,676 | 42,589 |
| **Outcome:** | % LTSS Clients Receiving HCBS | 72.9% | 73.5% | 74.0% | 76.3% | 76.6% |

| Process: | Provide PACE Services to Appropriate Long-Term Care Clients | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # LTSS Clients | 42,965 | 44,979 | 46,226 | 52,016 | 55,623 |
| **Output:** | # LTSS Clients Enrolled in PACE | 2,055 | 2,402 | 2,578 | 2,942 | 3,590 |
| **Outcome:** | % LTSS Clients Enrolled in PACE | 4.8% | 5.3% | 5.6% | 5.7% | 6.5% |

| Process: | Reduce Growth Rate of Per Capita Nursing Facility Costs | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # LTSS Clients in Nursing Facilities | 9,570 | 9,511 | 9,437 | 9,398 | 9,444 |
| **Output:** | $ Total Cost for Nursing Facilities | $521,244,769 | $532,405,250 | $550,941,713 | $556,980,209 | TBD |
| **Outcome:** | $ Per Capita Cost for Nursing Facilities | $54,467 | $55,978 | $58,381 | $59,266 | TBD |

| Process: | Reduce Growth Rate of Per Capita HCBS Costs | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # LTSS Clients Receiving HCBS | 31,324 | 33,051 | 34,211 | 39,676 | 42,589 |
| **Output:** | $ Total Cost for HCBS Services | $272,008,186 | $293,492,008 | $351,353,558 | $379,434,321 | TBD |
| **Outcome:** | $ Per Capita Cost for HCBS | $8,684 | $8,880 | $10,270 | $9,563 | TBD |

*Goal targeted in State of Health: Colorado's Commitment to Become the Healthiest State.* The Department's goal is to transition 100 individuals each year from long term care institutions to community-based settings through 2017. This represents 500 individuals federally funded by grant. Transitioning these individuals into community-based care will dramatically improve their quality of life, and provide more cost-effective care.

The Colorado Choice Transitions (CCT) program is made possible by a five-year federal grant designed to build Home and Community Based Services (HCBS) infrastructure to assist residents of long term care facilities transition to and receive services in a home of their choice. Clients receive additional services such as case management, independent-living skills training, and community transition services for one year in addition to traditional community-based services already available in the Medicaid HCBS programs.

The table below represents the Department's data with regard to the Colorado Choice Transitions program.

| Process: | Transition Appropriate Nursing Facility Clients to Community Care | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # LTSS Clients in Nursing Facilities | 9,570 | 9,511 | 9,437 | 9,398 | 9,444 |
| **Output:** | # NF Clients Transitioned to HCBS | N/A | 4 | 39 | 100 | 100 |
| **Outcome:** | % NF Clients Transitioned to HCBS | N/A | 0.0% | 0.4% | 1.1% | 1.1% |

***Medicaid Children Well Child Visits:*** The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 enrolled in Medicaid. EPSDT ensures that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. The Department and each Regional Care Collaborative Organization work with Healthy Communities to communicate what a well-child visit is and when it can be done, with the ultimate goal of reaching the federal requirement of 80% of eligible children receiving at least one well-child visit within the measurement year.

Due to EPSDT methodology changes in 2013, requiring 90 days of eligibility, children who have a well-child check in the first 90 days are not counted in the new methodology. The Department tracks well child visits as defined by HEDIS annually and is being used to report, track and trend the number of children 15 months of age with no annual well-child visits in FY 2013-14.

In FY 2013-14, the Department selected well-child visits as a Key Performance Indicator for the Accountable Care Collaborative (ACC). The Regional Care Collaborative Organizations (RCCOs) have been partnering with Healthy Communities to educate providers on the components of a well-child visit and why they are important. Additionally, the Department has adopted the Bright Futures periodicity schedule, whose guidelines recommend at least one well-child visit each year for children 21 and under.

The following table includes data with regard to well-child visits for children. The data reflects children with no annual-well child visits in the first 15 months of life. Low rates are favorable for this particular measure.

| Process: | Promote Well-Child Visits | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Medicaid Children (15 months of age) | TBD | 16,253 | TBD | TBD | TBD |
| **Output:** | # Children 15 months of age with no Annual Well Child Visits | TBD | TBD | TBD | TBD | TBD |
| **Outcome:** | % Children with no Annual Well-Child Visit in the first 15 months of life | 2.1% | 1.9% | 1.5% | TBD | TBD |

***Prevention and Wellness****:* The Department is taking a proactive role in promoting preventive health and wellness services for its Medicaid clients. For example, the Department has launched depression-specific educational campaigns targeting adolescents, youth and adults. Among the recommendations for prevention and wellness for Medicaid clients, the U.S. Preventive Services Task Force (USPSTF) recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. The USPSTF also recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.

In January 2014, the Affordable Care Act (ACA) expanded Medicaid benefits to cover adult depression screenings. The Department worked with stakeholders to select adolescent and adult depression screenings as one of the quality indicators that must be achieved in order to participate in shared savings.

Preventive oral healthcare is also a Department priority, as there is a strong correlation between positive oral health outcomes and the general health and wellness of children in the Medicaid and Child Health Plan *Plus* (CHP+) programs. Although recommended by the American Dental Association and the American Academy of Pediatrics, only 3% of children were visiting the dentist before their first birthday in 2010. Medicaid covers dental services for all child enrollees as part of a set of comprehensive benefits, referred to as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The CHP+ program provides medical and dental

coverage for uninsured Colorado children through age 18 whose families earn too much to qualify for Medicaid but cannot afford private insurance.

The following tables include data with regard to prevention and wellness. The Department monitors adolescents and adults screened for depression, preventive dental services for Medicaid and CHP+ eligible children, and the percentage of low birth-weight newborns.

| Process: | Promote Adolescent Depression Screening | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # Medicaid Adolescents (age 11-20) | 117,158 | 133,306 | 163,966 | 195,120 | 219,237 |
| Output: | # Adolescents Screened for Depression | 1,914 | 4,436 | 6,559 | TBD | TBD |
| Outcome: | % Adolescents Screened for Depression | 1.6% | 3.3% | 4.0% | 5.0% | 7.0% |

| Process: | Promote Adult Depression Screening | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # Medicaid Adults (age 21+ excluding Duals) | 183,166 | 209,617 | 257,829 | 306,816 | 344,739 |
| Output: | # Adults Screened for Depression | TBD | TBD | TBD | TBD | TBD |
| Outcome: | % Adults Screened for Depression | TBD | TBD | 2.0% | 3.0% | 5.0% |

| Process: | Promote Preventive Dental Services for CHP+ Kids | 3 Yrs - Actuals | | | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | FY2013-14 | FY2014-15 | FY2016-17 |
| Input: | # CHP+ Children (age 0-18) | TBD | TBD | TBD | TBD | TBD |
| Output: | # CHP+ Children Receiving a Dental Service | TBD | TBD | TBD | TBD | TBD |
| Outcome: | % CHP+ Children Receiving a Dental Service | 39.6% | 41.6% | 41.9% | TBD | TBD |

| Process: | Promote Preventive Dental Services for Medicaid Kids | 3 Yrs - Actuals | | | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | FY2013-14 | FY2014-15 | FY2016-17 |
| Input: | # Medicaid Children (up to age 21) | 391,253 | 420,440 | 481,579 | 531,740 | 648,281 |
| Output: | # Medicaid Children Receiving a Dental Service | 198,991 | 214,706 | 232,634 | 259,600 | 323,272 |
| Outcome: | % Medicaid Children Receiving a Dental Service | 50.9% | 51.1% | 48.3% | 48.8% | 49.9% |

| Process: | Prevent Low Birth-Weight Babies | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # Medicaid Women with Child Delivery | 21,431 | 22,101 | 27,184 | 32,349 | 36,348 |
| Output: | # Newborns Weighing <2500 Grams | 2,843 | 3,067 | 3,115 | TBD | TBD |
| Outcome: | % Low Birth-Weight Newborns | 13.3% | 13.9% | 14.0% | 13.0% | 13.0% |

## Payment Methodology

The Department's goal for payment methodology reform is intended to transition the current system away from a traditional fee-for-service model to a system that aligns financial incentives with client outcomes and rewards performance. Many of the new pay-for-performance methodologies are new to the health care industry and will require extensive stakeholder engagement and outreach to ensure full and consistent implementation. Additionally, data analytics capacity and infrastructure must be in place in order to ensure effective evaluation of the new systems. The results of this reform are likely to impact all Medicaid clients, and may fundamentally change some of Medicaid's core operations.

***ACC Net and Per Capita Savings*:** In FY 2011-12, the Department conservatively estimated $34 per member per month (PMPM) in gross savings across the ACC and estimates that this amount has decreased approximately 10% in the past fiscal year as healthier clients have been enrolled in the ACC in greater numbers. This equates to $30.60 PMPM in gross savings, totaling $44.3 million in gross savings – or $6.3 million net savings – in FY 2012-13. The method used to arrive at these estimates compared costs for ACC enrollees against costs for clients not enrolled in the ACC. Rather than compare costs of the two groups in the same year, the Department used baseline cost data from before the implementation of the ACC and applied an actuarially determined growth rate to account for medical inflation and create a benchmark for comparison.

The following tables include data with regard to both ACC and Fee-for-Service. The Department monitors per capita costs for children, adults, and persons with disabilities.

| Process: | Reduce Growth Rate of Per Capita Costs - ACC Children | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Child ACC Enrollees (up to age 21) | TBD | 121,951 | 248,965 | 270,587 | TBD |
| **Output:** | $ Total - ACC Children | N/A | $174,879,414 | $391,270,904 | $398,877,708 | TBD |
| **Outcome:** | $ Per Capita - ACC Children | N/A | $1,434 | $1,572 | $1,474 | $1,406 |

Not risk adjusted. Based on MSP aggregate per-capita expenditures by population - adjusted for expected saving. The Department will retrospectively adjust figure to account for difference in case mix.

| Process: | Reduce Growth Rate of Per Capita Costs - ACC Adults | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Adult ACC Enrollees (age 21 and older excluding Duals) | TBD | 82,871 | 201,745 | 402,666 | TBD |
| **Output:** | $ Total - ACC Adults | N/A | $228,167,596 | $915,141,547 | $1,865,253,605 | TBD |
| **Outcome:** | $ Per Capita - ACC Adults | N/A | $2,753 | $4,536 | $4,632 | $4,706 |

Not risk adjusted. Based on MSP aggregate per-capita expenditures by population - adjusted for expected saving. The Department will retrospectively adjust figure to account for difference in case mix.

| Process: | Reduce Growth Rate of Per Capita Costs - ACC Disabled | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # ACC Disabled | N/A | 21,677 | 34,823 | 53,160 | 72,281 |
| **Output:** | $ Total - ACC Disabled | N/A | $199,265,912 | $522,775,412 | $805,320,308 | $1,102,468,975 |
| **Outcome:** | $ Per Capita - ACC Disabled | N/A | $9,193 | $15,012 | $15,149 | $15,253 |

Not risk adjusted. Based on MSP aggregate per-capita expenditures by population - adjusted for expected saving. The Department will retrospectively adjust figure to account for difference in case mix.

