Performance Plan FY 2015-16

JULY 1, 2015

COLORADO

Department of Health Care Policy & Financing

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Introduction

The Department of Health Care Policy and Financing is the federally designated Single State Agency to receive Medicaid funding from the federal government for administration or supervision of Colorado's Medicaid program. To receive federal financial participation, the Department is responsible for the provision of health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. 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. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services, which 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.

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.

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. It 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 incorporated process improvement into its business operations and culture, 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 4) 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. Six strategic policy initiatives were identified as critical to fulfilling the Department's mission while ensuring 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 in 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.

Strategy Map

Due to the cross-functional nature of teamwork within the Department, its FY 2015–16 Performance Plan follows the strategy-based organization of its Strategy Map (see page 4). The Department's major functions are carried out by six 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).

Department of Health Care Policy & Financing Strategy Map

VISION: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

MISSION: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources

STRATEGIES

Customer	Communications	Technology	People	Process	Financing
Improve health outcomes, client experience and lower per capita costs	Sustain effective internal and external relationships	Provide exceptional service through technological innovation	Build and sustain a culture of recruiting and retaining talented employees	Enhance efficiency and effectiveness through process improvement	Ensure sound stewardship of financial resources

GOALS & Performance Measures

Customer	Communications	Technology	People	Process	Financing
Integrated Delivery System	Internal Communications	Health Information Technology	Workforce Development	Strategic Management	Cost Containment
Benefit / Program Design	External Communications	SharePoint Management	Employee Engagement	LEAN Community	Fraud, Waste & Abuse Prevention
Payment Methodology	Government Relations		Human Resources Optimization		Grants Management
Eligibility & Enrollment					
Client Engagement					

Customer

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

The Department's customer strategy focuses on improving health outcomes and member experience while reducing the growth rate of costs. The Affordable Care Act reshaped the Medicaid landscape by expanding eligibility for Medicaid, and creating structured financial incentives for states aimed at improving health, health care outcomes and experience of people served by Medicaid.

The following five goal areas have been established for achieving this strategic policy initiative:

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

Integrated Delivery System

In fulfilling its Integrated Delivery System goal, the Department seeks to establish full integration of medical, behavioral and dental services for members. Programs supporting this goal focus on:

- establishing regional referral systems;
- creating regional networks of medical and social services;
- coordinating member care through a primary care medical provider;

- adopting technology that facilitates shared access to patient information among providers; and
- identifying members with complex medical needs and managing their care across providers.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) is the cornerstone of the Department's efforts to improve member health while containing costs. The ACC is a central part of Medicaid reform that incentivizes care coordination and the wise use of health services. The ACC focuses on the needs of its members and leverages local resources to best meet those needs, while fostering integration and collaboration across the spectrum of member health care. It connects and supports providers to make collaboration possible, using the following framework:

- seven Regional Care Collaborative Organizations (RCCOs) throughout the state whose responsibilities include developing a network of providers; managing and coordinating member care; reporting on costs, utilization and outcomes;
- primary care medical providers contracted with a RCCO to serve as medical homes for ACC members; and
- a health information technology contractor providing data based on claims to support decision-making of RCCOs and primary care medical providers.

ACC Performance Tables

Process:	Increase Enrollment of Medicaid Members into the ACC	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# Individuals Served Through Colorado Medicaid	682,994	860,957	1,161,133	1,289,493	1,450,606
Output:	# ACC Members	223,967	449,021	754,439	919,403	1,082,754
Outcome:	% ACC Members of Total Medicaid Population	33%	52%	65%	71%	75%

Medicaid-only caseload, annual average of monthly enrollment (excludes dual-eligible clients).

Process:	Enroll ACC Eligible Medicaid Adults into the ACC	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# ACC Eligible Medicaid Adults (age 21 and older excluding Duals)	125,435	289,342	419,000	557,619	677,712
Output:	# Adult ACC Members (age 21 and older excluding Duals)	69,059	150,197	326,245	410,223	504,615
Outcome:	% Adults Enrolled in ACC	55%	52%	78%	74%	74%

Annual average of monthly enrollment (excludes dual-eligible clients). Projections years percentages are lower than FY 2014-15 due to anticipated rampup of eligible individuals.

Process:	Enroll ACC Eligible Medicaid Children into ACC	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# ACC Eligible Medicaid Children (up to age 21)	248,599	419,992	460,000	604,087	651,135
Output:	# Child ACC Members (up to age 21)	47,940	268,861	388,613	443,400	496,160
Outcome:	% Children Enrolled in ACC	19%	64%	84%	73%	76%

Annual average of monthly enrollment (excludes dual-eligible clients). Projections years percentages are lower than FY 2014-15 due to anticipated rampup of eligible individuals.

Process:	Increase ACC Primary Care Provider Site Locations	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Output:	# Unique ACC Primary Care Medical Provider Sites	135	N/A	720	932	1,226

Primary Care Medical Providers (PCMP), for ACC purposes, include specific classifications of Medicaid Providers. A Provider can be an individual, a group of individuals, or a unique location of a multi-location practice. PCMP Practices data for FY 2013-14 is not available.

Process:	Attribute ACC Members to Primary Care Providers in RCCO Network	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# ACC Members	223,967	449,021	754,439	919,403	1,082,754
Output:	# ACC Members w PCMP	N/A	322,395	650,400	753,910	920,341
Outcome:	% ACC Members w PCMP	N/A	72%	86%	82%	85%

Emergency Department Visits

Reducing non-emergent emergency department visits is a measure of success in the Department's goal to limit unnecessary or inappropriate use of medical care and services. The Department is engaging hospitals through a new emergency department-based incentive offered through Colorado Medicaid's Hospital Quality Incentive Payment (HQIP) program. Participating hospitals have the opportunity to increase their incentive payments if they implement a specified number of initiatives focused on reducing emergency department visits. As of July 2014, a total of 65 hospitals with emergency departments (90% of Colorado hospitals with emergency departments) have agreed to participate.

To investigate additional best practices for ensuring appropriate emergency department use, the Department is evaluating initiatives in other states, including expanded use of urgent care centers.

Emergency Department Visits Performance Measure Table

Process:	Reduce Emergency Department Visits	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid Fee-for-Service Member Months	607,241	777,664	872,889	986,914	1,214,963
Output:	# Medicaid Fee-for-Service Emergency Dept Visits	523,071	648,160	725,933	789,531	911,222
Outcome:	# Emergency Dept Visits per Thousand Member Months	861	833	832	800	750

Hospital Readmissions

The hospital readmission rate is a key indicator for the Department's goal of optimizing care outcomes of clients. In support of this goal, the Hospital Quality Incentive Payment program (HQIP) has included a 30-day hospital readmission reduction incentive since 2013. Participating hospitals receive incentive payments if 30-day readmission rates are equal to or less than the statewide average.

Hospital Readmission Performance Measure Table

Process:	Reduce Hospital Readmissions	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Acute Care Inpatient Hospital Discharges	55,266	67,977	80,893	85,462	92,763
Output:	# Hospital Readmission Events within 30 Days of Discharge	6,185	7,308	8,494	8,682	8,987
Outcome:	% Hospital Readmissions within 30 Days of Discharge	11%	11%	11%	10%	10%

Medicaid Providers

The Department seeks to increase the number of providers and physicians serving Colorado Medicaid members, with an emphasis on enrolling primary care practitioners in Medicaid and the Accountable Care

Collaborative (ACC). The Department's Regional Care Collaborative Organizations assist in meeting this goal by encouraging providers to enroll in Medicaid and in the ACC.

Provider enrollment in Colorado Medicaid and participation in the ACC program are demonstrating significant growth. In 2014, the Department's Client and Clinical Care Office hired a Chief Nursing Officer to supplement provider recruitment-focused networking and outreach to providers and professional organizations. Also in March 2014, the Department established a Provider Relations Unit, recognizing the need for dedicated resources to address provider recruitment, retention and relations. The Unit is tasked with ensuring the Colorado Medicaid provider network is adequate and comprehensive, with sufficient physical, behavioral, dental and long-term services.

Medicaid Providers Performance Measure Tables

Process:	Enroll New Medicaid Providers	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	# Colorado Providers Serving Medicaid	39,821	43,867	47,405	51,070	58,400

2,821 Medicaid providers do not have NPI numbers and would not be present in the National Plan and Provider Enumeration System (NPPES) database used to count the total number of Colorado providers. Colorado providers with addresses that could not be located using geographic information software were excluded.

Process:	Improve Access to Medicaid Primary Care Providers	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	# Colorado Primary Care Providers Serving Medicaid	16,641	18,822	20,429	22,323	26,111

Primary Care Providers includes specific classifications of Medicaid providers. In this table, the term is intended to align with the ACC definition of a PCMP. The Department is assessing current methodology and may revise numbers upon completion of its review. See table: Enroll Primary Care Providers into the ACC Program for more information.

Behavioral Health

To meet its goal of improving health outcomes and successful recovery of members requiring treatment for mental health and substance use disorders while lowering per capita costs, the Department seeks to increase the number of Medicaid members utilizing Behavioral Health Organization (BHO) services.

On January 1, 2014, the Department integrated substance use disorder (SUD) benefits—previously offered on a limited fee-for-service basis—into its statewide managed care Community Behavioral Health Services (CBH) program. The program utilizes regional BHOs to ensure the provision of medically necessary behavioral health services. Delivering SUD benefits through the CBH program expanded the array of benefits available to Medicaid members.

Integrating mental health and SUD under the same managed care system results in greater integration of services, improved overall treatment of behavioral health conditions, and decreased expenditures through the administration and operation of a single system. Member use of BHO-based SUD benefits and services has been significant. It was originally estimated that by FY 2014–15, approximately 14,251 members would utilize SUD services through the CBH program. However, as early as September, 2014, 16,533 members had utilized the services. Access to care standards in the CBH contracts are now the same for mental health services as they are for SUD treatment, creating consistency across behavioral health and improving access to SUD treatment.

Traditionally, mental health and SUD services have been systemically separated from physical health services. A health system in which physical health is separated from behavioral health—and in which only one condition is treated at a time—is less effective and more expensive. The Department executed five new BHO contracts that started on July 1, 2014. The new contracts focus on increasing the number of co-located physical health and behavioral health providers, and require increased coordination with other entities that serve and/or represent Colorado Medicaid members.

Behavioral Health Performance Table

Process:	Increase Medicaid Members Receiving a BHO Service	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# BHO Clients	659,104	849,236	1,094,003	1,270,151	1,428,847
Output:	# BHO Clients Receiving a BHO Service	88,829	113,647	147,690	165,120	185,751
Outcome:	% BHO Clients Receiving a BHO Service	13%	13%	13%	13%	13%

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 Benefits Collaborative has developed more than a dozen benefit coverage standards. These include home health, dental services, and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21.

