Department of Health Care Policy and Financing
Strategic Plan
FY 2009-10 Budget Request

November 3, 2008

I. EXECUTIVE LETTER

November 3, 2008

The Honorable Bernie Buescher, Chairman
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Buescher:

On February 13, 2008 Governor Ritter announced his "Building Blocks to Health Care Reform" plan. The plan's goals are to increase client access to health care, improve the quality of care provided to clients, and manage rising health care costs. In addition, it closely follows the recommendations of the 208 Commission for Health Care Reform and marks the first major investment in health care in many years.

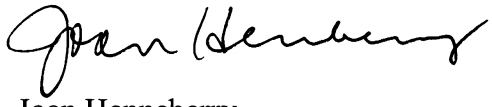
The Department is committed to ensuring that clients are healthier when they leave the Medicaid and Children's Basic Health Plan programs than when they entered. To that end, the Department is proposing a set of enhancements as a part of the second phase of its Building Blocks to Health Care Reform plan. This second phase is designed to enhance administrative and program functions and interventions in order to maximize the health, functioning and self-sufficiency of Medicaid clients and providers. It focuses on increasing efficiencies in Medicaid programs, benefit packages and pharmacy administration. In addition, these enhancements would help improve operational sustainability to support growth in both the number of clients enrolled and the number of programs administered by the Department.

The primary goals of the second phase of the Building Blocks plan are to (1) deliver seamless, integrated care to clients between different delivery systems, (2) maximize client health and satisfaction, and (3) achieve greater cost-effective care. The common underlying thread is making the health care delivery system, and access to programs, more outcomes-focused and client-centered. These enhancements and programmatic changes are consistent with Governor Ritter's vision of a system based on shared responsibility; where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents.

Over the past year, the Department has achieved many of its goals related to improving the health and health care for Colorado residents. The Department expanded eligibility in the Children's Basic Health Plan and increased enrollment. A presumptive eligibility program for children on both Medicaid and the Children's Basic Health Plan was implemented to improve access to the Department's programs. The Department enrolled over 15,000 children in Medical Homes since the start of FY 2007-08 as well as implemented five new disease management programs to improve the quality and cost-effectiveness of care provided to clients with chronic conditions.

In the coming fiscal year, the Department will continue to work towards improving the overall health and health care for clients on its programs. The Department will continue to strengthen partnerships with local and federal partners, providers, legislators and other community stakeholders in order to continue progress on the Building Blocks to Health Care plan to improve health care in Colorado.

Sincerely,



Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing

II. INTRODUCTION

The Department of Health Care Policy and Financing is the federally designated Single State Agency to receive Medicaid (Title XIX) funding from the federal government for administration or supervision of the administration of the Medicaid program. As such, in order to receive federal financial participation, the Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services that provides roughly 50% of the Department's Medicaid budget, and 65% of the funding for the Children's Basic Health Plan. The Department also provides health care policy leadership for the State's Executive Branch.

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

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

- 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 Old Age Pension State Medical Program provides limited medical care for individuals eligible for Old Age Pension grants.

- The Comprehensive Primary and Preventive Care Grant Program provides grants to health care providers in order to expand primary and preventive health care services to Colorado's low-income residents.