| Process: | Reduce Growth Rate of Per Capita Costs - Non-ACC Children | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # FFS Non-ACC Children | TBD | 187,199 | 199,459 | 184,453 | 181,878 |
| **Output:** | $ Total - FFS Non-ACC Children | TBD | $356,732,030 | $350,513,290 | $305,662,600 | $288,630,944 |
| **Outcome:** | $ Per Capita - FFS Non-ACC Children | TBD | $1,906 | $1,757 | $1,657 | $1,587 |

Fee-for-Service (FFS)

| Process: | Reduce Growth Rate of Per Capita Costs - Non-ACC Adults | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # FFS Non-ACC Adults | TBD | 141,552 | 60,349 | 24,520 | 11,308 |
| **Output:** | $ Total - FFS Non-ACC Adults | TBD | $1,186,892,287 | $569,651,109 | $249,830,602 | $122,167,582 |
| **Outcome:** | $ Per Capita - FFS Non-ACC Adults | TBD | $8,385 | $9,439 | $10,189 | $10,804 |

Fee-for-Service (FFS)

| Process: | Reduce Growth Rate of Per Capita Costs - Non-ACC Disabled | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # FFS Non-ACC Disabled | TBD | 48,096 | 30,366 | 26,251 | 18,102 |
| **Output:** | $ Total - FFS Non-ACC Disabled | TBD | $723,208,009 | $473,451,793 | $413,796,613 | $287,707,292 |
| **Outcome:** | $ Per Capita - FFS Non-ACC Disabled | TBD | $15,037 | $15,592 | $15,763 | $15,893 |

Fee-for-Service (FFS)

***ACC Pay for Performance and Payments Linked to Outcomes:*** The Department is transitioning from a pay-for-volume system to a pay-for-value system by creating financial incentives for providers to maintain and improve client health outcomes and medical service utilization. The ACC provides a per-member, per-month payment to Regional Care Collaborative Organizations (RCCOs) to coordinate client care. In July 2012, the Department began withholding one dollar of the per-member per-month (PMPM) capitation paid to ACC RCCOs and Primary Care Medical Providers (PCMPs) for a pay-for-performance incentive plan. The RCCOs and PCMPs may recover this dollar if certain thresholds are achieved as measured by four Key Performance Indicators (KPIs): Hospital All-Cause Thirty (30) Day Readmissions, Emergency Room (ER) Visits, High Cost Imaging Services, and Well Child Visits. This incentivizes RCCOs to meet or exceed quality and cost containment metrics, while the savings directly lower costs to the state. A November 1, 2012 impact analysis of the ACC indicates reduced rates in these areas when compared with clients not enrolled in the program.

The tables below include data with regard to ACC pay for performance and payments linked to outcomes. The Department monitors ACC net savings, provider payments linked to outcomes, and ACC pay for performance.

| Process: | Achieve ACC Net Savings Targets | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | $ Total ACC Admin Costs (payments to RCCOs, PCMPs, SDAC) | $17,907,833 | $40,921,370 | $80,855,667 | $119,120,223 | $164,176,208 |
| **Output:** | $ ACC Gross Savings Per Member Per Month | $30 | $22 | $22 | $17 | $18 |
| **Outcome:** | $ ACC Net Savings (Range Minimum) | ($2,708,711) | ($6,930,854) | ($14,114,438) | ($20,061,005) | ($27,122,101) |

| Process: | Link Payments to Outcomes | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | $ Total Acute Care Expenditure | $1,797,425,015 | $1,964,342,304 | $2,603,236,494 | $3,227,441,120 | $3,605,974,939 |
| **Output:** | $ Total Provider Incentive Payments (ACC, HMO, NFs, HQIP) | TBD | TBD | TBD | TBD | TBD |
| **Outcome:** | % Provider Payments Linked to Outcomes | 1.5% | 1.6% | 1.8% | 2.1% | 3.3% |

Hospital Quality Incentive Payment (HQIP)

| Process: | Promote ACC Pay for Performance | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Regional Care Collaborative Organizations | 7 | 7 | 7 | 7 | 7 |
| **Output:** | # RCCOs Achieving Level 1 Pay for Performance on at least three Key Performance Indicators for at least one quarter of the Fiscal Year | N/A | 5 | 0 | 1 | 2 |
| **Outcome:** | % RCCOs Achieving Level 1 Pay for Performance | N/A | 71.4% | 0.0% | 14.3% | 28.6% |

Regional Care Collaborative Organization (RCCO)

***Hospital Quality Incentive Payment (HQIP) program:*** The HQIP program provides for hospital incentive payments based on performance related to improving health care outcomes for their patients. The HQIP program is a collaboration between the Department and hospitals to identify the quality measures and payment structure of the incentive payments. Work of the HQIP subcommittee is overseen by the Hospital Provider Fee and Oversight Advisory Board. Quality measures and payment structure used to assess performance are defined by the rules of the state Medical Services Board. Hospitals submit quality outcome data to the HQIP subcommittee on an annual basis and in return are eligible to receive incentive payments based on their performance in relation to other hospitals or national averages when possible. The HQIP subcommittee operates under the guidelines of the Triple Aim: improving population health, improving the patient experience and reducing the cost of care.

Two recent goals of the HQIP subcommittee are to increase the number of hospitals eligible to receive an incentive payment and to focus on measures affecting the Medicaid client population. The subcommittee is working hard to identify quality measures that apply to rural hospitals and hospitals that do not perform deliveries for implementation in FY 2015-16.

The table below contains data with regard to increasing the percentage of hospitals that participate in HQIP.

| Process: | Promote Hospital Participation in HQIP | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Hospitals Eligible to Submit Data for all HQIP Measures | 66 | 86 | 86 | 86 | 86 |
| **Output:** | # Eligible Hospitals Submitting Data for all HQIP Measures | 40 | 36 | TBD | TBD | TBD |
| **Outcome:** | % Eligible Hospitals Submitting Data for all HQIP Measures | 60.6% | 41.9% | 45.0% | 65.0% | 75.0% |

Hospital Quality Incentive Payment (HQIP)

## Eligibility & Enrollment

The Department's goal for Eligibility and Enrollment includes improving client access to quality health care services by enrolling eligible clients into Medicaid, and once enrolled, supporting continuous enrollment if clients remain eligible. The Patient Protection and Affordable Care Act of 2010 (ACA) expanded access to health care in a variety of ways. In addition, the Colorado legislature passed HB 09-1293 "Colorado Health Care Affordability Act" and SB 13-200 "Expand Medicaid Eligibility" expanding Medicaid coverage for low-income Coloradans. In addition to these Medicaid expansions, the legislature also passed SB 11-200 "Health Benefit Exchange" to provide a framework for Coloradans to be able to purchase health insurance through the new state health insurance exchange, known as Connect for Health Colorado. The Department is working closely with Connect for Health Colorado on a "no wrong door" approach for finding health care coverage in Colorado. Clients may apply online, in person, by phone, or using a paper application to find out if they are eligible for Medicaid, CHP+, or for financial assistance to offset the cost of private insurance.

***Timely Eligibility Determinations and Redeterminations:*** Eligibility sites statewide process eligibility determinations and redeterminations in order to enroll clients in the appropriate Medicaid program. This must be accomplished within established standards for processing timeliness. Through communication and outreach efforts with counties and medical assistance sites, the Department has heightened awareness of timeliness, processing standards, and corrective action plans to ensure timely processing of eligibility determinations and redeterminations. This occurs through weekly and monthly reports to eligibility sites on timeliness percentages, site visits, focused technical assistance, trainings and funds for eligibility staff to perform overtime. Furthermore, the Department trains eligibility sites on process improvements and Lean techniques to provide ongoing support to sites as they initiate changes.

The tables below include data with regard to eligibility. The Department monitors timely eligibility determinations and redeterminations.

| Process: | Increase Timely Eligibility Determinations | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Medicaid Applications Processed | 408,237 | 405,795 | 676,387 | 696,679 | 739,106 |
| **Output:** | # Eligibility Applications Processed Timely | 330,669 | 364,783 | 623,682 | 654,878 | 708,064 |
| **Outcome:** | % Eligibility Applications Processed Timely | 81.0% | 89.9% | 92.2% | 94.0% | 95.8% |

| Process: | Increase Timely Eligibility Redeterminations | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Eligibility Redeterminations Processed | 977,692 | 1,289,646 | 1,394,325 | 1,436,155 | 1,523,617 |
| **Output:** | # Eligibility Redeterminations Processed Timely | 697,690 | 1,173,681 | 1,305,460 | 1,381,581 | 1,505,334 |
| **Outcome:** | % Eligibility Redeterminations Processed Timely | 71.4% | 91.0% | 93.6% | 96.2% | 98.8% |

The tables below include data with regard to long term care enrollments through the Community Living Office. The Department monitors enrollment into the Children's Extensive Support (CES) Waiver, the Developmental Disabilities (DD) Waiver, and the Supported Living Services (SLS) Waiver, including changes in the number of individuals on waiting lists for these waivers.

| Process: | Increase Enrollment for Children's Extensive Support (CES) Waiver | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Individuals on CES Waiver Waiting List | N/A | TBD | 375 | 0 | 0 |
| **Output:** | # Individuals Enrolled through CES Waiver | 364 | 356 | 704 | 1,285 | 1,429 |
| **Outcome:** | % of CES Eligible Individuals in Need of Immediate Services Enrolled | N/A | TBD | 65.2% | 100.0% | 100.0% |

% of total eligible individuals in need calculation = # on wait list/(# enrolled + # on wait list)

| Process: | Increase Enrollment for Developmental Disabilities Services (DD) Waiver | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Individuals on DD Waiver Waiting List | N/A | TBD | 1,641 | 1,750 | 1,920 |
| **Output:** | # Individuals Enrolled through DD Waiver | 4,171 | 4,173 | 4,648 | 4,818 | 4,868 |
| **Outcome:** | % of DD Eligible Individuals in Need of Immediate Services Enrolled | N/A | TBD | 73.9% | 73.4% | 71.7% |

% of total eligible individuals in need calculation = # on wait list/(# enrolled + # on wait list)

| Process: | Increase Enrollment for Supported Living Services (SLS) Waiver | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Individuals on SLS Waiver Waiting List | N/A | TBD | 1,473 | 0 | 0 |
| **Output:** | # Individuals Enrolled through SLS Waiver | 3,052 | 3,088 | 3,134 | 5,471 | 5,549 |
| **Outcome:** | % of SLS Eligible Individuals in Need of Immediate Services Enrolled | N/A | TBD | 68.0% | 100.0% | 100.0% |

% of total eligible individuals in need calculation = # on wait list/(# enrolled + # on wait list)

***Expand Public and Private Health Insurance Coverage:*** Implementation of the Affordable Care Act will ensure Coloradans have adequate health insurance coverage and build more value into health insurance while bending the healthcare cost curve. The Department is partnering to expand private insurance coverage through Connect for Health Colorado, Colorado's health insurance exchange, and has expanded Medicaid to cover all Coloradans living on less than 133% of the Federal Poverty Level. By leveraging federal funds and partnerships, Colorado will implement both of these approaches with no impact to the state's General Fund.