The Department is also working through the Community Living Advisory Group, to redesign Long Term Services and Supports (LTSS) delivery systems 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 in transitioning to the community with the services and supports they need to live as independently as possible.

Coverage Design

To meet its goal of improving health outcomes and containing costs in Medicaid coverage design, the Department seeks to successfully use evidence-based processes, apply person-centered principles, and ensure that covered services are limited to those necessary and effective to provide quality health care.

Coverage standards that define Colorado Medicaid covered services are developed through the Benefits Collaborative process, which incorporates feedback of diverse and knowledgeable stakeholder groups, such as the Medical Advisory Committee and Children's Services Steering Committee. The Collaborative seeks to define coverage that:

- is based on the best available clinical evidence and best practices;
- outlines the appropriate amount, scope and duration of Medicaid services;

- is cost effective and sets reasonable limits upon services; and
- promotes the health and functioning of Medicaid members.

Clearly defined coverage provides guidance for service providers, increases client understanding of their benefits, and ensures responsible allocation of taxpayer dollars.

Coverage Design Performance Table

Process:	Increase Medicaid Benefits Defined by Collaborative (Replacement)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# of Medicaid Benefits to be Defined by Collaborative	67	68	62	62	68
Output:	# Medicaid Benefits Defined by Collaborative	20	23	28	44	68
Outcome:	% Medicaid Benefits Defined by Collaborative	30%	34%	45%	71%	100%

This table replaces the similarly named table in Appendix A due to a change in reporting methodology. Data previously reflected the number of rules completed as result of process. Data now reflects the number of benefits defined.

Long Term Services and Supports

The Department's goal for long term services and supports is to provide person-centered, quality services to seniors and persons with disabilities. Programs and supports in place to achieve this goal are the Medicaid Home and Community Based Services (HCBS) waiver programs, nursing facilities, Program of All-Inclusive Care for the Elderly (PACE), hospital back-up, and Colorado Choice Transitions.

HCBS provides services in clients' homes and communities as an alternative to placement in a nursing facility or other institutional setting. For qualifying clients in HCBS waiver programs, the Department makes available consumer-directed attendant support services (CDASS), a service delivery option that allows clients to direct their own care.

Long Term Services and Supports Performance Tables

Process:	Place Appropriate Long Term Services and Supports Clients in Nursing Facilities	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients	45,372	45,965	47,904	51,625	55,694
Output:	# LTSS Clients in Nursing Facilities	9,528	9,462	9,654	9,581	9,529
Outcome:	% LTSS Clients in Nursing Facilities	21%	21%	20%	19%	17%

Includes clients in waiver programs administered by HCPF and the Department of Human Services; PACE; and Class I and II nursing facilities.

Process:	Provide Waiver Services to Appropriate Long Term Services and Supports Clients	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients	45,372	45,965	47,904	51,625	55,694
Output:	# LTSS Clients Receiving HCBS Waiver Services	33,442	34,246	35,597	39,105	42,587
Outcome:	% LTSS Clients Receiving HCBS Waiver Services	74%	75%	74%	76%	76%

Includes clients in waiver programs administered by HCPF and the Department of Human Services; PACE; and Class I and II nursing facilities.

Process:	Provide PACE Services to Appropriate Long Term Services and Supports Clients	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients	45,372	45,965	47,904	51,625	55,694
Output:	# LTSS Clients Enrolled in PACE	2,402	2,257	2,653	2,939	3,578
Outcome:	% LTSS Clients Enrolled in PACE	5%	5%	6%	6%	6%

Includes clients in waiver programs administered by HCPF and the Department of Human Services; PACE; and Class I and II nursing facilities.

Process:	Reduce Growth Rate of Per Capita Nursing Facility Costs	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients in Nursing Facilities	9,528	9,462	9,654	9,581	9,529
Output:	$ Total Cost for Nursing Facilities	$537,512,812	$565,810,157	$591,261,908	$603,622,028	$611,382,425
Outcome:	$ Per Capita Cost for Nursing Facilities	$56,414	$59,798	$61,245	$63,002	$64,160

Includes Class II nursing facilities.

Process:	Reduce Growth Rate of Per Capita HCBS Costs	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients Receiving HCBS Waiver Services	33,442	34,246	35,597	39,105	42,587
Output:	$ Total Cost for HCBS Services	$639,883,504	$709,511,074	$767,700,305	$873,781,895	$948,950,315
Outcome:	$ Per Capita Cost for HCBS	$19,134	$20,718	$21,566	$22,345	$22,283

Includes clients in waiver programs administered by HCPF and the Department of Human Services.

Process:	Reduce Growth Rate of Per Capita PACE Costs	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients Enrolled in PACE	2,402	2,257	2,653	2,939	3,578
Output:	$ Total Cost for PACE Services	$97,346,358	$100,474,817	$133,718,198	$140,174,136	$174,962,910
Outcome:	$ Per Capita Cost for PACE	$40,527	$44,517	$50,403	$47,695	$48,900

Colorado Choice Transitions

The goal of the Colorado Choice Transitions (CCT) program is to assist residents of long-term care facilities in transitioning to and receiving services in a home of their choice. In addition to community-based services already available through Medicaid Home and Community Based Services (HCBS), CCT clients receive case management, independent-living skills training, and community transition services for one year.

Colorado Choice Transitions Performance Table

Process:	Transition Appropriate Nursing Facility Clients to Community Care	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# LTSS Clients in Nursing Facilities	9,528	9,462	9,654	9,581	9,529
Output:	# NF Clients Transitioned to HCBS through Community Choice Transitions (CCT)	4	42	58	63	63
Outcome:	% NF Clients Transitioned to HCBS through Community Choice Transitions (CCT)	0.0%	0.4%	0.6%	0.7%	0.7%

Well-Child Visits

The Department's goal for well-child visits is to meet the federal requirement of 80% of eligible children ages 20 and under receiving at least one visit within the measurement year. Based on the most recent federal data for this demographic, Colorado is at 64%. Several efforts are underway to improve well-child visits performance, including use of the well-child visits Key Performance Indicator (KPI).

The Department narrowed the focus of its well-child KPI to 3–9 year-olds during FY 2014–15, recognizing that well-child visits for this age group shows significant opportunity for improvement (see table below). The Department uses this and other KPIs to measure improvements to member health in its Accountable Care Collaborative (ACC) and to incentivize best practices in the ACC's Regional Care Collaborative Organizations (RCCOs) through financial incentive payments for achieving defined targets. The age 3–9 indicator has provided insight into the success of several efforts promoting well-child visits.

To further improve performance with regard to well-child visits, the RCCOs have partnered with the Colorado Medicaid outreach and case management program Healthy Communities. One goal of this partnership is to educate providers regarding the importance and the components of well-child visits.

In 2013, the Department adopted the American Academy of Pediatrics Bright Futures periodicity of visits schedule, and began requesting that all contractors and managed care entities follow Bright Futures guidelines for well care. Bright Futures recommends at least six visits for children less than one year of age, four visits for children between one and three years, and a yearly well-child check from ages four–21 years.

Well-Child Visits Performance Measure Table

Process:	Promote Well-Child Visits (Replacement)	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# ACC Children Age 3-9	N/A	N/A	144,265	145,852	148,711
Output:	# ACC Children Age 3-9 with at Least One Annual Well Child Visit in the Past 12 Months	N/A	N/A	70,522	74,384	81,791
Outcome:	% ACC Children Age 3-9 with at Least One Annual Well-Child Visit in the Past 12 Months	N/A	N/A	49%	51%	55%

This table replaces the Medicaid Children (15 months of age) table, available in Appendix A. Going forward, the measure set will track Children Age 3-9. At the time of reporting, data was available through November of 2014. The data in this table covers the twelve months prior to that.

Prevention and Wellness

To determine success in its goal of promoting preventive health and wellness services for Medicaid clients, the Department has selected as performance measures 1) adolescents and adults screened for depression, 2) preventive dental services for Medicaid and CHP+ eligible children, and 3) postpartum visits for women who gave birth in the last 12 months.

Several programs and efforts underway during FY 2014–15 contributed to meeting the prevention and wellness goal. The Department launched depression-specific educational campaigns targeting adolescents, youth, and adults to promote screening, accurate diagnosis, effective treatment, and follow-up. These campaigns align with prevention and wellness recommendations of the U.S. Preventive Services Task Force. Additionally, the Department updated the Accountable Care Collaborative (ACC) Key Performance Indicators (KPIs) to include a measure related to postpartum visits for women.

Preventive oral health care is an important measure of prevention and wellness due to the strong correlation between positive oral health outcomes and the general health and wellness of children. Medicaid covers dental services for all child enrollees as part of its EPSDT program. The Child Health Plan *Plus* 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.

Prevention and Wellness Performance Measure Tables

Process:	Promote Adolescent Depression Screening	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid Adolescents (age 11-20)	133,306	172,804	224,092	266,573	378,367
Output:	# Adolescents Screened for Depression	4,436	8,192	15,102	16,215	28,683
Outcome:	% Adolescents Screened for Depression	3%	5%	7%	6%	8%

Process:	Promote Adult Depression Screening	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid Adults (age 21+ excluding Duals)	209,617	413,431	565,692	677,149	755,681
Output:	# Adults Screened for Depression	TBD	944	3,085	5,091	11,455
Outcome:	% Adults Screened for Depression	TBD	0.2%	0.5%	0.8%	1.5%

Process:	Promote Preventive Dental Services for CHP+ Kids	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# CHP+ Children (age 0-18)	77,836	61,553	54,561	49,432	48,330
Output:	# CHP+ Children Receiving a Preventive Dental Service	35,485	33,844	29,650	26,600	26,000
Outcome:	% CHP+ Children Receiving a Preventive Dental Service	46%	55%	54%	54%	54%

Number of CHP+ Children in this table are those with 90+ days of continuous eligibility and eligible for dental service benefit.

Process:	Promote Preventive Dental Services for Medicaid Kids	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid Children (up to age 21)	420,440	531,736	561,506	612,344	694,925
Output:	# Medicaid Children Receiving a Preventive Dental Service	214,706	244,717	269,600	306,172	375,260
Outcome:	% Medicaid Children Receiving a Preventive Dental Service	51%	46%	48%	50%	54%

Medicaid Children are included if they are eligible for at least 90 continuous days in a Title XIX eligibility type and they are between ages 1 and 21 as of the end of the measurement year.

Process:	Increase Postpartum Visits	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# ACC Women Who Gave Birth in the Past 12 Months	N/A	N/A	9,561	9,666	9,855
Output:	# ACC Women Who Gave Birth in the Past 12 Months Who had at Least One Postpartum Visit	N/A	N/A	6,671	6,960	7,293
Outcome:	% ACC Women Who Gave Birth in the Past 12 Months Who had at Least One Postpartum Visit	N/A	N/A	70%	72%	74%

This table replaces the Prevent Low-Birthweight Babies table available in Appendix A. Going forward, the measure set will track Postpartum Visits. At the time of reporting, data was available through November of 2014. The data in this table covers the twelve months prior to that.

Payment Methodology

The Department's goal for reducing the growth rate of per capita costs while improving health outcomes centers on transitioning away from a traditional fee-for-service payment model to one that rewards performance. This transition is an evolving process that aligns certain financial incentives with patient outcomes. It is likely to impact all Medicaid members by streamlining care and reducing unnecessary services, and may fundamentally transform Medicaid's core operations.

ACC Savings

The ACC is central to the Department's goal of reducing the growth rate of health care costs by incentivizing care coordination and the wise use of health services. Subsequent to enrollment of Medicaid expansion populations beginning in January 2014, overall savings in the ACC increased. During FY 2013–14, the ACC generated over $98M in gross savings. After subtracting administrative expenses, net savings for FY 2013–14 exceeded $29M.

ACC Savings Performance Tables

Process:	Achieve ACC Net Savings Targets	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	$ Total ACC Admin Costs (payments to RCCOs, PCMPs, SDAC)	$36,728,931	$68,570,330	$112,702,667	$146,180,966	$176,060,935
Output:	$ ACC Gross Savings Per Member Per Month	$16	$18	N/A	$13	$14
Outcome:	$ ACC Net Savings (Range Minimum)	($6,930,854)	($29,330,495)	N/A	N/A	N/A

Annual budgeted net savings benchmarks fluctuate by caseload mix – final estimates are provided each February.

Process:	Reduce Growth Rate of Per Capita Costs - ACC Children	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# Child ACC Members (up to age 21)	47,940	268,861	388,613	443,400	496,160
Output:	$ Total - ACC Children	$193,115,317	$442,752,558	$573,924,828	$697,024,570	$779,963,779
Outcome:	$ Per Capita - ACC Children	$4,028	$1,647	$1,477	$1,572	$1,572

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		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# Adult ACC Members (age 21 and older excluding Duals)	69,059	150,197	326,245	410,223	504,615
Output:	$ Total - ACC Adults	$303,745,899	$561,258,351	$1,062,843,054	$1,476,802,435	$1,816,612,403
Outcome:	$ Per Capita - ACC Adults	$4,398	$3,737	$3,258	$3,600	$3,600

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		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# ACC Disabled	18,247	29,964	39,581	67,646	78,659
Output:	$ Total - ACC Disabled	$255,383,099	$405,019,074	$526,817,198	$974,102,967	$1,132,684,569
Outcome:	$ Per Capita - ACC Disabled	$13,996	$13,517	$13,310	$14,400	$14,400

Not risk-adjusted. Based on MSP aggregate per-capita expenditures by population – adjusted for expected savings. 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		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# FFS Non-ACC Children	337,916	173,783	126,949	113,277	123,623
Output:	$ Total - FFS Non-ACC Children	$461,294,868	$354,468,197	$492,350,485	$315,350,541	$289,207,529
Outcome:	$ Per Capita - FFS Non-ACC Children	$1,365	$2,040	$3,878	$2,784	$2,339

Process:	Reduce Growth Rate of Per Capita Costs - Non-ACC Adults	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# FFS Non-ACC Adults	156,220	191,279	238,499	237,458	225,794
Output:	$ Total - FFS Non-ACC Adults	$1,173,316,916	$1,357,092,249	$2,293,365,209	$1,770,857,006	$1,695,743,736
Outcome:	$ Per Capita - FFS Non-ACC Adults	$7,511	$7,095	$9,616	$7,458	$7,510

Process:	Reduce Growth Rate of Per Capita Costs - Non-ACC Disabled	Historical Actual		FY 2014-15	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14	Estimate	FY 2015-16	FY 2017-18
Input:	# FFS Non-ACC Disabled	53,612	46,873	41,246	17,489	18,435
Output:	$ Total - FFS Non-ACC Disabled	$778,650,515	$765,991,277	$856,183,577	$330,694,060	$463,172,051
Outcome:	$ Per Capita - FFS Non-ACC Disabled	$14,524	$16,342	$20,758	$18,909	$25,124

ACC Pay for Performance and Payments Linked to Outcomes

To meet the Department's goal of decreasing its reliance on an unmanaged, pay-for-volume system, the ACC's RCCOs are paid on a per-member, per-month basis for their services. Primary Care Medical Providers receive a per member per month payment, in addition to fee-for-service payments, for their role as medical homes for ACC clients. ACC payment methodology further incentivizes value by rewarding improvement in member health and medical service utilization patterns. Regionally-calculated incentive payments are offered to RCCOs and medical providers who demonstrate, through performance indicators,

that they are influencing more appropriate utilization of services. These performance indicators are tracked regularly by the Department, the RCCOs and the Primary Care Medical Providers. The performance indicators for FY 2015–16 are designed to:

- decrease unnecessary utilization of emergency rooms;
- increase well-child visits among children ages 3–9;
- increase postpartum follow-up care among new mothers following delivery;
- increase the number of primary care providers who meet enhanced practice standards such as extended office hours;
- increase follow-up care within 30 days of hospital discharge; and
- increase the number of members connected to a primary care medical provider.

ACC Pay for Performance and Payments Linked to Outcomes Performance Tables

Process:	Link Payments to Outcomes (Replacement)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	$ Total Provider Incentive Payments (ACC, HMO, NFs, HQIP)	$29,604,682	$46,096,303	$46,066,748	$75,268,885	$80,852,521
Outcome:	% Change in Provider Payments from Prior Year	468%	56%	0%	63%	N/A

This table replaces the similarly-named table in Appendix A due to a change of reporting structure.

Process:	Promote ACC Pay for Performance	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
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	5	3	0	4	5
Outcome:	% RCCOs Achieving Level 1 Pay for Performance	71%	43%	0%	57%	71%

Previously, this process assessed based on having achieved Pay for Performance benchmark standards in at least three of four categories in at least one quarter of the fiscal year. Benchmarks may be replaced from year to year. The measure has been adjusted to count the number of RCCOs achieving Pay for Performance on at least two key performance indicators for six consequtive months during the fiscal year. Projections are based on the adjusted benchmark.

Hospital Quality Incentive Payment (HQIP) program

To meet its goal of improving population health, improving patient experience and reducing the cost of care, the HQIP program seeks to increase the number of hospitals eligible to receive incentive payments and identify meaningful incentive measures. The program has created four optional incentive measures for 2015. These are designed to increase the number of hospitals eligible to submit data by opening participation to hospitals that do not provide care types specified by current HQIP measures.

HQIP incentive payments to hospitals are based on hospital performance related to improving patient care outcomes. The program establishes quality measures forming the basis for individual incentive payments, and is administered through a collaboration between the Department and hospitals. A hospital maintains its eligibility to participate and receive incentive payments by submitting annual quality outcome data to the HQIP partnership.

HQIP Performance Measure Table

Process:	Promote Hospital Participation in HQIP	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Hospitals Eligible to Submit Data for all HQIP Measures	86	87	87	87	87
Output:	# Eligible Hospitals Submitting Data for all HQIP Measures	36	45	57	65	78
Outcome:	% Eligible Hospitals Submitting Data for all HQIP Measures	42%	52%	66%	75%	90%

Eligibility and Enrollment

Implementation of the Affordable Care Act enabled the Department to significantly expand Medicaid eligibility for Coloradans. The Department's goal for this coverage expansion is to provide adequate coverage and efficient enrollment and eligibility determinations for those eligible. The Department's goals for eligibility and enrollment include improving access to quality health care services by enrolling eligible Coloradans in Medicaid and Child Health Plan *Plus* (CHP+) and supporting continuous enrollment for those who remain eligible. The Department works closely with the Connect for Health Colorado health insurance exchange to ensure those seeking health insurance through the exchange receive the opportunity to apply for Medicaid. Other points of access include applying through the Colorado PEAK website, in-person, by phone, or via paper application.

Timely Eligibility Determinations and Redeterminations

Designated sites statewide process eligibility determinations and redeterminations to enroll Coloradans in Medicaid and Child Health Plan *Plus* (CHP+). To ensure timely eligibility determinations and redeterminations, the Department has implemented processing standards and corrective action plans by means of communication and outreach efforts with enrollment sites statewide. The Department provides training and ongoing support to these sites to assist with eligibility system changes and process improvement.

Eligibility and Enrollment Performance Tables

Process:	Increase Timely Eligibility Determinations for New Applications	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid/CHP+ Determinations Processed	405,795	647,837	435,645	539,205	574,819
Output:	# Eligibility Determinations Processed Timely	364,783	594,620	420,982	523,586	563,588
Outcome:	% Eligibility Determinations Processed Timely	90%	92%	97%	97%	98%

Process:	Increase Timely Eligibility Redeterminations	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Eligibility Redeterminations Processed	1,289,646	1,412,845	1,559,388	1,706,010	1,880,876
Output:	# Eligibility Redeterminations Processed Timely	1,173,681	1,330,946	1,485,705	1,639,739	1,833,720
Outcome:	% Eligibility Redeterminations Processed Timely	91%	94%	95%	96%	97%

Home and Community Based Services for Individuals with Intellectual and Developmental Disabilities

Home and Community-Based Services (HCBS) waivers enable the Department to waive certain Medicaid State Plan requirements to furnish an array of services to targeted populations in order to promote community living, and provide an alternative to services delivered in institutions.

This section and the tables focus on three of the 11 HCBS waivers administered by the Department:

- Developmental Disabilities (HCBS-DD),
- Supported Living Services (HCBS-SLS), and
- Children's Extensive Support (HCBS-CES).

The Colorado General Assembly appropriated funding to eliminate the waiting list for the HCBS-CES waiver in 2013, and in 2014 appropriated funding to eliminate the waiting list for the HCBS-SLS waiver. The Department, working closely with local Community Centered Boards, is still in the process of enrolling all eligible individuals for these two waivers. During 2014, the Assembly enacted a bill requiring the Department to develop, in consultation with intellectual and developmental disability system stakeholders, a comprehensive strategic plan for ensuring timely access to services for all eligible individuals with intellectual and developmental disabilities by the year 2020.