The following tables contain data with regard to the number of individuals enrolled through Connect for Health Colorado into Medicaid and subsidized health insurance.

| Process: | Enroll Individuals into Medicaid through the Connect for Health Colorado Marketplace (C4HC) | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Output:** | # Determined Medicaid-Eligible through C4HC | N/A | N/A | 178,508 | TBD | TBD |

| Process: | Enroll Individuals into Subsidized Insurance through the Connect for Health Colorado Marketplace (C4HC) | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Signed up for Private Health Insurance through (C4HC) | N/A | N/A | 127,233 | TBD | TBD |
| **Output:** | # Individuals Enrolled into Subsidized Insurance through C4HC | N/A | N/A | 75,067 | TBD | TBD |
| **Outcome:** | % C4HC Enrollees Eligible for Financial Assistance | N/A | N/A | 59.0% | TBD | TBD |

Source: Connect for Health Colorado through 4/15/2014

## Client Engagement

To define how health care quality and health improvement functions can be informed by client and family input, the Department has identified client engagement as a strategic priority — the first step in transforming relationships with clients, families and other stakeholders into positive, productive and meaningful collaborations. Client engagement redefines health care relationships by placing an emphasis on collaboration with clients of all ages, at all levels of care, and in all settings. This approach shifts the relationship between health care professionals, clients, and their

families from the traditional focus of "doing to and for" them, and instead embraces the approach of partnering with clients and families. The Department's goal for Client Engagement includes building effective engagement strategies and competence in these new collaborative partnerships. Educational and training plans for all employees are also underway, helping them learn how to effectively involve clients in benefits design, get input on key initiatives, and prepare clients and others to serve as advisors to the Department. Creating an environment where clients and families are more involved in their health care allows those same clients and families to act as community liaisons and inspire others to actively participate in their own health and wellness.

***CAHPS Ratings:*** To improve the health care experience of clients, the Department uses an annual client satisfaction survey – the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report for Adults in Medicaid. This survey allows clients who recently interacted with the Department to gauge their experience and provide input regarding satisfactory outcomes and areas of improvement. The survey includes four ratings measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often and Getting Needed Care. The Department uses the results of the CAHPS survey to identify opportunities to improve client experience and implement appropriate changes through its contracts for health care services.

The following table includes data with regard to the Consumer Assessment of Healthcare Providers and Systems Report. The Department monitors client satisfaction with health care experience based on the four global ratings measures described above as compared to the national average.

| Process: | Improve Client Satisfaction with Health Care Experience | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # CAHPS Global Ratings Measures | 4 | 4 | 4 | 4 | 4 |
| Output: | # Measures ≥ National Average | 4 | 2 | TBD | 4 | 4 |
| Outcome: | % Measures ≥ National Average | 100.0% | 50.0% | TBD | 100.0% | 100.0% |

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

***Call Center Management:*** The Department's call center is focused on improving productivity to increase the number of calls answered and reduce calls abandoned. Call center processes are being evaluated using Lean strategies with the aim of reducing staff handling and processing time. The Department has received money through a budget appropriation for new Customer Relationship Management (CRM) software. This new software will allow for easy mining of call data, and there are funds budgeted for a contract to help conduct focus groups involving clients and stakeholders.

New technological solutions in the form of CRM software and an Interactive Voice Response (IVR) system will allow clients to automate services that previously required an agent. This will enable agents to provide first contact resolution more effectively for clients. The additional call volume expected from eligibility expansions under the Affordable Care Act, and time required to procure and implement the new technology, have challenged the call center's efforts to reach its target 72% answer rate and 28% abandon rate during FY 2013-14. As an example of the

Affordable Care Act's impact on the center, call volume from FY 2013-14 increased by more than 86,000 calls, a 42% increase as compared to volume from FY 2012-13.

With the addition of new technological solutions, the call center can now track performance more precisely. With enhanced reporting of data, the center is also expanding on how performance is measured. In addition to answer rate, the center is working to capture data on First Contact Resolution (FCR) to further assess the effectiveness and efficiency of the center.

The table below includes data with regard to call center management.

| Process: | Optimize Call Center Calls Handled | 3 Yrs - Actuals | | | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | FY2013-14 | FY2014-15 | FY2016-17 |
| **Input:** | # Customer Service Calls Received | 215,108 | 205,156 | 310,192 | 340,000 | 435,000 |
| **Output:** | # Customer Service Calls Answered | 108,206 | 137,771 | 155,368 | TBD | TBD |
| **Outcome:** | % Customer Service Calls Answered | 50.3% | 67.2% | 50.1% | 51.5% | 51.7% |

## Strategic Policy Initiative: Communications

*"Sustain effective internal and external relationships"*

The implementation of the Affordable Care Act and reforms to the Medicaid program have ushered in a transformational time in Colorado health care policy. Sweeping changes to rules, laws, and Department programs require a comprehensive and robust communications effort from the Department. The Department regularly interfaces with internal Department staff, external stakeholders, community partners, state agencies, and government offices. To ensure these interfaces work to further the Department's mission and vision, the Department's strategic policy initiative for Communications seeks to **"**Sustain effective internal and external relationships" by means of the four goals in support of this strategy:

### Internal and External Communications

***Communication Strategic Plan***

In order to sustain effective internal and external relationships, the Department has developed a Communication Strategic Plan that includes strategies intended to move the organization from a *reactive* communications environment to a *proactive* approach, supplying clear, concise, consistent and current messaging through a variety of channels. Proactive key messaging will tie directly to the Department's Vision and Mission, balancing a broad public-friendly message with necessary details to answer common questions from stakeholders, clients, providers and Department staff. The Policy, Communications and Administration Office provides timely, accurate information through relevant channels to effectively reach target audiences and inform the public about Department programs and policy changes. For example, the Department's website is the quickest, and most accessible way to make information available to external stakeholders and the general public. Due to the time and content sensitivity of Department communications, messaging must keep stakeholders up-to-date on policy changes and the impacts these changes will bring to them in a transparent and consistent tone.

In addition to proactive key messaging, other guiding principles from the Communication Strategic Plan include collaborating with state agencies and external stakeholders. This helps to reinforce key messaging and the implementation of the Communications Strategic plan. Having other organizations and state agencies echo the Department's message will help to inform and educate clients and potential clients of the value of the health care benefits and services that Colorado Medicaid provides. A collaborative approach allows the Department to maximize education and awareness of policy changes by leveraging existing resources, networks and channels. In order to reach the varied populations served by Medicaid, the Department's Communication tactics should be based on research and evidence. This approach will ensure that Department messaging is culturally and linguistically appropriate.

Additionally, the Communication Strategic Plan aims to maximize employee engagement and to create open lines of communication from senior management to front line staff. Implementation

of this section of the plan requires close collaboration with the Workforce Development and Human Resources sections.

The table below shows the percentage increase in unique visitors to the Department website.

***Website***

The internet is an important tool to reach both internal customers and external clients. The Department monitors the use of the public website, and is taking action to increase the number of unique users that visit.

| Process: | Increase Public Use of Department Website | 3 Yrs - Actuals | | | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | FY2013-14 | FY2014-15 | FY2016-17 |
| Output: | # Unique Visitors to Department Website | 457,297 | 563,236 | 700,000 | 750,000 | 824,634 |
| Outcome: | % Increase in Unique Visitors to Department Website | N/A | 23.2% | 24.3% | 7.1% | 6.4% |

## Government Relations

The Department's goal for Government Relations includes the coordination of communications between the Department, the Governor's Office, and the State Legislative Branch. Through planned outreach efforts, Department Government Relations staff informs legislators and the Governor's Office about the Department's legislative priorities. The Government Relations unit represents the public face of the department to key decision makers and builds relationships with members of the state General Assembly, their staff, the Governor's office, and with other leaders and stakeholders across the state. The Department's legislative liaison and legislative analyst meet with members of the Joint Health Committees and Joint Budget Committee prior to the start of the legislative session to outline and clarify the Department's legislative and budget agenda.

During the legislative session, liaisons from the Department are in constant communication, with their counterparts in the other two main health agencies, the Colorado Department of Public Health and the Environment (CDPHE) and the Colorado Department of Human Services (CDHS). This ensures that each Department's legislative priorities are broadly supported and that information and positions on bills relevant to multiple agencies are coordinated and aligned. Additionally, the legislative liaisons and executive team members from these agencies have a monthly breakfast meeting to share legislative, regulatory, and statutory information critical to all three agencies.

As necessary, the Government Relations unit meets with individual legislators during the legislative session to discuss their sponsored legislation and communicate to them the Department's plan to review legislation, recommend changes, and to implement laws as they pertain to Department operations and policy. The section also provides year-round support to legislators responding to Medicaid-related constituent issues. Out of session, staff travel to individual member districts across the state to gain a better understanding of how a legislator's local community is impacted by the Department and the Colorado Medicaid program.

Additionally, the unit's role includes internal communications to department staff regarding department initiatives, updates on the legislative process during the legislative session, technical assistance to legislators in drafting legislation, and responding to legislator requests for information about the Department's projects and initiatives.

**Interagency Collaboration**

Several of its initiatives require the Department to establish and maintain strong working relationships with other state agencies, federal and local governments as well as with community partners and non-profit organizations. To achieve this, the Department has established a goal to build relationships and collaborate with other state agencies in efforts such as ACA implementation, including the expanded adoption and use of Health Information Technology (HIT), the establishment and oversight of a state Health Information Exchange (HIE), interagency communication, and collaboration on special projects, such as the Colorado Opportunity Project.

For example:

- Department communications staff have a monthly conference call with Public Information Officers from CDPHE, CDHS, Governor's Office of Information Technology (OIT), the Division of Insurance, the Health Professions Division at the Department of Regulatory Agencies, and Connect for Health Colorado. These calls ensure the coordination and alignment of communication strategies around common issues and initiatives.
- Efforts to establish the HIE require four government agencies to interface, including the Department, the Colorado Department of Revenue, the Division of Insurance, and the Internal Revenue Service. In addition, collaboration is needed with external stakeholders like the Colorado Regional Health Information Organization (CORHIO), and other local Health Information Exchange (HIE) partners to efficiently deploy HIT across Colorado.
- The Department is partnering with CDPHE, CDHS and the Brookings Institute, to align data measurements within the state's service system infrastructure through the Colorado Opportunity Project. To further integrate health care services in Colorado, the departments will work with the Brookings Institute and external stakeholders to identify high-quality, evidenced-based public programs and metrics to include in the project framework. The first collaborative project, results from which are due out in July 2014, focuses on collecting behavioral health data and developing initiatives that foster improvement in needed areas. This collaborative data project is currently aligning child health measures between the three agencies. The goal is to standardize data sets across the life span and annually update measures to provide an overall picture of health in Colorado.

**Strategic Policy Initiative: Technology**

*"Provide exceptional service through technological innovation"*

Streamlined, fully integrated information technology (IT) systems require considerable political will, dedicated resources, and an organizational commitment to long term strategy. In its final report in 2009, the state's Health [redacted] positive health outcomes achievable specifically through the adoption of electronic health systems. Health Information Technology (HIT) and Health Information Exchange (HIE) implementation is not intended as an end in itself, but rather a means to radically transform the state's health care system, improving health outcomes for clients, reducing waste, fraud and abuse in the Medicaid program, and reducing the overall cost of health care.