Accordingly, ensuring timely enrollment and access to services and supports and eliminating the waiting lists are high priority goals for the Department. The following paragraphs detail Department efforts planned through FY 2016-17 to meet these goals by 2020. These efforts include administrative and system changes to improve data collection, tracking, and reporting; simplifying and streamlining processes, including redesign of waiver programs; and strengthening communications with clients and stakeholders.

Needs of individuals waiting for services can change—for example, from requiring services at a later date to requiring services immediately, or vice versa. Contacting individuals on the waiting list regularly to assess their level of need and determine if they still require services immediately is essential to maintaining accurate counts of clients who are actually waiting for services. Beginning in July 2015, the Department is increasing its outreach to clients, including reassessment of individuals' support needs and preferences.

Management of enrollments for the three waivers is done either by Department staff or by local Community Centered Boards, depending on the waiver. With regard to enrollment management, the Department plans to establish standardized processes for data collection and reporting, and streamline the enrollment process statewide. Particular focus will be on systems improvements and data management capability. These improvements will include tracking of timely enrollment for services and provider participation. With these updates, web-based waiting list information will be made available to clients.

To improve access to services, the Department plans to implement a redesigned waiver for adults with intellectual and developmental disabilities, with the goal of replacing the HCBS-DD and HCBS-SLS waivers. Targeted for implementation in November 2016, this consolidated waiver will simplify processes to obtain services and supports, permit greater flexibility, and promote clients' self-direction of services

and supports. The Department will also be redesigning its service delivery and case management structures to align with federal regulations. These systemic changes will bifurcate what is, in the existing system, a concurrent provision of case management and provider agency functions by the same entities. Separating these functions will promote client independence, choice, and person-centered planning, and prevent potential conflicts of interest arising between service providers and case management agencies.

In order to be determined eligible for waiver services for individuals with intellectual and developmental disabilities, individuals must have a developmental disability determination completed. A part of this process includes an assessment completed by a professional level provider. Gaps have been identified in stakeholder understanding that these assessments can be paid for by Medicaid, if the individual is enrolled in Medicaid. Further, as a part of its system capacity efforts, the Department will work to identify additional professionals in order to provide better access to these assessments. The addition of Consumer Directed Attendant Support Services (CDASS) to the HCBS-SLS waiver in October 2015 will help address gaps in provider capacity, especially in rural areas. CDASS will allow clients to hire, train, manage and direct their caregivers, which may include family members.

The Department is committed to providing accurate, clear, and consistent information to clients and stakeholders in order to increase access and equity in its waiver programs. A communication plan and handbook for waiver programs is targeted for release in September 2015.

Home and Community Based Services Performance Tables

Process:	Increase Enrollment for Children's Extensive Support (CES) Waiver	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Individuals on CES Waiver Pending Enrollment	440	340	120	0	0
Output:	# Individuals Enrolled through CES Waiver	377	607	1,150	1,278	1,846
Outcome:	% of CES Eligible Individuals in Need of Immediate Services Enrolled	46%	64%	91%	100%	100%

*This table contains a minor wording adjustment from previous years.

*% CES Eligible Individuals in Need calculation = # Enrolled/(# Enrolled + # Pending Enrollment).

Process:	Increase Enrollment for Developmental Disabilities Services (DD) Waiver	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Individuals on DD Waiver Waiting List	1,567	1,670	1,994	2,232	2,831
Output:	# Individuals Enrolled through DD Waiver	4,384	4,392	4,970	5,038	5,291
Outcome:	% of DD Eligible Individuals in Need of Immediate Services Enrolled	74%	72%	71%	69%	65%

% of DD Eligible Individuals in Need calculation = # Enrolled/(# Enrolled + # on Waiting List)

Process:	Increase Enrollment for Supported Living Services (SLS) Waiver	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Individuals on SLS Waiver Pending Enrollment	1,439	1,405	909	0	0
Output:	# Individuals Enrolled through SLS Waiver	3,178	3,183	4,411	4,526	4,880
Outcome:	% of SLS Eligible Individuals in Need of Immediate Services Enrolled	69%	69%	83%	100%	100%

*This table contains a minor wording adjustment from previous years.

*% of SLS Eligible Individuals in Need calculation = # Enrolled/(# Enrolled + # Pending Enrollment).

Client Engagement

To meet the goal of improving the health and well-being of clients, the Department seeks to provide seamless and coordinated member experiences and engagement throughout the Medicaid and CHP+ programs.

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. Educational and training plans for Department employees are 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.

Transforming the Client Experience

The department seeks to provide personalized, seamless, and coordinated service and experience for members, beginning with the application process and extending to case management, healthy living, and service delivery. Planned initiatives fall into three overarching goal areas:

- attaining organizational excellence;
- personalizing client health care goals, and coaching clients on how to attain them; and
- giving clients the tools they need to take control of and improve their health.

Person and Family Centeredness

As part its goal of improving the health and well-being of Coloradans through client engagement, the Department seeks to provide seamless and coordinated member service and engagement throughout the Medicaid and CHP+ programs.

To strengthen member-inclusiveness in its business processes, policies, and partnerships, the Department has embarked on a two-year Client and Family Centeredness initiative. This initiative will cultivate an understanding of member experience and perspectives in order to:

- inform policy decisions,
- increase employee awareness and sensitivity about member needs, and
- engage members in their health and health care.

Two complementary initiatives form the foundation of this pilot to enhance collaboration between the Department and its members:

- The Person and Family-Centeredness Advisory Council, representative of the Colorado Medicaid and CHP+ populations, provides the Department with input and instruction from members and their families.

- The Department-wide Employee Champions Team was established to gain insights and perspectives from staff members. This team is tasked with heightening member-needs awareness and sensitivity among Department staff, as well as soliciting, presenting and supporting implementation of staff ideas for person-and-family centeredness.

CAHPS Ratings

Colorado's results for the Consumer Assessment of Healthcare Providers and Systems Report for Adults *in Medicaid* (CAHPS) annual client satisfaction survey are compared to the national average to measure success in the Department's goal of improving client experience. The CAHPS survey utilizes four ratings measures: 1) Rating of All Health Care, 2) Rating of Personal Doctor, 3) Rating of Specialist Seen Most Often, and 4) Getting Needed Care. By sharing de-identified respondent-level raw data from the survey with its health plans and Regional Care Collaborative Organizations, the Department leverages CAHPS results to support design of interventions and corrective action plans.

CAHPS Performance Measure Table

Process:	Improve Member Satisfaction with Health Care Experience	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# CAHPS Ratings Measures	4	4	4	4	4
Output:	# Measures ≥ National Average	2	4	4	4	4
Outcome:	% Measures ≥ National Average	50%	100%	100%	100%	100%

*This table contains a minor wording adjustment from previous years: the word "global" has been removed from this measure.

*Information provided to the Department from Health Services Advisory Group (HSAG). For FY 2013-14, HSAG determined that differences between state program aggregate scores and NCQA national averages was not statistically significant. Data for FY 2014-15 is a projection and will not be known until late in the calendar year.

Customer Call Center

Unprecedented call volume following Colorado's Affordable Care Act Medicaid implementation in October 2013 challenged the customer call center's ability to meet its service level goals, including the FY 2015–16 goal of answering 80% of all calls received within five minutes. To meet this challenge while maintaining the Department's commitment to operational excellence and high quality customer service, the center has incorporated new technological solutions, and is utilizing efficiency models and skills-based routing to meet needed staffing and service levels.

Customer relationship management (CRM) software funded through a budget appropriation has facilitated the center's tracking of client interactions and mining of call data. This data is being used to maximize the effectiveness of interactive voice response (IVR) system features such as self-service options and automated responses. The center is building on these enhanced data reporting capabilities by expanding how it measures performance. In addition to its Call Answer Rate metric, the center is collecting data on First Call Resolution (FCR), which tracks the effectiveness and efficiency with which representatives resolve customer issues. An important advantage of FCR is its usefulness in assessing new initiatives such as procedural changes, training, and coaching. Measuring FCR before and after introduction of an initiative enables the call center to track success and make adjustments if necessary. Finally, the center is

collecting data on workforce management service levels to determine appropriate staffing levels and track success in meeting its service level goal.

Customer Call Center Performance Measure Tables

Process:	Optimize Call Center Calls Handled	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Customer Service Calls Received	205,156	310,164	311,546	386,060	481,116
Output:	# Customer Service Calls Answered	137,771	155,431	196,945	204,640	251,865
Outcome:	% Customer Service Calls Answered	67%	50%	63%	53%	52%

Medicaid expansion and implementation of the federal Affordable Care Act resulted in significant impact to inbound Call Center calls beginning in 2013.

Process:	Improve Call Center Answer Speed	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Customer Service Calls Answered	137,771	155,431	196,945	204,640	251,865
Output:	# Customer Service Calls Answered in Five Minutes or Less	N/A	N/A	75,670	163,712	201,492
Outcome:	% Customer Service Calls Answered in Five Minutes or Less	N/A	N/A	38%	80%	80%

Process:	Improve Call Center First Call Resolution	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Customer Service Call Tickets Created	N/A	N/A	200,080	366,757	457,060
Output:	# Customer Service Call Tickets Closed after First Call	N/A	N/A	180,785	330,081	443,348
Outcome:	% Tickets Closed after First Call	N/A	N/A	90%	90%	97%

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. Communication staff 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 Communications
- External Communications
- Government Relations and Partner Outreach
- Interagency Collaboration

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 evolve with technology and changes in end user preferences. 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.

Website & Social Media

The internet is an important tool to reach both internal customers and external clients. The Department monitors the use of the public website, social media channels and has created a content strategy to align with the communications plan. The Department is taking action to increase the number of unique users that visit its website, and works closely with customer service to ensure that frequently asked questions and other information to divert callers is available and accessible online.

Department Website Performance Table

Process:	Increase Public Use of Department Website	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	# Unique Visitors to Department Website	563,236	801,489	850,000	890,000	980,000
Outcome:	% Increase in Unique Visitors to Department Website	23%	42%	6%	7%	5%

Government Relations and Partner Outreach

The Department's goal for Government Relations includes the coordination of communications between the Department, the Governor's Office and the State Legislative Branch. Partner Outreach includes

communications with counties, community partners and tribal relations. Through planned outreach efforts, Department Government Relations staff informs legislators and the Governor's Office about the Department's legislative and budget priorities. Staff represent the Department to key decision makers and builds relationships with members of the state General Assembly, their staff, the Governor's office, county officials, tribal partners, and with other leaders and stakeholders across the state.