Colorado began implementing a phased strategy for the development and expanded adoption of Health Information Technology (HIT) and Electronic Health Records (EHR) in 2011. Successful adoption among state agencies and Medicaid providers will contribute significantly to statewide improvements in patient outcomes and reduction of health care costs. The established goals are the reprocurement and upgrade of the Department's Medicaid Management Information System (MMIS), the adoption and incorporation of HIT into the health care delivery system through the expanded use of EHRs by Medicaid providers, as well as expanded internal collaboration and file sharing through Microsoft SharePoint. To this end, the Department's strategic policy initiative with regard to technology seeks to **"**Provide exceptional service through technological innovation" by means of the two goals in support of this strategy: Health Information Technology and SharePoint Management.

**Health Information Technology (HIT)**

***Electronic Health Records:*** The Department is encouraging the adoption of electronic health records (EHRs) for Medicaid clients through a federally-funded EHR incentive program. Creating a personal EHR will allow Medicaid clients and their providers to see their claims, their service utilization and costs compared to similar clients, as well as monitor their personal wellness needs. Linking this data to the Statewide Data and

STATE OF HEALTH GOAL:

- Colorado maintains a physician EHR adoption rate that is consistently higher than the national average. All 17 of Colorado's Federally Qualified Health Centers and all 17 Community Mental Health Centers have been using EHRs for years. Roughly 75% of Colorado's rural clinics have, or are in the process, of adopting EHR systems. These facilities are committed to achieving Meaningful Use, which means these facilities are now fully-functional in the use of EHR technology to improve quality, safety, and efficiency. Four million Colorado residents will receive care from providers who have achieved Meaningful Use in the Medicare and Medicaid EHR Incentive Programs[2].

[2]Colorado Rural Health Center, 2013

Analytics Contractor for the Accountable Care Collaborative will allow Medicaid providers access to a broader picture of client resource needs.

To be considered eligible for the EHR incentive program, individual health care professionals such as physicians, nurse practitioners, certified nurse-midwives, dentists and physician assistants must have:

- a minimum 30% Medicaid patient volume, or
- 20% Medicaid patient volume for pediatricians, or
- practice predominately in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals.

Providers who meet the eligibility criteria can qualify for limited-time incentive payments to help offset the costs of adopting EHR. The incentive payments occur over a six-year period, but the six years are not required to be consecutive for Medicaid providers. Eligible health professionals may then attest that the services provided meet the 15 core measures established by the Centers for Medicare and Medicaid Services. In the first year, providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate "Meaningful Use", or declare that the services provided meet the core measures, in order to receive incentive payments. Hospitals may also qualify for incentives if they meet Meaningful Use program requirements.

The Department continues in its efforts to increase provider adoption of HIT in ways that accommodate a range of EHR functionalities – from the most basic electronic transactions to fully functional systems. In addition to the EHR incentive program, the Department supports the expanded use of personal health records and other consumer access solutions to increase the participation of consumers (patients) in their health care.

The following tables include data on Meaningful Use and EHRs. The Department is working to monitor four processes with regard to EHRs and Meaningful Use: the increase of Meaningful Use of EHRs among Medicaid providers, which measures the percentage of Medicaid providers receiving EHR incentive payments; the increase of Meaningful Use of EHRs for hospitals, which measures the percentage of hospitals that are receiving EHR incentive payments; the increase of registration in Meaningful Use EHRs, which measures the percentage of professionals that are registered and eligible for EHR incentive payments; and the increase of professionals demonstrating the Meaningful Use of EHRs, which measures the percentage of professionals receiving EHR incentive payments.

| Process: | Increase Meaningful Use of Electronic Health Records (EHR-MU) - Medicaid Providers | 3 Yrs - Actuals | | | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | FY2013-14 | FY2014-15 | FY2016-17 |
| **Input:** | # EHR-MU Eligible Medicaid Providers | TBD | TBD | TBD | TBD | TBD |
| **Output:** | # Medicaid Providers Receiving EHR-MU Incentive Payments | TBD | 1,514 | 1,641 | TBD | TBD |
| **Outcome:** | % Medicaid Providers Receiving EHR-MU Incentive Payments | TBD | TBD | TBD | TBD | TBD |

| Process: | Increase Meaningful Use of Electronic Health Records (EHR-MU) - Hospitals | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Eligible Hospitals | TBD | TBD | 76 | 76 | 76 |
| **Output:** | # Hospitals Demonstrating EHR-MU | 57 | 69 | 70 | 71 | 72 |
| **Outcome:** | % Hospitals Receiving EHR-MU Incentive Payments | TBD | TBD | 92.1% | 93.4% | 94.7% |

| Process: | Increase Registered Intent to Achieve Meaningful Use of Electronic Health Records (EHR-MU) | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Eligible Professionals | N/A | N/A | 12,331 | 12,359 | 12,415 |
| **Output:** | # Professionals Registered with Intent to Achieve EHR-MU | 2,375 | 3,526 | 4,243 | 4,774 | 5,509 |
| **Outcome:** | % Professionals Eligible Registered for EHR-MU Incentive Payments | N/A | N/A | 34.4% | 38.6% | 44.4% |

Source: HealthIT.gov

| Process: | Increase Meaningful Use of Electronic Health Records (EHR-MU) - Medicare and Medicaid Providers | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Eligible Professionals | N/A | N/A | 12,331 | 12,359 | 12,415 |
| **Output:** | # Professionals Demonstrating EHR-MU | 32 | 971 | 2,992 | 4,051 | 4,675 |
| **Outcome:** | % Professionals Receiving EHR-MU Incertive Payments | N/A | N/A | 24.3% | 32.8% | 37.7% |

Source: HealthIT.gov

***MMIS Reprocurement and COMMIT Project:*** The Department's Medicaid Management Information System (MMIS) is the hardware, software, and business process workflows designed to meet the criteria for a "mechanized claim processing and information retrieval system" required by federal law to participate in the Medicaid program.

The MMIS's core function is to adjudicate and process the Department's medical claims and capitations for payment; it also provides other important functions including provider enrollment and management, certain client management functions, and analytics and reporting. Since the MMIS electronically processes approximately 97% of the Department's claims, its capabilities and limitations play a pivotal role in how the Department administers the Medicaid program. While the current MMIS is sufficient to process a high volume of claims, it lacks the enhanced capabilities of modern IT solutions. This transformation of the Department's Health Information Technology (HIT) components will allow for the development of data-driven program and payment models that reward high-quality, coordinated care and reductions in avoidable costs.

In late 2013, the Department selected a new contractor to design, develop, test and implement a new state of the art Medicaid Management Information System (MMIS), now known as the Colorado interChange. Colorado interChange is a modernized provider enrollment tool that includes updated processes for provider enrollment and reenrollment. The new provider enrollment process will help the Department implement the new federally mandated electronic provider screening for providers with legal or regulatory actions. The Department will work with Hewlett Packard in order to provide support for providers during the reenrollment process and provide manuals to reflect the new processes and procedures. Colorado interChange will launch in September 2014. The reprocurement of the MMIS core functions and supporting Fiscal Agent

services are part of a larger IT project known as the Colorado Medicaid Management Innovation and Transformation (COMMIT) project. Through this reprocurement, the new system will also advance the Department's analytic and business intelligence capabilities through the procurement of a new Business Intelligence and Data Management (BIDM) vendor. In addition to the MMIS core service upgrade and the BIDM, the COMMIT project includes a new Pharmacy Benefit Management System (PBMS) which will provide the Department the best technology and functionality available for claims processing, drug utilization review, and other pharmacy benefit management functionality.

***Claims Processing***

Redesigning the Department's IT infrastructure and improving its data analytics capacity will result in more efficient and effective administration of the Medicaid program. The reprocurement and upgrades to the Medicaid Management Information System (MMIS) will modernize Medicaid claims processing. This allows the Department to design and manage health benefits for specific populations, better address health outcomes, and reduce duplicate or unnecessary services. The Department is encouraging the adoption of electronic health records (EHRs) for Medicaid clients, and is also working with Colorado's Regional Health Information Exchange (CORHIO) and the All-Payer Claims Database (APCD) to expand the use of Health Information Technology (HIT) among Medicaid providers.

The timely payment of healthcare provider claims is something the Department monitors on a yearly basis. The table below shows the percentage of "clean" claims that are paid in a timely fashion.

| Process: | Pay Health Care Provider Claims Timely | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Input: | # "Clean" Claims Received | 4,791,447 | 4,915,955 | 2,455,228 | 5,174,908 | 5,447,502 |
| Output: | # "Clean" Claims Paid | 4,791,277 | 4,915,366 | 2,454,938 | 5,174,288 | 5,446,848 |
| Outcome: | % "Clean" Claims Paid Timely | 99.99% | 99.98% | 99.98% | 99.98% | 99.98% |

Source: HealthIT.gov

**SharePoint Management**

In 2012, the Department implemented Microsoft SharePoint 2007 to improve collaboration and communication on group projects, including file sharing, editing and version control of documents. In July of 2013, the Department migrated to SharePoint 2013 Online with Microsoft Office 365. SharePoint is a Microsoft product which provides internal web sites for file sharing, team project collaboration, blogs, wikis and other organization information and announcements. It is fully integrated with other Microsoft products such as Microsoft Office, Lync and OneDrive. The Department's goal for SharePoint Management includes improved collaboration and communication on group projects, file sharing, editing and control of documents. The Department's use of SharePoint has improved availability of reliable and accurate Department, State and federal information for internal perusal, research and distribution. It is intended that this information will be accessible to all workforce members at the Department.

To facilitate successful implementation, the Department has chosen a percentage of personnel to act as Power Users. These individuals possess elevated permissions in SharePoint, receive

routine training, and consult with the SharePoint Operations Coordinator, to develop team sites wherein their business Unit, Section, or Division, can work effectively. These individuals also coordinate with their staff subject matter experts to migrate files from the network shared drives to SharePoint in efforts to provide organized, logical and functional working solutions for current and archive material. By promoting project collaboration ideas and expertise sharing through SharePoint, the Department intends to improve performance by aligning SharePoint activities with the Department's other strategic goals, eliminating the duplication of existing content and providing an online hub of up-to-date files across the Department. The successful implementation of SharePoint will also clear the way to move information currently on the Department's network drives to sites on SharePoint, where they will be available to Department users, and can be subjected to automated retention rules. Utilizing the Share feature in SharePoint, within both team sites and OneDrive personal storage, the activity of emailing documents throughout the Department is eliminated, thereby reducing the duplication of files and offering improved version control.

In addition, because the application is web-based, Department employees can access it from any computer with internet connectivity. This will enable more flexible alternative work arrangements such as Flex Place (telecommuting), Job Sharing, and working from an Alternate Office, as Department laptops or employees' home computers will no longer require an active

The table below shows the number of megabytes stored on SharePoint.

Virtual Private Network (VPN) client to gain access to Department documents and files remotely.

| Process: | Increase Use of SharePoint | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | # Megabytes of Storage on SharePoint | TBD | TBD | 67,731 | 135,000 | 303,750 |

## Strategic Policy Initiative: People

*"Build and Sustain a Culture of Recruiting and Retaining Talented Employees"*

The Department recognizes that the greatest assets it has are hardworking and dedicated employees. Hiring, training, and retaining employees is a central Department focus point due to employee turnover which is costly not only in the time and effort it takes to replace vacant positions, but also due to the loss of institutional knowledge and business intelligence. A competent and engaged workforce is a critical component of the Department's ability to deliver its services effectively. To this end, the Department's strategic policy initiative with regard to People seeks to **"**Build and sustain a culture of recruiting and retaining talented employees" by means of the three goals in support of this strategy:

- Workforce Development
- Employee Engagement
- Human Resources Optimization

**Workforce Development**

The Workforce Development section exists to develop and implement a system that ensures Department staff have the appropriate skills and competencies to fulfill the Department's business objectives. The Department's goal for Workforce Development is designed to meet two of the most important of these business objectives: improving the skill level of managers and supervisors in the areas of personnel management and leadership; and providing high quality onboarding for new employees. These areas have been shown to be primary drivers of employee engagement.

Managers who are better trained in leadership and the supervisory role have higher performing teams. These teams produce higher quality work, are more engaged with their work, and are more resilient to change. Part of the section's core function involves training managers to hone their leadership skills and increase their effectiveness. The section solicits and analyzes feedback that managers provide in post-training surveys. The feedback is used to adapt its training programs to better meet the needs of the trainees. One of the key measures in the survey is the managers' confidence in their ability to use the skills they learned in the training, and the relevance of the training to the work they and their teams perform.

The table below contains the Department's data on increasing supervisor skills in personnel management and leadership. This process measures the outcome of favorable responses to the survey question "I am confident in my ability to use what I learned."

| Process: | Increase Supervisor Skills in Personnel Management & Leadership | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Supervisors | 62 | 65 | 80 | 80 | 80 |
| **Output:** | # Supervisors Responding Favorably | N/A | N/A | 75 | 75 | 75 |
| **Outcome:** | % Favorable Responses to "Confident will Use" Question | N/A | N/A | 93.8% | 93.8% | 93.8% |

## Employee Engagement

The Department's goal for employee engagement addresses employee retention, recruitment, efficiency, and productivity. Efficient and productive work teams require a combination of the right technical skills as well as the ability to collaborate, resolve differences quickly, and integrate alternative thinking and working styles to solve problems and address increasing work complexities. The goal for employee engagement addresses all of these areas of focus. New employees, existing staff, and managers have expressed a need to provide new employees with a basic understanding of Medicaid and how the Department administers the various programs that provide Medicaid services. The New Employee Ambassador Program was implemented in December 2013. The program is an onboarding process that provides a consistent experience to new employees. Quality on-boarding of new employees complements the Department's effort to recruit and retain talented employees.

Engaging new employees through the Ambassador Program is very important to the Department. This process measures the percentage of participants that believe the Ambassador program positively impacted their new employee experience.

| Process: | Engage New Employees through the Ambassador Program | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # New Employees | 61 | 70 | 101 | 117 | 157 |
| **Output:** | # New Employees Participating in the Ambassador Program | N/A | N/A | 70 | 75 | 85 |
| **Outcome:** | % of Participants that State the Ambassador Program Positively Impacted Their New Employment Experience | N/A | N/A | 75.0% | 80.0% | 90.0% |

The 2013 Statewide Employee Engagement Survey indicated improvements in the dimensions of Customer Focus, Engagement, Leadership, Public Service, Resources, Values, and Work Processes. However, the survey also showed a large number of unfavorable responses in the Growth and Development dimension. The survey item about new employees receiving the training needed to perform their jobs was rated unfavorably by 47% of the respondents.

| Process: | Engage Employees through "5 Key Drivers" | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # HCPF Respondents to DPA Survey "Good Place to Work" | 286 | N/A | 285 | 300 | 340 |
| **Output:** | # Favorable HCPF Responses to "Good Place to Work" | 135 | N/A | 168 | TBD | TBD |
| **Outcome:** | % Favorable HCPF Responses to "Good Place to Work" | 47.2% | N/A | 58.9% | TBD | TBD |

The Department measures the number of days from job requisition to offer in the hiring process. The table below shows the percentage of positions filled within 60 days of requisition.

| Process: | Strengthen Trust and Confidence in Department Leadership | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # HCPF Respondents to DPA Survey "Trust & Confidence" in Leaders | 289 | N/A | 286 | 300 | 340 |
| **Output:** | # Favorable HCPF Responses to "Trust & Confidence" in Leaders | 114 | N/A | 140 | TBD | TBD |
| **Outcome:** | % Favorable HCPF Responses to "Trust & Confidence" in Leaders | 39.4% | N/A | 49.0% | TBD | TBD |

The department has committed to improving this measure in FY 2014-15 and FY 2015-16. It is the primary goal in the Action Planning process that is utilized by all state agencies to follow-up on the Statewide Employee Engagement Survey. Strengthening trust and confidence in Department leadership and employees rating the Department as a good place to work are two measures monitored by the Department. The data for these measures are shown

The Workforce Development Section continues to deliver training courses identified in the Supervisors' Training Curriculum as well as new training and staff development programs such as the Culture of Improvement Academy and the Transformational Leadership Academy that will be added to the Section's course offerings.

**Human Resources Optimization**

In an effort to optimize its Human Resources function, the Department has identified two major areas needing improvement: a reduction in the time required to hire new employees, and

ensuring that quality employees are hired and retained. With regard to the former, the Department estimated lead time of 142 days to hire in FY 2011–12. This is not sufficient to recruit and hire quality employees. Through a Department-facilitated Lean project, a goal was set to reduce time to hire to an average of 60 days.

| Process: | Expedite and Improve Quality of New Hires | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Permanent FTE Positions Filled | 95 | 132 | 168 | 205 | 278 |
| **Output:** | # Filled Within 60 Days of Requisition | 49 | 75 | 101 | 133 | 209 |
| **Outcome:** | % Filled Within 60 Days of Requisition | 51.6% | 56.8% | 60.1% | 65.0% | 75.0% |

## Strategic Policy Initiative: Process

*"Enhance efficiency and effectiveness through process improvement"*

In January of 2012, the Department initiated a new strategic management process which operates year-round to formulate, implement, and evaluate strategy. Strategy formulation activities in calendar year 2012 centered on development of a strategy map to visually connect Department performance measures to its strategic policy initiatives, mission, vision and goals. In developing its strategy map, the Department recorded over 500 "touch points" or interactions with managers and staff who contributed to its content.

The Department also established a Lean Community for process improvement in 2012. The Lean Community empowers employees to eliminate waste and maximize value in their daily work activities, and fosters a culture of continuous improvement through training and project management. To this end, the Department's strategic policy initiative for Process seeks to "Enhance efficiency and effectiveness through process improvement" by means of the two goals in support of this strategy: Strategic Management and the Lean Community.

### Strategic Management

The Department monitors progress toward its goals through performance measures using a continuous evaluation process. This strategic management process engages staff in the formulation, implementation, and evaluation of strategies to achieve its mission, vision and goals. This process also ensures that proposed projects and initiatives across the Department are prioritized according to strategic impact. Another objective of this process is to create understanding, a sense of value, and "line of sight" from individual staff roles to attainment of the Department's vision, mission and goals.

| Process: | Create "Line of Sight" between Employees and Strategic Goals | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # "Line of Sight" Presentations Delivered | N/A | 19 | 17 | 4 | 4 |
| **Output:** | # Employees Trained in "Line of Sight" | N/A | 164 | 110 | 50 | 50 |
| **Outcome:** | % Favorable Survey Responses to "Understand Strategic Role" | 36.6% | 41.5% | 66.1% | 70.0% | 75.0% |

The Department is committed to promoting a Lean culture throughout the Department. This process measures the percentage of favorable survey responses to the question, "Did your work get done more efficiently and with less waste?"

**Lean Community**

Lean is an approach to continuous process improvement that aims to maximize customer value while minimizing waste in an organization's business processes. The Department's Lean Community is a central location for information, resources and training used by staff to improve global Department processes as well as individual work. The Department is using training,

The table below shows the progress of the Department in creating line of sight between employees and strategic goals. This process measures the percentage of favorable responses from employees to the question, "Do you understand your strategic role?"

coaching, global projects and rapid improvement sessions called "Quick Hits" to deploy Lean throughout the Department, and to create a Lean culture that is customer-centric, and focused on continuous improvement and data-driven decision-making.

Lean creates an organizational mindset of understanding products, services, and processes from the viewpoint of the customer to maximize value and eliminate waste. Based upon a standard organizational Lean Maturity Assessment tool, the Department identified gaps and designed a Lean rollout strategy to progress from an introductory level of Lean implementation (Level 1) to an initial results level with some successes (Level 2 & Level 3) by FY 2014-15. The Department ultimately strives to achieve successful and mature deployment (Level 4), and its Lean Community is having a significant impact on meeting that goal. The Department tracks Lean-trained staff and identifies "champions" and project leaders who can apply their skills to further the successful deployment of Lean. In addition, the Department has developed and rolled out a

"Culture of Improvement Academy," a certificate program that facilitates and enhances staff skills to improve decision making, design and manage processes, create standard work, and manage risks.

| Process: | Promote a LEAN Culture Throughout the Department | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| **Input:** | # Employees Trained/Participating in LEAN Projects | N/A | 101 | 108 | 120 | 120 |
| **Output:** | # LEAN Projects and Quick Hits | N/A | 6 | 19 | 22 | 22 |
| **Outcome:** | % Favorable Survey Responses to "Work Done > Efficiently w < Waste" | 43.0% | N/A | 49.0% | 60.0% | 75.0% |

## Strategic Policy Initiative: Financing

*"Ensure sound stewardship of financial resources"*

The Department is strengthening efforts to control costs and increase value in Medicaid by ensuring clinically appropriate services, preventing unnecessary or duplicative services, and ensuring use of the most effective care at the lowest cost. Passage of the Patient Protection and Affordable Care Act (ACA) in 2010 compelled state Medicaid agencies to rethink delivery of health care services, and how to optimize health outcomes achieved relative to dollars spent, with the goal of fundamentally resetting the program's cost trajectory.

At its present rate of growth, Colorado Medicaid is financially unsustainable, which one day may affect other state budget priorities such as education and public safety. Public health insurance

programs are not alone in the need to bend the cost curve. Across the entire health care system, costs have increased at a rate greater than the economy as a whole for 31 of the past 40 years.[3]

The Department must improve the efficiency of its payment systems to incentivize value rather than volume; increase the effectiveness of health care delivery; leverage advancements in health information technology to improve quality and continuity of care; and redesign administrative infrastructure to reduce losses through fraud, waste and abuse. To this end, the Department's Financing strategic policy initiative seeks to **"**Ensure sound stewardship of financial resources" by means of three goals in support of this strategy:

- Cost Containment
- Fraud, Waste & Abuse Prevention
- Grants Management

**Cost Containment**

The Department's goal for cost containment is to reduce the growth rate of Medicaid expenditures through implementation of programs that lower per capita costs while improving health outcomes and the experience of people served by Medicaid. Multiple strategic goals across the Department promote cost containment, including integrated service delivery, benefit/program design, and reformation of payment methods to incentivize value and outcomes over volume of services. Cost containment also depends on achieving health information technology goals for meaningful use of electronic health records, developing new administrative efficiencies, and preventing fraud, waste, and abuse of state and federal Medicaid dollars.