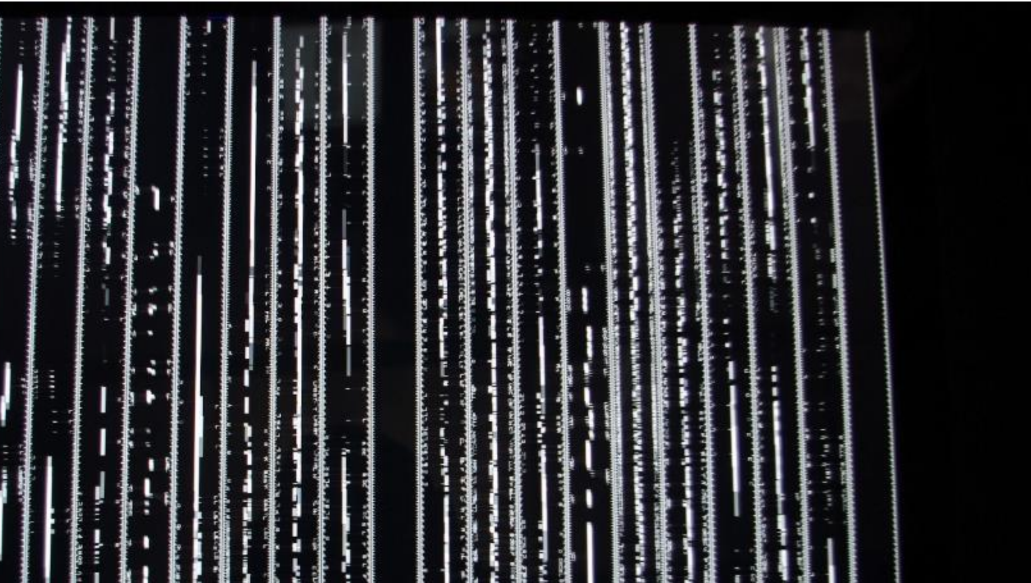
During the legislative session, liaisons from the Department are in constant communication with their counterparts from the other two main health agencies, the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Department of Human Services (CDHS). This ensures that each Department's legislative and budget priorities are broadly supported and that information and positions on bills relevant to multiple agencies are coordinated and aligned.

As necessary, the Department's legislative team 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 implement laws pertaining 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.

Throughout the year, partner outreach staff work with counties to resolve concerns and communicate department policy changes with county leaders. Staff regularly travel to county partner sites for site visits and oversee the county grant and incentive programs. Staff hold a tribal consultation and ensure program information sharing with tribal partners.

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. The state's Health Information Technology Advisory Committee has identified key 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 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, and expanded internal collaboration and file sharing through Microsoft SharePoint.

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, service utilization and costs compared to similar clients, and monitor their personal wellness needs. Linking this data to the Statewide Data and 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.

Electronic Health Records Performance Tables

Process:	Increase Meaningful Use of Electronic Health Records (EHR-MU) - Hospitals	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Eligible Hospitals	TBD	76	77	77	78
Output:	# Hospitals Demonstrating EHR-MU	69	73	74	74	75
Outcome:	% Hospitals Receiving EHR-MU Incentive Payments	TBD	96%	96%	96%	96%

Information comes from CMS EHR data, and is based on the number of eligible hospitals under Medicare or Medicaid. Information for FY 2014-15 is through December 2014. Source: HealthIT.gov

Process:	Increase Meaningful Use of Electronic Health Records (EHR-MU) - Medicare and Medicaid Providers	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Eligible Professionals	N/A	12,331	12,411	12,491	12,651
Output:	# Professionals Demonstrating EHR-MU	971	4,915	6,597	7,869	9,741
Outcome:	% Professionals Receiving EHR-MU Incentive Payments	N/A	40%	53%	63%	77%

Information comes from CMS EHR data, and is based on the number of professionals demonstrating under Medicare or Medicaid. Source: HealthIT.gov. Count based on annual "program year" records: Program year 2012 is proxy for FY 2012-13 actuals. Program year 2013 is proxy for FY 2013-14 actuals. Data for FY 2014-15 is through December 2014. "Provider" includes the following types: Acute care hospitals, children's hospitals, certified nurse midwives, dentists, nurse practitioners, physicians, and physician assistants.

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 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 2016. The new system will also advance the Department's analytic and business intelligence capabilities through a new Business Intelligence and Data Management (BIDM) vendor. In addition to the MMIS core service upgrade and the BIDM, a new Pharmacy Benefit Management System (PBMS) will provide 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.

Claims Processing Performance Table

`	Pay Health Care Provider Claims Timely	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# "Clean" Claims Received	4,915,955	6,942,978	6,501,184	6,658,015	7,057,496
Output:	# "Clean" Claims Paid	4,915,366	6,937,881	6,500,688	6,654,535	7,053,807
Outcome:	% "Clean" Claims Paid Timely	99.98%	99.93%	99.99%	99.95%	99.95%

Includes claims received from practitioners, nursing facilities, and hospitals, and for which no additional information from the provider or a third party was required to make payment.

SharePoint Management

The Department's goal for SharePoint Management includes improved collaboration and communication on group projects, file sharing, editing and version control of documents. The Department has implemented Microsoft SharePoint and Office 365 to help achieve this goal. SharePoint 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 Office, Skype and OneDrive. 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 old network drives to SharePoint to provide organized, logical and functional solutions for current and archive material. By promoting project collaboration ideas and sharing of expertise through SharePoint, the Department intends to improve performance by visibly aligning projects with strategic goals, eliminating duplication of content, and providing an online hub of up-to-date information across the Department. By using the Share feature in SharePoint and OneDrive, the activity

of emailing documents throughout the Department is eliminated, thereby reducing duplication of files and improving version control.

In addition, because the application is web-based, Department employees can access it from any computer with internet connectivity. This enables more flexible alternative work arrangements such as Flex Place (telecommuting), Job Sharing, and working from an Alternate Office.

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

SharePoint Management

Process:	Increase Use of SharePoint	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	# Megabytes of Storage on SharePoint	TBD	90,796	247,727	300,000	500,000

Storage usage was not retrieved on June 30, 2014 for FY 2013-14. The number reported is estimated usage based on data retrieved in February and November 2014.

People

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

The Department's greatest assets are its hardworking and dedicated employees. Hiring, training, and retaining employees are central to its People strategic policy initiative, due to the extremely costly nature of employee turnover, not only in time and effort required to fill vacant positions, but also in 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. The following three goal areas support this strategic policy initiative:

- 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 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."

Workforce Development Performance Table

Process:	Increase Supervisor Skills in Personnel Management & Leadership (Replacement)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Supervisors Responding to Supervisor Training Survey	N/A	N/A	33	50	50
Output:	# Supervisors Responding Favorably to "Confident will Use" (training)	N/A	N/A	30	40	40
Outcome:	% Favorable Responses to "Confident will Use" Question	N/A	N/A	91%	80%	80%

This table replaces the similarly named table in Appendix A due to a change of reporting methodology. The Department began tracking supervisor participation and survey response rate in the 3rd Quarter of FY 2014-15. The response data for FY 2014-15 is as of February 19, 2015.

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. New employees, existing staff, and managers have expressed a need for a new employee onboarding process that would provide a basic understanding of Medicaid and how the Department administers programs that provide Medicaid services. The Employee Ambassador Program, implemented in December 2013, provides a consistent onboarding experience to new employees. Quality onboarding of new employees complements the Department's effort to recruit and retain talented employees.

Employee Engagement Performance Table

Process:	Engage New Employees through the Ambassador Program	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# New Employees	70	101	75	86	98
Output:	# New Employees Participating in the Ambassador Program	N/A	58	19	60	70
Outcome:	% of Participants that State the Ambassador Program Positively Impacted Their New Employment Experience	N/A	84%	25%	75%	75%

Data on employees participating in the Ambassador Program, as well as responses to a related assessment survey, for FY 2014-15 is as of mid-year.

Results from the most recent (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.

The department has committed to improving this measure in FY 2015–16. It is the primary goal in the action planning process used 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 below.

Employee Engagement Performance Tables

Process:	Engage Employees through "5 Key Drivers"	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# HCPF Respondents to DPA Survey "Good Place to Work"	N/A	285	127	N/A	N/A
Output:	# Favorable HCPF Responses to "Good Place to Work"	N/A	168	88	N/A	N/A
Outcome:	% Favorable HCPF Responses to "Good Place to Work"	N/A	59%	69%	60%	60%

In years when the Department of Personnel and Administration does not conduct a survey, the Department conducts its own survey using identical language and evaluation metrics.

Process:	Strengthen Trust and Confidence in Department Leadership	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# HCPF Respondents to DPA Survey "Trust & Confidence" in Leaders	N/A	286	124	N/A	N/A
Output:	# Favorable HCPF Responses to "Trust & Confidence" in Leaders	N/A	140	77	N/A	N/A
Outcome:	% Favorable HCPF Responses to "Trust & Confidence" in Leaders	N/A	49%	62%	60%	60%

In years when the Department of Personnel and Administration does not conduct a survey, the Department conducts its own survey using identical language and evaluation metrics.

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 have been added to the Section's course offerings.

Human Resources Optimization

To meet its goal of a competent and engaged workforce, the Department seeks to ensure that qualified and effective employees are hired in a timely manner, and that employee turnover is kept as low as possible. In an effort to optimize its Human Resources function, the Department has identified two objectives for improvement: reducing the time required to hire new employees, and ensuring that quality employees are hired and retained.

Human Resources Optimization Performance Table

Process:	Expedite and Improve Quality of New Hires	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Permanent FTE Positions Filled	132	167	151	187	233
Output:	# Filled Within 60 Days of Requisition	75	95	88	116	151
Outcome:	% Filled Within 60 Days of Requisition	57%	57%	58%	62%	65%

FY 2013-14 benchmark includes an estimated 35 employees transfering from DHS to HCPF under HB 13-1314

Process

"Enhance efficiency and effectiveness through process improvement"

To maximize the efficiency and effectiveness of its business processes, the Department strives to be responsive to change, attain clear alignment between strategic goals, programs and initiatives, and establish a culture of continuous improvement.

The following two goal areas support this strategic policy initiative:

- Strategic Management
- Lean Community

Strategic Management

The Department's goal for Strategic Management is to engage staff in the formulation, implementation, and evaluation of strategies to achieve its mission, vision and goals. It also seeks to align organizational strategy with daily operations to ensure projects and initiatives are prioritized accordingly. Progress toward goals is monitored and reported using performance measures, continuous evaluation and feedback, and adjustments to strategy are made as needed to achieve goals. By involving staff in the Strategic Management process, staff gain understanding, or "line of sight", about how their individual roles connect to and help the Department achieve its mission.