*Goal targeted in State of Health: Colorado's Commitment to Become the Healthiest State.* The Department projects future cost avoidance of at least $280 million by 2023. The table on the next page shows annual milestones representing a 1% annual reduction in projected Medicaid expenditures.

| Year | Costs Avoided |
|---|---|
| July 2014 | $3,900,000 |
| July 2015 | $14,268,182 |
| July 2016 | $30,804,545 |
| July 2017 | $52,531,818 |
| July 2018 | $79,450,000 |
| July 2019 | $111,084,848 |
| July 2020 | $147,436,364 |
| July 2021 | $188,130,303 |
| July 2022 | $232,318,182 |

[3] Institute of Medicine. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Washington, D.C.: The National Academies Press, 2013.

As an overall indicator of administrative efficiency, the Department also tracks data on General Fund expenditure for administration. It has a goal of containing the ratio of General Fund expenditure on administrative activities to total General Fund expenditure at 3% as shown in the table below.

| | |
|---|---|
| July 2023 | $280,000,000 |

Changing the incentives in health care service delivery to hold providers accountable for health outcomes is central to this goal. The establishment of the Accountable Care Collaborative (ACC) will create the infrastructure for data informatics, and enable greater provider coordination and behavioral health integration. Conversely, the modernization of the long term care delivery system enables clients to transition out of nursing facilities and regional centers into home and community based settings.

To transition the current system away from purchasing fee-for-service volume to purchasing value in terms of client outcomes and cost effectiveness, the ACC provides a per-member, per-month payment (PMPM) to Regional Care Collaborative Organizations (RCCOs) to coordinate client care, a portion of which is paid on a performance basis. This payment methodology incentivizes RCCOs to meet or exceed specified quality and cost containment metrics, specifically regarding costly services such as emergency room visits, hospital readmissions, and imaging technologies.

To impact costs through effective benefit/program design, the Department is using extensive stakeholder outreach through its Benefits Collaborative program. The Benefits Collaborative reviews Medicaid program benefit packages to ensure clinical appropriateness, cost effectiveness, and client benefit. Additionally, the Department's efforts at service utilization management prevent unnecessary or duplicative services, as does the establishment of a preferred drug list to ensure use of the most effective pharmaceutical products at the lowest cost.

Redesigning the Department's Information Technology (IT) infrastructure and improving its data analytics capacity will result in more efficient and effective administration of the Medicaid program. The reprocurement and upgrades to the Medicaid Management Information System (MMIS) will modernize Medicaid claims processing. This allows the Department to design and manage health benefits for specific populations, better address health outcomes, and reduce duplicate or unnecessary services. The Department is also encouraging the adoption of electronic health records (EHRs) for Medicaid clients, and is working with Colorado's Regional Health Information Organization (CORHIO) and the All-Payer Claims Database (APCD) to expand the use of Health Information Technology (HIT) among Medicaid providers.

| **Process:** | **Contain General Fund Expenditure for Administration at 3%** | **Historical Actual** | | **FY2013-14 Estimate** | **1 and 3 Yr Projections** | |
|---|---|---|---|---|---|---|
| | | **FY 2011-12** | **FY 2012-13** | | **FY2014-15** | **FY2016-17** |
| **Outcome:** | General Fund Expenditure - Administration Ratio | -- | 3.0% | 3.0% | 3.0% | 3.0% |

## Fraud, Waste & Abuse Prevention

The Department is actively reorganizing personnel infrastructure and workflows, as well as investing in efforts to prevent fraud, waste, and abuse. This will improve the quality and efficiency of services provided to clients. The Department's approach to fraud, waste and abuse prevention focuses on recovering dollars spent in overpayments to providers, and in the recovery of payments owed by liable third parties. Signed into law on May 24, 2013, Colorado Senate Bill 13-137 significantly alters that course. The law's stated intent is to "implement waste, fraud, and abuse detection, prevention, and recovery solutions to improve program integrity in the State's Medicaid Program and create efficiency and cost savings through a shift from a retrospective '*pay and chase*' model to a prospective prepayment model."

The Department initiated a Request for Information (RFI) on June 18, 2013, utilizing information from the RFI responses to develop business requirements for the Business Intelligence and Data Management Services (BIDM) as part of the Department's reprocurement of the Medicaid Management Information System (MMIS). The BIDM Request for Proposals included a Predictive Analytics Tool requirement. The BIDM RFP requirement is for a tool which identifies patterns of behavior in provider claims billing data, predicts relationships with high fraud probability, and identifies potential program vulnerabilities. More robust predictive analytics services may be solicited, which could operate prior to payment and which could incorporate additional data from external sources. The fundamental strategy to combat fraud, waste, and abuse will then involve the prevention of money from being paid out in the first place, while continuing to pursue the recovery of provider payments made either in excess of the necessary level of care, or payments made in error when a third party is liable for the payment.

| Process: | Recover Overpayments from Health Care Providers | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | $ Program Integrity Recoveries | $11,700,000 | $11,900,000 | $12,000,000 | $12,000,000 | $12,000,000 |

| Process: | Pursue Third Party Payment of Medical Costs for Medicaid Clients | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | $ Third Party Liability Collections | $45,069,263 | $51,551,285 | $45,668,183 | $49,111,410 | $54,888,519 |

## Grants Management

The Department's Goal for Grants Management seeks to utilize grant funding to further the Department's strategic goals. Grants allow the department to pursue necessary and innovative pilot programs initiatives and infrastructure building that are not funded under the regular budget process, and also to fulfill legislative directives that require gifts, grants, or donations to implement. The Grants Management section is responsible for the coordination and oversight of all Department grants. The Department currently has 10 active grants managed by the Grants

The following tables represent the Department's data on recovering overpayments from healthcare providers and pursuing third party payments of medical costs for Medicaid clients. These processes measure the dollars the Program Integrity department recovers, and the dollars recovered by third party liability collections.

Management section, and there are usually two to five grants in the proposal process at any given time.

To succeed, a grant funded project must align with Department's goals and receive approval from its executive team as well as the Governor's office. It must use stakeholder input, fulfill funder expectations and aims, be well thought out and well written, with contributions from staff across the Department, and be organized according to the requirements of each project. The Grants Management section maintains strong relationships with private foundations, especially health-focused ones based in Colorado, as well as with federal project officers from the Centers for Medicare and Medicaid Services. The section works with Department staff to generate project ideas and respond to solicitations, and also works with its executive team and management to prioritize projects and seek funding.

| Process: | Use Grant Funding to Further Strategic Goals | Historical Actual | | FY2013-14 Estimate | 1 and 3 Yr Projections | |
|---|---|---|---|---|---|---|
| | | FY 2011-12 | FY 2012-13 | | FY2014-15 | FY2016-17 |
| Output: | $ Total Grant Expenditures | $8,766,203 | $6,245,234 | $6,495,716 | $5,508,149 | $5,508,149 |

The Department monitors the process of using of grant funding to further strategic goals. This process measures the total dollar amount of grant expenditures per fiscal year.

## HEALTH CARE POLICY AND FINANCING

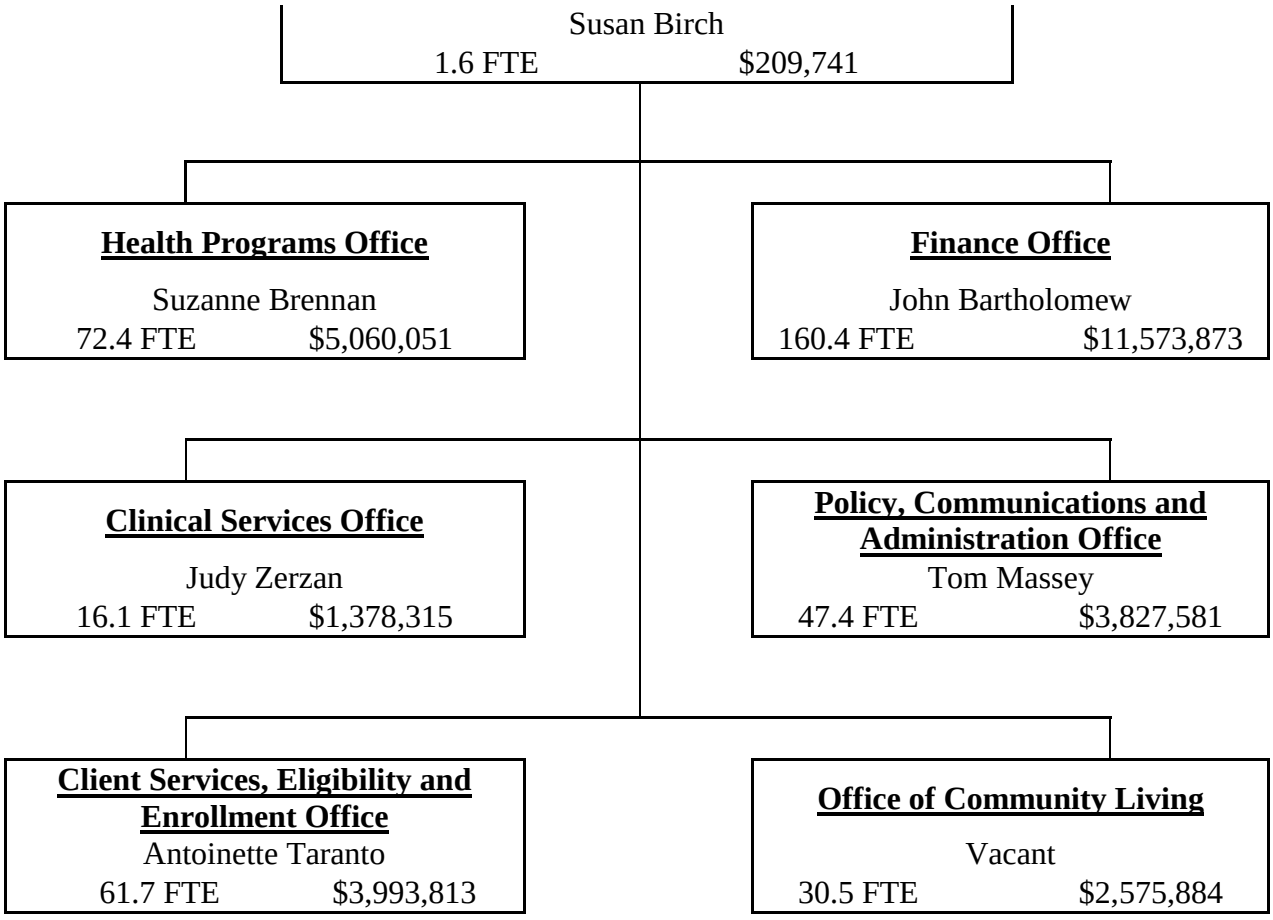
## Organizational Chart

***Major Programs***

***State of Colorado***

***The mission of the Department of Health Care Policy and Financing is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.***

**Executive Director's Office**




| TOTAL: | 390.1 | FTE | $28,619,258 | |
|---|---|---|---|---|
| General Fund | Cash Fund | | Reappropriated Funds | Federal Funds |
| $10,171,673 | $2,714,919 | | $1,885,519 | $13,847,147 |

## BACKGROUND INFORMATION

The Department of Health Care Policy and Financing (the Department) receives federal funding as the single state agency responsible for administering the Medicaid program (Title XIX) and the Child Health Insurance Program (Title XXI), known as the Children's Basic Health Plan. In addition to these programs, the Department administers the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Primary Care Fund, as well as the Home- and Community-Based Services Medicaid waivers. The Department also provides health care policy leadership for the state's Executive Branch. The Medicaid program receives approximately 60% of its funding from the federal government and the Children's Basic Health Plan is approximately 65% federally funded.