The table below measures the percentage of favorable responses from employees to the question, "Do you understand your strategic role?"

Strategic Management Performance Table

Process:	Create "Line of Sight" between Employees and Strategic Goals	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# "Line of Sight" Presentations Delivered	19	15	4	4	4
Output:	# Employees Trained in "Line of Sight"	164	100	65	50	50
Outcome:	% Favorable Survey Responses to "Understand Strategic Role".	42%	66%	66%	68%	70%

The favorable "Understand Strategic Role" percentage rating in this table is from a Departmentwide survey and not necessarily directly correlated to Line of Site training.

Lean Community

The Department seeks to empower engaged employees to eliminate waste and maximize value in their daily work routines. To meet this goal, the Lean Community uses process improvement techniques such as training, coaching, 4-day improvement events, and concentrated 2-4 hour sessions called “Quick Hits”. To date, over 275 Department employees have learned how to apply Lean concepts and tools through training and participation. These employees have completed more than 220 focused improvements, including risk management plans, SWOT analyses, and electronic forms (to eliminate paper processes). In addition, a department-wide process documentation initiative is underway with 350 processes documented for the dual purpose of preserving institutional knowledge and facilitating future prioritization of processes to be streamlined.

These efforts are generating a business culture that is customer-centric and focused on continuous improvement and data-driven decision making. According to a January 2015 internal survey, 88% of Department staff are familiar with Lean, and 51% percent are getting work done more efficiently with less waste of money and other resources.

Lean Community Performance Table

Process:	Promote a Lean Culture Throughout the Department	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Employees Trained/Participating in LEAN Projects and Quick Hits	101	132	133	120	120
Output:	# LEAN Projects and Quick Hits	6	19	25	22	22
Outcome:	% Favorable Survey Responses to "Work Done > Efficiently w < Waste"	N/A	49%	51%	55%	58%

Financing

"Ensure sound stewardship of financial resources"

The Department's goals for its financing strategy include improving efficiency of payment systems to incentivize value rather than volume; increasing the effectiveness of health care delivery; leveraging advances in health information technology to improve quality and continuity of care; and reducing losses through fraud, waste and abuse. These are summed up in three goal areas:

- 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, and preventing fraud, waste, and abuse of state and federal Medicaid dollars. The Department seeks to maximize administrative efficiency, which can be measured by its percent of expenditure for administration (see table below).

Changing the incentives in health care service delivery to hold providers accountable for health outcomes is central to this goal. 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. RCCOs are also eligible for performance-based payments. This payment methodology incentivizes RCCOs to meet or exceed specified quality and cost containment metrics for reducing emergency department visits and increasing postpartum care and well-child visits (for those age 3–9).

To impact costs through effective benefit/program design, the Department is using extensive stakeholder outreach through its Benefits Collaborative process. 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 will allow 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.

Cost Containment Performance Table

Process:	Contain General Fund Expenditure for Administration at 3%	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Outcome:	General Fund Expenditure - Administration Ratio	3.0%	3.0%	3.0%	3.0%	3.0%

Administrative expenditures include those related to the Department's Executive Director Office, the Division for Individuals with Developmental Disabilities, and reappropriations to the Department of Human Services.

Fraud, Waste, and Abuse Prevention

The Department's approach to fraud, waste, and abuse prevention focuses on recovering dollars spent in overpayments to providers, recovery of payments from liable third parties, and ensuring payment by third parties prior to payment by Medicaid. Overpayments are recovered from providers as the result of claims reviews by staff and contingency fee contractors. Third party liability collections are derived from recoveries from personal injury settlements, Medicare, commercial health payers, and other third parties, and include monies recovered from trusts and by the estate recovery program.

The Department is putting in place advanced data analytics tools to assist in identifying post payment aberrant billing patterns or patterns indicating high fraud probability. The tools will be provided by the

business intelligence and data management services (BIDM) contract in November 2016 which is a part of the reprocurement of the Department's Medicaid Management Information System (MMIS).

Fraud, Waste, and Abuse Prevention Performance Measure Tables

Process:	Recover Overpayments from Health Care Providers	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	$ Program Integrity Recoveries	$11,876,801	$10,366,659	$9,000,000	$10,000,000	$10,000,000

Recoveries from the Department's Program Integrity Section, the Diagnosis Related Group audit vendor, and the recovery audit contractor.

Process:	Pursue Third Party Payment of Medical Costs for Medicaid Members	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	$ Third Party Liability Collections	$51,551,285	$52,896,045	$55,851,500	$55,000,000	$55,000,000

Recoveries from tort & casualty payments, trust repayment, estate recovery, post-pay, and other programs.

Grants Management

The Department's goal for grants management is to apply for, be awarded and utilize outside funding and resources, including federal, private foundation, monetary and technical assistance to further its strategic goals. Grants or other outside funding and resources enable the Department to pursue necessary and innovative pilot programs, initiatives, and infrastructure building that are not funded through the State's regular budget process, and to fulfill legislative directives requiring gifts, grants, or donations for implementation. The Department currently has 14 active grants, and several in the proposal process, which are overseen by the Grants Management section.

To succeed, a grant funded project must align with the Department's goals and receive approval from the 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.

Grant Funding Performance Table

Process:	Use Grant Funding to Further Strategic Goals	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	$ Total Grant Expenditures	$6,245,234	$8,507,753	$6,883,700	$41,273,749	$18,837,970

Organizational Chart FY 2015-16

Executive Director's Office
Susan Birch
1.8 FTE $217,811

Health Programs Office
Gretchen Hammer
46.2 FTE $3,392,855

Finance Office
John Bartholomew
96.0 FTE $7,281,089

Client and Clinical Care Office
Judy Zerzan
30.7 FTE $2,662,263

Policy, Communications, and Administration Office
Tom Massey
89.1 FTE $5,707,517

Health Information Office
Chris Underwood
91.7 FTE $6,695,583

Community Living Office
Jed Ziegenhagen
65.8 FTE $5,275,679

Total: 421.2 FTE		**$31,232,797**	
General Fund	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
$11,304,336	$3,079,098	1,501,543	$15,347,820

Department Description

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.

The Department's customers include members eligible and enrolled in Medicaid and the Children's Basic Health Plan, as well as those who receive care through the other programs described above. In addition, customers include providers of medical services, such as physicians, dentists, nurses, nurse practitioners, medical practices, hospitals, community centered boards, nursing facilities, etc. There are also a number of stakeholders who are active in Colorado communities and who advocate for important causes impacted by the Department's administration of medical assistance programs. These stakeholders are customers of the Department as well. Other customers include the 64 counties in Colorado, local government agencies, and medical assistance sites that help eligible but not enrolled individuals apply for benefits.

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.

Health Programs Office

The Health Programs Office designs, implements, administers, monitors and improves Medicaid acute care and the Children's Basic Health Plan (CHP+) programs. The Office is made up of three divisions: Delivery System and Payment Innovation, Provider Relations and Dental Program, and Health Programs Benefits and Operations.

Delivery System and Payment Innovation Division

The Delivery System and Payment Innovation Division is responsible for administering Colorado Medicaid and CHP+ acute care physical and behavioral health programs, including the Accountable Care Collaborative. Its responsibilities also include program monitoring, performance, innovation/delivery system reform, and payment reform.

Provider Relations and Dental Program Division

The Provider Relations and Dental Division is responsible for provider outreach, enrollment support, retention and ongoing relations. The division manages the dental program for children and adults including stakeholder relations, policy development and implementation, contract management and performance, and program administration.

Health Programs Benefits and Operations Division

The Health Programs Benefits and Operations Division is responsible for Medicaid acute care benefits management and operations activities. The Benefit Management Section defines, updates, implements, and manages Colorado Medicaid fee-for-service benefits, including defining coverage standards, and implementing, monitoring, and evaluating benefits. The Operations Section develops, oversees, and executes numerous processes that support the acute care fee-for-service benefits and managed care programs. These processes include client and provider appeals, the Benefits Collaborative process, project management, utilization management, and federal and state compliance activities.

Finance Office

The Finance Office consists of the Chief Financial Officer, the Budget Division, Controller Division, Payment Reform Section, Special Financing Division, Audits and Compliance Division, Financial Analytics Unit, and Strategy Section.

The Chief Financial Officer (CFO) is accountable for the financial and risk management operations of the Department, and oversees control systems that report financial results and maintain Department compliance. The CFO is responsible for the Department's financial data and reporting, and its use of data analytics to define value and measure quality with regard to Department operations. The CFO develops the Department's financial and operational strategy, and generates actionable analytics tied to that strategy.

Budget Division

The Budget Division presents and defends the Department's budgetary needs to Colorado executive and legislative authorities and monitors the Department's caseload and expenditures throughout the fiscal year. Additional Division functions include preparing fiscal impact statements for proposed legislation and ballot initiatives, performing the Department's federal reporting, and coordinating with other State agencies on budgetary issues presenting mutual impact.

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 available federal funds for Medicaid and the Children's Basic Health Plan. 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 proper recording and reporting of Department revenues, and that expenditures comply with generally accepted accounting principles and state and federal rules and regulations. The Division is comprised of:

- the Operations Unit, which is responsible for recording of cash receipts, accounts receivable, accounts payable, and payroll;
- the Financial Reporting and Cash Management Unit, whose cash management functions include reporting for State and federal cash as well as private grants and non-Medicaid federal grants; and
- the Medicaid and Provider Fee Unit.

Payment Reform Section

The Payment Reform Section develops rate-setting methodology and implements managed care rates for contracted health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers. The Section monitors and updates rates paid for home and community-based services. The Section is also responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics.

Special Financing Division

The Special Financing Division administers 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 Division is also responsible for developing Colorado Medicaid provider fee structures: developing fee models, coordinating stakeholder and board review, and submitting them as Colorado Medicaid plan amendments to the Centers for Medicare and Medicaid Services for approval.

Audits and Compliance Division

The Audits and Compliance Division is responsible for ensuring compliance with state and federal law and for identifying and recovering improper Medicaid payments. The Division is comprised of the Program Integrity Section, the Internal Audits Section, and the Federally Required Eligibility and Claims Review Unit.

The Program Integrity Section is responsible for monitoring and improving provider accountability to the Medicaid program. Functions include identifying and investigating fraud, improper utilization, and improper billing, as well as recovering payments and referring providers to legal authorities when appropriate. The Section’s Claims Investigation Unit holds primary responsibility for detection and deterrence of provider fraud, waste, and abuse, and prepares cases for recovery of identified overpayments. The Unit is also responsible for delivering guidance and instruction to assist providers in complying with Medicaid standards, rules, and regulations.

The Compliance Section is responsible for ensuring Department compliance with federal and state rules, laws, and regulations.

The Federally Required Eligibility and Claims Review Section manages the following review-oriented programs and oversight contracts:

- The federally-required Medicaid Eligibility Quality Control (MEQC) Program assesses the accuracy and timeliness of Colorado Medicaid eligibility determinations
- The CMS-required Payment Error Rate Measurement (PERM) Program examines the accuracy of eligibility determinations and claims payments
- The federally mandated Recovery Audit Contract (RAC) is responsible for identifying over- and underpayments
- Contingency based contracts conduct post-payment reviews of provider claims

The Section's Recovery Officer is responsible for tracking provider overpayments identified by the Unit and its oversight contractors.

Financial Analytics Unit

The Financial Analytics Unit collaborates with Department staff and external stakeholders including providers and member advocates to develop financial reporting and innovative analytics tools to support Department programs and functions. The Unit develops and maintains regular financial reporting for front-line policy staff and senior management, creates tools to evaluate the performance of Colorado Medicaid providers, and supports the Department's payment reform efforts. It utilizes a variety of data sources, evaluating existing ones and seeking out new ones—this unit's purpose is to continually improve the Department's ability to analyze available financial data.

Strategy Section

The Strategy Section is responsible for developing and articulating the Department's strategy, mission, and goals. The Section provides strategy-related guidance throughout the Department; develops, edits, and produces public-facing reports including the Department Performance Plan; and collects, manages, and publishes Department performance data. The Strategy Section leads the Department's Lean Community, which is responsible for implementing a culture of continuous improvement throughout the Department. It facilitates Lean process improvement initiatives for groups and administrative units throughout the Department. In partnership with the Workforce Development Section, it presents an in-depth Culture of Improvement Academy training for Department employees on a quarterly basis.

Client and Clinical Care Office

The Client and Clinical Care Office provides clinical expertise and advice regarding Department services, programs, policy, client and provider relations, and performance. The Office is comprised of the Chief Nursing Officer, the Pharmacy Section, the Data Analysis Section, and the Quality and Health Improvement unit. It focuses on preventing the onset of disease and helping the Department's clients manage chronic diseases in such a way that their health improves.

Pharmacy Section

The Pharmacy Section oversees access to medication for Medicaid fee-for-service and Medicare-Medicaid enrollees, and administers the Rx Review Program (drug therapy counseling sessions for Medicaid clients). The Section ensures clinically appropriate and cost-effective use of medications through the Colorado Preferred Drug List Program, drug-utilization analysis, and input from the Colorado Drug Utilization Review Board. Additional responsibilities include collecting federal and supplemental drug rebates from pharmaceutical manufacturers, ensuring pharmacy benefit compliance with federal and state statutes and regulations, and providing pharmacy benefits information and assistance to clients, pharmacies, and prescribers.

Data Analysis Section

The Data Analysis Section establishes standards for analysis of data utilized in Department decision making. It is responsible for meeting internal data analysis needs, as well as extracting data for research, policy formation, report writing, forecasting, and rate setting for Department programs. It is also responsible for providing data and analytical services to stakeholders, partners, or others outside the Department who request it.

Quality and Health Improvement Unit

The Quality and Health Improvement Unit directs, conducts, and coordinates performance improvement activities supporting care and services delivered by Colorado Medicaid and Children's Basic Health Plan. Specific functions of the unit include:

- managing external quality review;
- monitoring managed care plan contract compliance;
- overseeing client satisfaction surveys for Medicaid managed care and the Children's Basic Health Plan;
- developing long term care quality tools and interagency quality collaborations;
- developing and implementing quality strategies; and
- consulting with program managers regarding performance measurement and improvement.

Policy, Communications, and Administration Office

The Policy, Communications, and Administration Office manages Department functions associated with government affairs, communication and media relations, client services, legal affairs and internal operations. It provides leadership and guidance regarding external communication and relations, legal affairs, and organizational development. Office staff represent the Department before external stakeholders that include policy makers, county partners, advocates, and the press. The work of the Policy, Communication and Administration Office crosses the Department and facilitates and supports the work of all staff.

The Office is comprised of the External Relations Division, the Client Services Division, the Operations Section, the Grants Unit, the Federal Policy and Rules Officer, the Engagement and Development Division, and the Legal Division.

External Relations Division

The External Relations Division is comprised of the Government Relations and Partner Outreach Section and the Communications Section.

The Government Relations and Partner Outreach Section is responsible for creating the Department's legislative agenda, informing legislators and the Governor's Office about the Department's legislative priorities, and advocating for passage of Department initiatives. It maintains relationships with members of the state General Assembly, their staff, the Governor's office, and other leaders and stakeholders across the state. The Section's Partner Outreach staff conduct educational, and collaboration-oriented outreach to county leadership, local public health, community partners, and other stakeholders including Connect for Health assistance sites.

The Communications Section develops and coordinates communications plans, products, and activities for external audiences. It is responsible for representing the mission and accomplishments of the Department to a range of external audiences including policy makers, clients, and stakeholders.

Operations Section

The Operations Section is responsible for department-wide safety and security, office administration, facilities management, and real estate services. Its office administration functions include ensuring coordination and compliance of standard operating procedures; event planning and coordination; office supplies oversight; and coordinating Department support staff and special projects. The Section houses the Governor's Citizen's Advocate, and is responsible for managing problems, disputes and issues pertaining to high needs Colorado Medicaid clients that reach federal and governor levels. The Section performs key security functions including managing physical security; oversight of the Department's public reception function and first point of contact, including identification badge issuing and compliance; and creating and managing the Department's Emergency Action Plan and Continuity of Operations Plan.

Grants Unit

The Unit requests and secures grant funding to pursue pilot program initiatives and strategic projects not funded through the regular budget process. Funding secured by the Unit also assists legislative directives requiring gifts, grants, or donations for implementation. Functions include:

- coordinating and overseeing use of funds from grants received;
- maintaining relationships with private foundations and federal project officers;
- working with Department staff to match funding needs with potential funders;
- responding to funding solicitations; and
- working with the executive team and management to prioritize projects related to grant funding.

Federal Policy and Rules Officer

The Federal Policy and Rules Officer is the Department's legal expert regarding compliance with federal rules and regulations. The Officer is responsible for managing the Department's State Plan and drafting

amendments. The Officer also oversees coordination of the Department's rule-making body, the Medical Services Board, and provides assistance to staff in drafting proposed Medical Services Board rules.

Engagement and Development Division

The Engagement and Development Division is comprised of the Human Resources Section and the Workforce Development Section.

The Human Resources Section is responsible for filling Department staff positions in accordance with State rules and procedures. Functions include:

- recruitment, testing and selection;
- position classification;
- salary administration;
- dispute resolution;
- performance management; and
- administration of annual compensation/benefits.

The section guides and assists Department managers and staff in their use of the State personnel system, and delivers workplace training on topics including sexual harassment, violence in the workplace, and maintaining a respectful workplace.

The Workforce Development Section is responsible for creating and delivering facilitated and e-learning employee engagement and professional development training to benefit the Department and its workforce. The Section also provides consultation and coaching for managers, employees and teams.

Client Services Division

The Client Services Division provides a high level of communication and assistance to all clients who contact the Department. The Division's 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. The Division's Program and Policy Training Unit produces and conducts training regarding the Department's policies and initiatives for a variety of internal and external customers. The Division's Eligibility Training Section provides training to counties and contracted agencies where Coloradans sign up for Medicaid and receive eligibility services (point of entry sites).

Legal Division

The Legal Division is comprised of the Appeals Section, the Americans with Disabilities Act Coordinator, the Privacy Officer, and the Benefits Coordination Section. The Division is responsible for HIPAA and ADA training and compliance. The Division also acts as records custodian and coordinates Colorado Open Records Act requests. Additional functions include:

- managing and coordinating external data requests through the Department's data review board;
- managing the Department's privacy database;
- coordinating the Department's relationship with the Attorney General's office;

- providing analysis and guidance to Department personnel regarding regulatory and legal issues;
- monitoring the impacts of federal health care reform; and
- through its Benefits Coordination Section, preventing or recovering Medicaid payments made for medical care from responsible third parties, including private health plans, and trusts and estates. The Benefits Coordination Section also administers the Department's Health Insurance Buy-In program.

Health Information Office

The Health Information Office develops, implements, and maintains the Department's Health Information Technology (HIT) and related Information Technology (IT) infrastructure, while coordinating with the Governor's Office of Information Technology and other stakeholders on HIT and IT projects that impact the Department. The Health Information Office is comprised of the Eligibility Division, the Purchasing and Contracting Services Section, the Health Data Strategy Section, the Health Information Office Systems Division, and the Health Information Office Operations Division.

Eligibility Division

The Eligibility Division is comprised of the Eligibility Contracts and Site Relations Section, the Eligibility Policy Section, and the Eligibility Project Management Unit. The Division is responsible for policy and operations related to Medicaid and CHP+ eligibility. It works with the Office of Information Technology and the systems vendor to manage the Colorado Benefits Management System (CBMS), Program Eligibility Application Kit (PEAK) and the Colorado PEAK website. It is also responsible for ensuring completion of system updates required by changes in eligibility due to changes in law. The Division interprets new and existing Medicaid/CHP+ law to define eligibility requirements for Coloradans, and oversees the site agreements, contracts, rules, processes, and systems involved in reviewing member qualifications for Medicaid/CHP+, granting membership, and redetermining eligibility. The Eligibility Project Management Unit provides coordination and management assistance for projects throughout the Department that impact the MMIS, CBMS, and PEAK. Among these projects are the MMIS reprocurement, the International Classification of Diseases 10th Revision (ICD-10) code set implementation, and CBMS modernization project implementation. The Unit works with Department staff, state agencies, federal partners, and vendors to guide project costs, time, scope, quality, and approval processes.

Purchasing and Contracting Services Section

The Purchasing and Contracting Services Section provides all aspects of procurement and contracting for the Department in compliance with state and federal laws, rules, policies, procedures and guidelines. The Section reviews Department contracts and purchase orders for compliance with state rules, regulations, and contracting standards and processes.

Health Data Strategy Section

The Health Data Strategy Section is responsible for managing the Department's Statewide Data Analytics Contractor (SDAC)/Business Intelligence and Data Management Services (BIDM) and implementing a Medicaid data infrastructure that supports strategic uses of Colorado health data. The Section serves as

the primary point of contact regarding data integration and interoperability for multiple external stakeholders, including the Office of Information Technology (OIT), the Center for Improving Value in Health Care (CIVHC), Colorado Regional Health Information Organization (CORHIO), and Quality Health Network (QHN). In addition, the Section provides data-related expertise to Colorado health reform efforts such as the Accountable Care Collaborative.