### Executive Director's Office

Susan Birch was appointed Executive Director of the Department effective January 18, 2011. The Executive Director has organized the Department to allow for greater focus on key program and operational areas. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

The State Medical Services Board was created by the Legislature effective July 1, 1994. The Board consists of 11 members appointed by the Governor and confirmed by the Senate. The members are persons who have knowledge of medical assistance programs, experience with the delivery of health care, and experience or expertise in caring for medically underserved children. The Board has the authority to adopt rules governing the Colorado Medicaid program and the Children's Basic Health Plan that are in compliance with state and federal regulations.

The Office of Community Living was created in July 2012 pursuant to an Executive Order by the Governor and codified by HB 13-1314 to meet the growing need for long term services and supports by aging adults and people with disabilities. The goal of the Office of Community Living is to provide strategic direction on the redesign of all aspects of the long term services and supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care.

### Health Programs Office

The Health Programs Office designs, implements, and administers Medicaid, Children's Basic Health Plan (CHP+), and Long Term Services and Supports Medicaid Programs. The office aims to improve the health status of all clients, achieve efficiencies in health care resource utilization, and promote effective partnerships with providers and contractors to achieve improved health and functioning of clients. The office implements innovative programs and approaches to improve how health care services are delivered and paid for. The office recognizes the diversity of geography, age, culture, ethnicity, psychosocial needs, income, and health among its clients and aims to deliver high-quality, client-centered services in a cost-

effective manner. The office is comprised of the Health Programs Services and Supports Division and the Long Term Services and Supports Division.

Health Programs Services and Supports Division

The Health Programs Services and Supports Division is responsible for the administration and performance of Medicaid fee-for-service, the Accountable Care Collaborative, managed-care services and programs, and CHP+. The division also seeks to maximize the health, functioning, and self-sufficiency of all Medicaid and CHP+ clients affordably. The services and programs include physical health, behavioral health, and dental benefits. The division is responsible for provider outreach, policy development, contract management, operations management, and overall Medicaid and CHP+ program performance.

Long Term Services and Supports Division

The Long Term Care Services and Supports Division oversees Medicaid funded home and community based services and nursing facilities. The division has a particular focus on affordably maximizing the health, functioning, and self sufficiency of clients in long term care, institutional, or community settings. The clients utilizing these services have complex health care needs, requiring coordinated and high quality services. Community based services are those services provided in clients' homes and communities as an alternative to placement in a nursing facility or other institutional setting. These community based services provide support for clients to remain at home and in the community, allowing for individual choice. This division oversees all Medicaid Home and Community Based Services waiver programs (HCBS) The division is also responsible for managing consumer-directed attendant support services which allow qualifying individual clients to direct their own in home care.

**Finance Office**

The Finance Office consists of the Budget Division, the Controller Division, the Rates and Analysis Division, the Safety Net Programs Section, the Audits and Compliance Division, and the Strategy Section. The Finance Office also houses the Provider Operations Division, which includes the Claims Systems and Operations Division and the Purchasing and Contracting Services Section.

Budget Division

The Budget Division's key responsibilities are to project, construct, present, monitor, and manage the Department's budget. In addition, the Budget Division presents and defends the Department's budgetary needs to the Executive and Legislative authorities. The division prepares each phase of the budget request process, including deliverables such as statistical forecasting of caseload and expenditure, requests for additional funding, and recommendations for reduced funding. This division also monitors caseload and expenditures throughout the fiscal year and ensures expenditures meet legal requirements while still coinciding with the Department's objectives. The Budget Division also tracks relevant legislation as it moves through the General Assembly and prepares fiscal impact statements for proposed legislation and ballot initiatives that may affect the Department. This division is responsible for federal reporting as well as coordinating with other State agencies on budgetary issues that affect multiple departments.

The Budget Division is also tasked with working closely with the Centers for Medicare and Medicaid Services (CMS) to ensure that the Department is maximizing federal Medicaid revenue. In addition, the Division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

Controller Division

The Controller Division oversees the accounting functions of the Department. The division ensures the proper recording and reporting of revenues and that expenditures in the Department are in compliance with generally accepted accounting principles and state and federal rules and regulations. All positions are responsible for monitoring the accurate reporting of assigned appropriations and working with Budget and Program personnel to resolve issues.

The Operations Unit is responsible for the proper recording of cash receipts, accounts receivable, accounts payable, and payroll. This includes processing and depositing checks and other receipts and properly recording this information in the State's financial records system, monitoring receivable balance sheet accounts and adjusting vendor accounts to properly account for amounts owed the State's Medicaid program, processing manual payments to vendors in the State's financial records system, and processing the Department's monthly and bi-weekly personnel payments through the State's central payroll system.

The Financial Reporting and Cash Management Unit is responsible for all accounting activities for the Children's Basic Health Plan, the Department of Human Services and County Administration Program, and Cash Management. Each accountant responds to the accounting needs of their program, and the Cash Management Accountant manages the State and federal cash as well as the reporting of private grants and non-Medicaid federal grants.

The Medicaid and Provider Fee Unit is primarily responsible for all accounting entries and issues related to the Medical Services Premiums and Behavioral Health Community Programs Long Bill groups, the Hospital Provider Fee, the Nursing Home Provider Fee, and tobacco taxes. Additional duties include recording the Departmental budget in the Colorado Financial Reporting System and performing and reconciling all entries related to the enhanced federal medical assistance percentage provided by the American Recovery and Reinvestment Act of 2009 (ARRA).

Rates and Analysis Division

The Rates Section of the Rates and Analysis Division develops rate-setting methodology and implements managed care rates for health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers. The section also monitors and updates rates paid for home and community-based services. In addition, this section is responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics. It is the responsibility of this section to make sure that rates comply with all applicable state statutes and federal regulations.

The Department recognizes the critical need for professional, efficient, consistent, and appropriate analysis of its statistical information, and as such, has a Data Analysis Section. The

section establishes standards for appropriate analytical methodologies for use in making strategic and fiscally responsible decisions. The focus of this section is to address the difficult and complex data analysis needs of both internal and external customers. This section extracts data for research, policy formation, report writing, forecasting, and rate setting for the Department's programs.

Safety Net Programs Section

The Safety Net Programs Section administers several programs that provide funding to hospitals and clinics that serve uninsured and underinsured individuals, and provide coverage for individuals not eligible for Medicaid or the Children's Basic Health Plan. The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado citizens, migrant workers, and legal immigrants with limited financial resources.

The Safety Net Programs section is also responsible for all modeling of provider fees utilized within the Department. Currently, these include the Nursing Facility Provider Fee and the Hospital Provider Fee. The Safety Net Programs section develops fee models, works with external stakeholders, advisory boards and providers, coordinates the approval of the fee models with the Medical Services Board, and submits State Plan Amendments to the federal Centers for Medicare and Medicaid Services for approval of these fee models.

Provider Operations Division

The Provider Operations Division is composed of the Purchasing and Contracting Services Section and the Claims Systems and Operations Division, which is made up of the Fiscal Operations Section, the Program Management Unit, the Claims System Section, and the Health Data Strategy Section.

The Purchasing and Contracting Services Section provides support for all aspects of procurement for the Department and ensures compliance with state procurement statutes and rules. The section also reviews departmental contracts for compliance with state rules, regulations, and contracting standards and processes.

Within the Claims Systems and Operations Division, the Fiscal Agent Operations Section manages the Department's Information Technology (IT) contracts and agreements, monitors IT vendors for contractual compliance, and provides IT vendor operational oversight. The section drafts and negotiates contracts and monitors contract performance as well as federal oversight of IT contracts. The primary IT contract that the section manages and monitors is the Medicaid Management Information System (MMIS) contract, which is a multi-year, multi-million-dollar contract. The section also works with the Budget Division to provide estimates for building in modifications to the system to reflect changes needed to implement legislation or shifts in policy direction. The Fiscal Agent Operations Section also provides oversight of all operational aspects of the MMIS contract, and is responsible for addressing escalated billing and provider enrollment issues that require state approval.

The Program Management Unit (PMU) assists in developing and implementing large projects such as the MMIS reprocurement and ICD-10 implementation. Additionally, the PMU acts as a bridge between multiple departments to reduce inefficiencies and timeframes for approvals and increases the lines of communication for smaller projects or for projects that do not have legislative approval. The PMU fills gaps that may exist between the Department's fiscal agent, departmental business analysts, and the various Department staff that are required to act together to complete projects in a timely manner. The PMU provides project management services for Claims and Operations Division projects, consolidated reporting of Claims and Operations Division projects, support division activities through strategic planning and develop methodologies and training for stakeholders on the methods and processes utilized in functional areas.

The Claims Systems Section ensures timely and accurate Medicaid and Children's Basic Health Plan claims processing and reporting. The section is responsible for directing the systems maintenance and enhancement of the MMIS by working closely with the systems staff of the fiscal agent, ACS Government Solutions. The section works with Department policy staff to gather requirements for the maintenance or enhancement of the MMIS by developing requirement documentation, reviewing and approving detail system design approaches, ensuring appropriate testing of changes, and by reviewing and approving all test outputs. Further, this section proposes IT solutions to program staff and implements those solutions to support Department policies. The section works with policy staff at the Department and its sister agencies as well as programmers and business analysts at the fiscal agent to ensure the MMIS accurately pays for approved services to eligible clients by enrolled providers.

The Health Data Strategy unit is primarily focused on implementing a Medicaid data infrastructure that supports strategic uses of Colorado health data. The unit manages existing business intelligence and data management (BIDM) vendors as well as consults on the procurement of new contracts by the Department to provide data and analytics. The unit serves as the primary point of contact for external stakeholders regarding data integration and interoperability, including entities such as the Office of Information Technology (OIT), the Center for Value and Improvement in Health Care (CIVHC), Colorado Regional Health Information Exchange (CORHIO), and Quality Health Network (QHN). In addition, the unit utilizes its technical expertise to evaluate data elements and methods for innovative reform efforts such as the Accountable Care Collaborative (ACC).

Audits and Compliance Division

The Audits and Compliance Division consists of the Program Integrity Section, the Internal Audits Section, and the Federally Required Eligibility and Claims Review Unit. These sections ensure compliance with state and federal law, as well as identifying and recovering any improper Medicaid payments.

The Program Integrity section monitors and improves provider accountability for the Medicaid program. The section identifies fraud, potentially excessive and/or improper utilization, and improper billing of the Medicaid program by providers. If aberrancies are identified, staff then investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Administrative, civil, and/or criminal sanctions may also

be pursued by the Department in coordination with the Attorney General's Medicaid Fraud Control Unit or the U.S. Attorney's office. Within the Program Integrity section is the Claims Investigation Unit, which has the primary responsibility for detection and deterrence of provider fraud, waste, and abuse in the Medicaid program and recovering identified overpayments. The unit also conducts post-payment claims reviews, which include desk reviews, records reviews, on-site visits, and data reviews to identify provider aberrancies that directly relate to Medicaid rules and regulations. In addition, the unit prepares cases for recovery of identified overpayments and provides education to providers to comply with Medicaid standards, rules, and regulations.

The Internal Audits section exists to ensure that the Department maintains compliance with federal and state rules, laws, and regulations. The section has several different functions that assist with this, including the Medicaid Eligibility Quality Control Unit, County Audits, Payment Error Rate Measurement (PERM) Program, Internal Audits/Review, and Department Audit Coordination.

The Federally Required Eligibility and Claims Review Unit manages four programs: the Medicaid Eligibility Quality Control (MEQC) Program, the Payment Error Rate Measurement (PERM) Program, the Contingency Based and Recovery Audit Contract (RAC) Manager, and the Recovery Officer. The MEQC program assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays. This program is required by the federal government. The PERM program is required by CMS to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine the accuracy of eligibility determinations and claims payment to ensure that the Department only pays for appropriate expenditures. The Contingency Based and RAC Manager is to manage two large and complicated contracts. The RAC contract is required under federal law to review/ audit all provider types for inappropriate payments. The RAC and the Contingency Based Contract are a method of deterring fraud, abuse, and waste while recovery overpayments. Finally, the Recovery Officer is to track and coordinate provider overpayments pursued by RAC, Contingency Based Contract, and PERM on behalf of the FEC Unit.

Strategy Section

The Strategy Section develops and guides the Department's strategic management process, and leads the Department's Lean Community for process improvement. As part of its role in developing the annual Department Performance Plan, the Strategy Section strives to create understanding, value, and line-of-sight from individual staff roles to attainment of the Department's vision, mission, and goals. In facilitating the Lean Community, its future vision includes a highly efficient and fulfilled workforce through strong commitment to continuous improvement. It strives to empower engaged employees to eliminate waste and maximize value in their daily work routines. The Strategy Section collaborates with staff across the Department to achieve integration of various initiatives, including health reform, and develops strategies to leverage resources. Overall, this Section provides structure and cohesion for implementing and prioritizing projects that align with the Department's strategic direction.

## Clinical Services Office

The Clinical Services Office provides clinical expertise across the Department. This Office focuses on preventing the onset of disease and helping the Department's clients to manage chronic diseases in such a way that their health improves. Staff in the Office advise clinically on medical services provided by the Medicaid agency, assist in policy development, program planning, quality improvement, provide clinical input on member and provider grievances and appeals, and act as liaisons with the provider community and other State agencies as needed. This Office includes Pharmacy, Strategic Projects and the Quality and Health Improvement units.

Pharmacy Section

The Pharmacy Section oversees access to medications for Medicaid clients, including the fee-for-service and dual-eligible (Medicare and Medicaid) populations. The section ensures that medications are used in a clinically appropriate and cost-effective manner through the Preferred Drug List Program and by performing drug-utilization analysis, with input from the Drug Utilization Review Board. The section aims to improve health care quality by addressing under-utilization, over-utilization, and inappropriate utilization of pharmaceuticals. This section administers the Rx Review Program (drug therapy counseling sessions for Medicaid clients). The section collects federal and supplemental drug rebates from pharmaceutical manufacturers. The section also ensures that pharmacy benefits are provided in compliance with federal and state statutes and regulations. Finally, the section provides pharmacy benefits information and assistance to clients, pharmacies, and prescribers to facilitate clients' access to their medications.

Quality and Health Improvement Unit

The Quality and Health Improvement Unit is responsible for directing, conducting, and coordinating performance-improvement activities for the care and services Medicaid and Children's Basic Health Plan clients receive. The unit works across programs, offices, and divisions to promote effectiveness and efficiency initiatives that support the Department's mission. Specific functions of the unit include process and outcome measurement and improvement, managing the external quality review of physical and behavioral managed care contractors and fee-for-service providers, monitoring managed care plan contract compliance, overseeing external review organization administration of satisfaction surveys to clients enrolled in Medicaid managed care and the Children's Basic Health Plan, development of long term care quality tools and interagency quality collaborations, and development and implementation of quality strategies and consulting to program managers regarding performance measurement and improvement.

## Policy, Communications and Administration Office

The Policy, Communications and Administration Office includes the Communications Section, the Policy Coordination Section, the Workforce Development and Human Resources Sections, and the Administrative Services Unit. The office bears responsibility for management of the functions associated with government affairs, communication and media relations, and internal Department operations.

The office provides leadership and advice to the Department to optimize internal and external communication and enhance internal and external relations. The staff represents the Department before a wide variety of external stakeholders, including but not limited to policy makers, county partners, advocates/stakeholders, and the press. Staff are responsible for working with Department managers on high-profile matters to make certain they are handled in a manner that is most beneficial to the citizens of Colorado and to the Department.

The Communications Section is responsible for developing a broad-scale communications plan, proactively addressing both internal and external audiences' needs. The Policy, Communications and Administration Office is responsible for crafting messages to policy makers, clients, and stakeholders that are accurate and that reflect the overall mission and accomplishments of the Department and programs.

The Policy Coordination Section creates the Department's legislative agenda and advocates for successful passage of Department initiatives, and creates and maintains positive relationships with all legislators and regularly communicates with legislators about the Department's initiatives. The Office also contains the Department's Federal Policy and Rules Officer and coordinates the Medical Services Board, the Department's rule-making body.

The Workforce Development Section sustains and improves the Department's ability to achieve its on-going mission and capacity to innovate by supporting employee engagement and professional development for all staff. The Workforce Development Section is responsible for effectively developing, managing, and improving programs to improve quality of the Department's workforce.

The Human Resources Section performs all functions necessary to properly classify Department staff positions and to fill those positions in accordance with the State constitution and the State personnel rules and procedures. Those functions include recruitment, testing and selection, classification, salary administration, dispute resolution, personnel performance management, and annual compensation/benefits. This section provides guidance, counseling, and technical assistance to Department managers and staff on the application of the State personnel system. The Human Resources Section is responsible for training all Department staff on Executive Orders such as sexual harassment, violence in the workplace, and maintaining a respectful workplace. The Human Resources Section also oversees the building Reception Unit, which provides identification badges to all department visitors to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The Administrative Services Unit is responsible for office administration, event planning and coordination, facilities management, and ensuring department-wide compliance with standard operation procedures. The Unit coordinates Department support staff and special projects. The unit also houses the Governor's Citizen's Advocate.

**Client Services, Eligibility, and Enrollment Office**

The Client Services, Eligibility, and Enrollment Office includes a diverse set of functions that promote the Department's mission of improving access to high-quality and cost-effective health

care services to Coloradans. Many of the activities focus on ensuring that those applying for state medical assistance programs have the support and information they need to make the process as easy as possible. Once enrolled in a program, several activities support the client's continued retention if they remain eligible and promote access to health care services in appropriate settings. Similarly, the projects within this Office are centered on ensuring that external partners, providers, stakeholders, and community-based organizations have opportunities to provide input regarding the implementation of programs and major initiatives of the Department. To this end, the Client Services, Eligibility, and Enrollment Office identifies ways to improve communication to further the goals of transparency and accountability.

Eligibility Division

The Eligibility Division exists to ensure access to Medicaid for eligible individuals, families, children, the elderly, and persons with disabilities. This section defines program eligibility through policy development, implementation, and training to statewide eligibility sites and other partners. The section also provides policy expertise on Medicaid eligibility for all categories for the rules-based eligibility determination system, serving as a liaison to the Colorado Benefits Management System (CBMS), managed by the Office of Information Technology (OIT).

Client Services Division

The Client Services Division provides a high level of communication and assistance to all clients who contact the Department. The Customer Contact Center serves as the major focal point for callers who require assistance with questions about eligibility and program information and who need help navigating a complex health care system. This Division also includes the Program and Policy Training Unit, which produces and conducts trainings for a wide variety of internal and external customers regarding the Department's policies and initiatives.

**Community Partnerships Office**

The Community Partnerships Office builds and manages community partnerships and relationships and assists with aligning the Department's strategy and activities with statewide and national health reform initiatives. The Office coordinates relationships between the Department and partners of the Department, including advocacy organizations, payers, business, providers, and other state agencies and units of state government. The Office includes the Legal and Grants Division.

Legal Division

The Legal Division is responsible for handling privacy and Health Insurance Portability and Accountability Act (HIPAA) training and compliance. The Division also acts as records custodian and coordinates Colorado Open Records Act requests. Other responsibilities of the Division include managing and coordinating external data requests through the Department's data review board, managing the Department's privacy database, managing the Department's State Plan and drafting amendments to the State Plan, providing assistance in drafting rules, coordinating the Department's relationship with the Attorney General's office, providing analysis and guidance to Department personnel on various regulatory and legal issues, and monitoring the impacts of federal health care reform.

The Legal Division includes the Benefits Coordination section, whose mission is to ensure Medicaid is the payer of last resort, extending public purchasing power by pursuing third-party payment of medical costs for Medicaid-eligible persons. The Benefits Coordination Section pursues responsible payment sources to recover costs for medical care paid for by Medicaid. The sources the Benefits Coordination Section pursues include trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively.

**Office of Community Living**

The Community Living Office was established within the Department by Executive Order D2012-027 in July 2012 by Governor Hickenlooper. A primary responsibility of the new Office is the development and implementation of strategy to promote self-direction & person-centered services & supports. The Office is charged with focusing on the needs of aging Coloradans & Persons with Disabilities. The Office exists to provide strategic direction on the redesign of all aspects of the Long Term Services and Supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care. On April 1, 2014, the Division for Intellectual and Developmental Disabilities, formerly the Division for Developmental Disabilities under the Department of Human Services, was transferred to the Department as first administrative unit under the Office of Community Living, as authorized by the passage of HB 13-1314.

<u>The Division for Intellectual and Developmental Disabilities</u>

The Division for Intellectual and Developmental Disabilities provides leadership for the direction, funding, and operation of individualized and flexible supports that enable persons with developmental disabilities to lead integrated and meaningful lives in the community. The Division also provides leadership for the direction, funding, and administration of services for persons with developmental disabilities in Colorado. State leadership and oversight includes: policy, planning, program and budget development, technical assistance, training, setting priorities, contracting, allocation of resources, program quality reviews, monitoring, evaluation and management information. The Division operates three of Colorado's Home and Community Based waivers: the waiver for Persons with a Developmental Disability, the Supported Living Services waiver, and the Children's Extensive Support waiver. Eligible clients on these waivers receive services enabling them to live in the least restrictive, community-based settings appropriate to their needs. The Division also oversees programs administered with state only funding, including the state-only Supported Living Services waiver, the Family Support Loan Program, and the Family Support Services Program.