Health Information Office Systems Division

The Health Information Office Systems Division is made up of the Colorado InterChange System Section, the Case and Care Management Section, and the MMIS Transition Unit. The Division is responsible for enhancing and maintaining the Department's health care claims payment system (Medicaid Management Information System or MMIS), by developing requirements documentation, reviewing system design approaches, proposing systems solutions to program staff, and implementing systems solutions to support Department policies. The Division manages maintenance of and updates to the MMIS, working closely with its contractor, and gathers requirements in consultation with policy staff. The section also proposes and implements IT solutions for program staff, and uses feedback from MMIS project stakeholders to verify and ensure accuracy of claims payment systems.

Health Information Office Operations Division

The Health Information Office Operations Division is comprised of the Fiscal Agent Operations Section and the Eligibility Monitoring and Quality Section. The Fiscal Agent Operations Section supports health care claims processing, provider reimbursement, provider enrollment, and State and federal audits of the Medicaid Management Information System (MMIS) related to health care claims processing and provider enrollment. The Eligibility Monitoring and Quality Section oversees the work and performance of eligibility sites statewide where Coloradans can sign up for Medicaid and receive eligibility services (point of entry sites). Section staff interpret state and federal regulations concerning Medicaid eligibility, ensure compliance with state and federal regulations and laws, and enroll members in Medicaid.

Office of Community Living

The Office of Community Living provides direction and strategic oversight of Colorado Medicaid's programs, services, and supports for older adults and persons with disabilities. The Office implements the Department's efforts to transform the Long Term Services and Supports system into a person-centered system that ensures responsiveness, flexibility, accountability, and person-centered supports for all eligible persons of Colorado.

The Office is comprised of the Division of Intellectual and Developmental Disabilities and the Long Term Services and Supports Division.

Division of Intellectual and Developmental Disabilities

The Division of Intellectual and Developmental Disabilities (DIDD) leads efforts for the direction, funding and operation of individualized and flexible supports enabling people with intellectual and developmental disabilities to live everyday lives in the community. The Division oversees three Home and Community Based Services waivers serving individuals with intellectual and developmental

disabilities: the state-funded Supported Living Services Program, the Family Services and Supports Program and Loan Fund, and Preventive Dental Hygiene services.

Long Term Services and Supports Division

The Long Term Services and Supports Division oversees Medicaid-funded Home and Community Based Services (HCBS) and its waiver programs. The Division also oversees the Program of All-Inclusive Care for The Elderly (PACE) and nursing facilities contracted with the Department. The Division is responsible for managing consumer-directed attendant support services enabling qualifying clients to direct their own care. The Division's work is informed by the goal of affordably maximizing the health, functioning, and self-sufficiency of clients in long term care, institutional, or community settings.

Appendix A: Discontinued Tables

The department has discontinued the performance tables below effective June 30, 2015.

Process:	Increase Medicaid Benefits Defined by Collaborative (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# of Medicaid Benefits to be Defined by Collaborative	67	68	62	62	68
Output:	# Medicaid Benefits Defined by Collaborative	1	4	5	N/A	N/A
Outcome:	% Medicaid Benefits Defined by Collaborative	1%	6%	8%	N/A	N/A

This table is being replaced by the table in the Coverage Design section due to a change of reporting methodology.

Process:	Promote Well-Child Visits (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid Children (15 months of age)	16,253	21,898	N/A	N/A	N/A
Output:	# Children 15 months of age with no Annual Well Child Visits	TBD	3,462	N/A	N/A	N/A
Outcome:	% Children with no Annual Well-Child Visit in the first 15 months of li	2%	16%	N/A	N/A	N/A

This table is being replaced by the table in the Well Child Visits section due to a change of reporting methodology. Children 15 Months of Age data is not available. Going forward, the measure set will be replaced tracking Children Ages 3-9.

Process:	Prevent Low Birth-Weight Babies (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Medicaid Women with Child Delivery	26,172	27,542	28,113	28,683	30,767
Output:	# Newborns Weighing <2500 Grams	3,385	3,752	3,812	3,872	4,154
Outcome:	% Low Birth-Weight Newborns	13%	14%	14%	13%	14%

This table is being replaced by the Postpartum Visits table in the Prevention and Wellness Section. Going forward, the measure set will track Postpartum Visits.

Process:	Link Payments to Outcomes (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	$ Total Acute Care Expenditure	$1,964,342,303	$2,549,009,445	$3,587,865,215	$3,965,695,735	$4,177,582,815
Output:	$ Total Provider Incentive Payments (ACC, HMO, NFs, HQIP)	$29,604,682	$46,096,303	$46,066,748	$75,268,885	$80,852,521
Outcome:	% Provider Payments Linked to Outcomes	2%	2%	1%	2%	2%

This table is being replaced by the table in the ACC Pay for Performance and Payments Linked to Outcomes section due to a change of reporting structure. The new table compares year over year incentive payments.

Process:	Enroll Individuals into Medicaid through the Connect for Health Colorado Marketplace (C4HC) (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Output:	# Covered Lives Enrolled into Medicaid during C4HC Open Enrollment	N/A	178,508	75,194	N/A	N/A

This table contains a minor wording adjustment from previous years. Data comes from Connect for Health Colorado website. C4HC is a stand-alone quasi-governmental organization not under the control of the State as per its authorizing statute. For this reason, the Department is discontinuing reporting of C4HC data.

Process:	Enroll Individuals into Subsidized Insurance through the Connect for Health Colorado Marketplace (C4HC) (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Signed up for Private Health Insurance through (C4HC)	N/A	138,978	153,945	N/A	N/A
Output:	# Individuals Enrolled into Insurance with Financial Assistance through	N/A	81,736	76,590	N/A	N/A
Outcome:	% C4HC Enrollees Receiving Financial Assistance	N/A	59%	50%	N/A	N/A

*This table contains a minor wording adjustment from previous years.

*Data for FY 2013-14 reflects submitted enrollments in medical and dental coverage between Oct. 1, 2013, and June 30, 2014. It does not reflect subsequent Special Enrollment Period totals or terminations.

*Data for FY 2014-15 reflects submitted enrollments in medical and dental coverage between Nov 15, 2014, and Feb. 28, 2015. Special Enrollment Period enrollments continue and totals will increase.

*Connect for Health Colorado (C4HC) makes projections on a calendar year basis, in line with industry practice. Projections for 2016 will be made in Q3 2015 and 2017 projections in Q3 2016.

Data comes from C4HC.

C4HC is a stand-alone quasi-governmental organization not under the control of the State as per its authorizing statute. For this reason, the Department is discontinuing reporting of C4HC data. HCPF works closely with C4HC on eligibility for financial assistance but does not enroll individuals into health plans. The C4HC board approves projections for out years. More information about board decisions can be found at connectforhealthco.com.

Process:	Increase Meaningful Use of Electronic Health Records (EHR-MU) - Medicaid Providers (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# EHR-MU Eligible Medicaid Providers	TBD	2,426	3,150	N/A	N/A
Output:	# Medicaid Providers Receiving EHR-MU Incentive Payments	1,514	1,945	2,175	N/A	N/A
Outcome:	% Medicaid Providers Receiving EHR-MU Incentive Payments	TBD	80%	69%	N/A	N/A

This table, previously associated with the Electronic Health Records section, is being discontinued. Forecasts are not being projected.

Process:	Increase Registered Intent to Achieve Meaningful Use of Electronic Health Records (EHR-MU) (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input:	# Eligible Professionals	N/A	12,331	12,411	12,491	12,651
Output:	# Professionals Registered with Intent to Achieve EHR-MU	3,526	6,842	9,287	N/A	N/A
Outcome:	% Professionals Eligible Registered for EHR-MU Incentive Payments	N/A	55%	75%	N/A	N/A

This table, previously associated with the Electronic Health Records section, is being discontinued. Forecasts are not being projected.

Process:	Increase Supervisor Skills in Personnel Management & Leadership (Discontinued)	Historical Actual		FY 2014-15 Estimate	1 and 3 Yr Projections	
		FY 2012-13	FY 2013-14		FY 2015-16	FY 2017-18
Input*:	# Supervisors	65	80	80	80	80
Output:	# Supervisors Responding Favorably	N/A	10	30	N/A	N/A
Outcome:	% Favorable Responses to "Confident will Use" Question.	N/A	13%	38%	N/A	N/A

This table is being replaced by the table in the Workforce Development section due to a change of reporting methodology. The new methodology compares responses against training attendees as opposed to all Departmental management staff (whether having attended the training or not).

Appendix B: Acronyms

ACA........................ Affordable Care Act

ACC........................ Accountable Care Collaborative

BHO .... Behavioral Health Organization

CBMS .... Colorado Benefits Management System

CCB........................ Community Centered Board

CDASS .... Consumer Directed Attendant Support Services

CES .... Children's Extensive Support (HCBS)

CCMS .... Community Contracts Management System

CHP+ .... Child Health Plan *Plus*

COMMIT .... Colorado Medicaid Management Innovation and Transformation

CMS........................ Centers for Medicare and Medicaid Services

DD .... Developmental Disability

DHS........................ Colorado Department of Human Services

DIDD...................... Developmental and Intellectual Disability Division

DPA........................ Colorado Department of Personnel and Administration

ED .... Emergency Department

EDO .... Executive Director's Office

EHR........................ Electronic Health Record

FCR........................ First Call Resolution

FY .... Financial Year

HCBS .... Home and Community Based Services

HCPF .... Colorado Department of Health Care Policy and Financing

HIT .... Health Information Technology

HMO .... Health Maintenance Organization

EHR-MU .... Electronic Health Records-Meaningful Use

HQIP .... Hospital Quality Improvement Payment

HSAG .... Health Services Advisory Group

IT .... Information Technology

LTSS .... Long Term Services and Supports

MMIS .... Medicaid Management Information System

MSP .... Medical Services Premiums

NCQA .... National Commission on Quality Assurance

NEOGOV .... The State of Colorado's Human Resources Management System

OSPB .... Governor's Office of State Planning and Budgeting

PEAK .... Program Eligibility Application Kit

PCMP .... Primary Care Medical Provider

PMPM .... Per Member Per Month

PACE .... Program of All-Inclusive Care for the Elderly

RCCO .... Regional Care Collaborative

SLS .... Supported Living Services

Appendix C: Image Credits

Customer .... Stock Photo

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