Statutory Authority

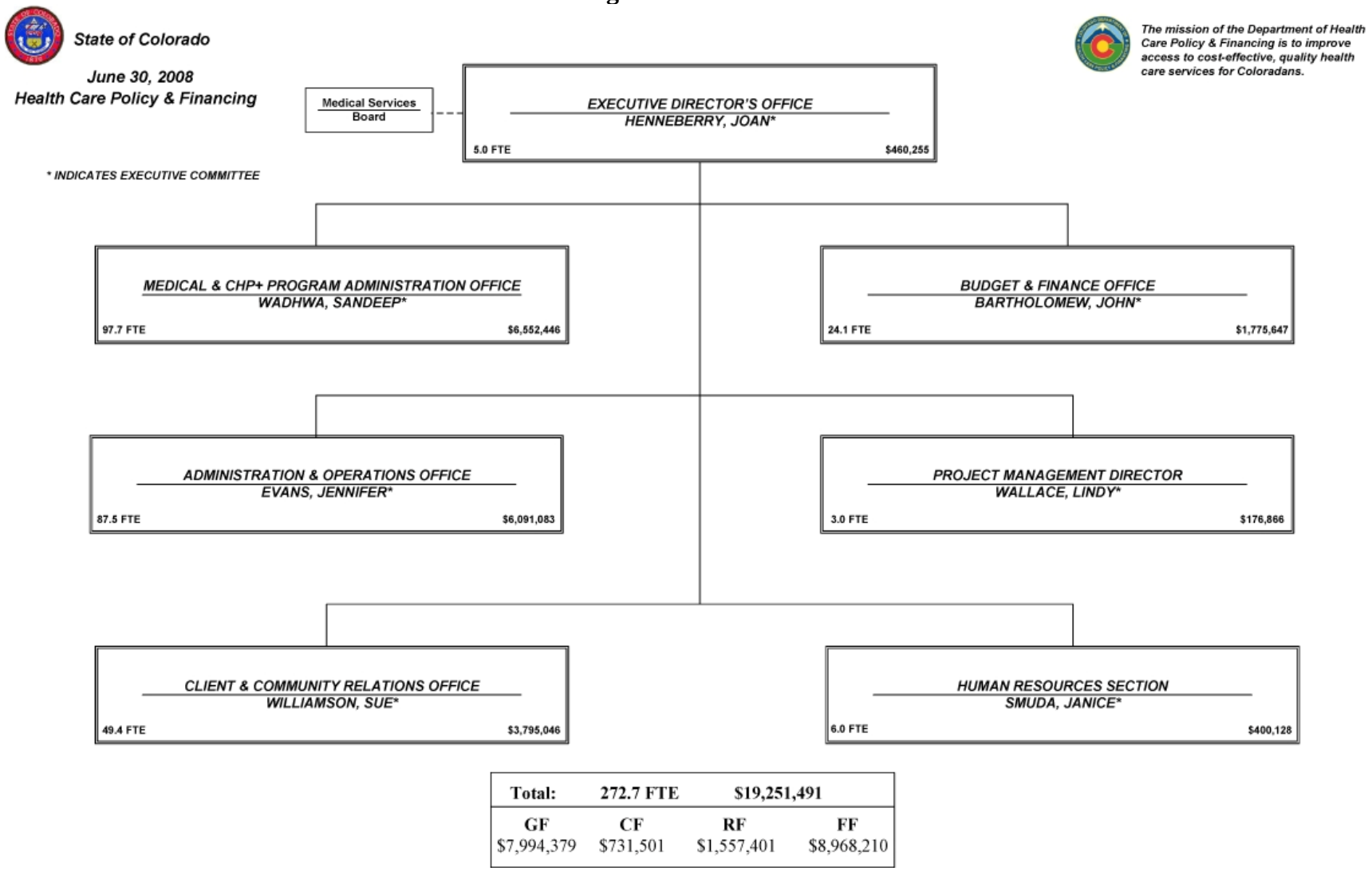
The statutory authority for the Department can be found at Title 25.5 of the Colorado Revised Statues, (2008).

25.5-4-104, C.R.S. (2008). Program of medical assistance - single state agency
(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

25.5-8-104, C.R.S. (2008). Children's basic health plan - rules
The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

25.5-3-104, C.R.S.(2008) Program for the medically indigent established - eligibility - rules
(1) A program for the medically indigent is hereby established, to commence July 1, 1983, which shall be administered by the state department, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The state board may promulgate rules as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.

Organizational Chart



Total:	272.7 FTE	$19,251,491	
GF	**CF**	**RF**	**FF**
$7,994,379	$731,501	$1,557,401	$8,968,210

III. STRATEGIC PLAN DIRECTION

Mission Statement

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

Vision

Leadership and staff will partner with stakeholders, providers and clients to achieve the goals of the Department, and to implement the health care initiatives outlined in the Colorado Promise. In fulfilling this vision, the Department's focus will be on ensuring delivery of appropriate, high quality health care in the most cost-effective manner possible while improving customer satisfaction with programs, services, and care. The Department's FY 2009-10 Budget Request is targeted to achieving these objectives as well as others outlined in its strategic plan by making the health care delivery system, and access to programs, more outcomes-focused and client-centered.

Goals

A. The Department will improve health outcomes for all clients and ensure that the health care the Department purchases are medically necessary, appropriate to the population, and cost-effective.

B. The Department will establish and maintain providers, clients, advocacy groups, counties, and other units of government as partners.

C. The Department will build and maintain a high quality, customer-focused team.

D. The Department will continuously improve its business processes, systems, eligibility determinations, payments, and financial projections.

Objectives

A. Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

B. Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

C. Value Department personnel through effective recruitment, hiring, training, and retention. Allocate its staff and resources in ways that ensure that the Department's priorities are met.

D. Audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.

E. Provide accurate and consistent information to internal and external customers.

F. Monitor expenditures for programs managed by the Department to ensure accurate financial reporting at all times.

IV. PERFORMANCE MEASURES

1. Integrated Care Management

Objective: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Department-wide					
Increase the number of clients served through targeted, integrated care management programs.	Benchmark	N/A	Add 500 clients	Add an additional 2,000 clients	Maintain enrollment of approximately 4,000 clients
	Actual	N/A	Added 2,000 clients	Unknown	Unknown

*Strategy***:** In Colorado, the Department estimates that 24% of the overall Medicaid population accounts for 65% of total Medicaid spending. Of this 24%, many clients receive their care in a fragmented and difficult to navigate fee-for-service health care system, and the Department is working to improve access and health outcomes for these clients. In May 2008, the Department entered into a partnership with Colorado Access to implement the Colorado Regional Integrated Care Collaborative (CRICC). The goal of the program is to improve the quality of care received by Colorado Medicaid's highest-need, highest-cost fee-for-service beneficiaries by better coordinating physical health, mental health and substance abuse services. Through CRICC, the Department is also partnering with the Center for Health Care Strategies, local health plans and providers, consumer organizations and other stakeholders to maximize the potential for the CRICC to generate sustainable and replicable models that could ultimately reach thousands of Medicaid's most vulnerable clients. Through its partnership with the Center for Health Care Strategies, the Department will be able to share best practices with other state Medicaid agencies in order to more effectively coordinate care for clients.

In order to enroll an additional 2,000 clients in FY 2008-09, the Department is in negotiations with possible contractors to further expand the program. In addition, Colorado Access will extend enrollment from the four counties currently served to add two more: Denver County in 2008 and Weld County in 2009. The Department anticipates the addition of these two counties will assist in the goal of enrolling 2,000 additional clients and maintaining enrollment of approximately 4,000 clients in FY 2009-10.

Evaluation of Prior Year Performance: The Department exceeded its benchmark for FY 2007-08 through its partnership with Colorado Access and CRICC. To date, Colorado Access has enrolled nearly 2,000 clients throughout Adams, Arapahoe, Boulder and Broomfield counties through a passive enrollment process with the opportunity to opt-out. Through extensive outreach activities and the availability of enhanced benefits, the Department was able to achieve an opt-out rate of only 22% of eligible individuals. Some of the enhanced benefits to enrollees

include: access to a care manager, zero co-pays, free over-the-counter medications with prescriptions, preventive health and disease education programs.

2. Medical Homes

Objective: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Department-wide					
Increase the number of children served through a dedicated medical home service delivery model.	Benchmark	N/A	Add 15,000 clients	Add 125,000 clients	Add 22,000 clients
	Actual	N/A	Added 15,865 clients	Unknown	Unknown

*Strategy***:** Medical homes for children are needed to assure delivery of appropriate, high-quality health care for all children and youth covered by the Department's programs. Medical homes are designed to improve health status and health outcomes and therefore improve customer satisfaction. Medical homes also improve customer satisfaction with programs, services, and care. In order to meet the benchmarks for enrolling clients in medical homes, the Department must ensure that there is an adequate network of primary care physicians who are willing to participate as medical homes. This means that the Department must ensure that rates paid to providers are fair and cover the costs of providing services. To ensure that rates paid to providers are adequate, the Department will increase all rates paid for preventive medicine codes to 90% of the equivalent Medicare rate. While the limited funding does not cover all expenses incurred by providers for medical home activities, the providers will be more willing to work with the Department in order to provide the highest possible care to eligible clients.

The Department must also actively recruit physicians in the state who have previously not been willing to participate in the Medicaid program to maximize the number of clients and providers participating in the medical home program. The Department intends to hire a contractor to recruit physicians as well as a contractor to provide training to physicians. In addition, the Department is working with the Children's Basic Health Plan managed care organizations to implement medical homes so that all children in the Children's Basic Health Plan have a medical home by FY 2009-10.

Evaluation of Prior Year Performance: During the 2007 legislative session, the General Assembly passed SB 07-130, which required the Department to develop systems and standards to maximize the number of children enrolled in the Medicaid program who have a medical home. SB 07-130 did not contain any appropriation for the purpose of raising provider rates associated with medical home services. During meetings associated with the Primary Care Provider Rate Task Force (as required by Footnote 22 of HB 06-1385), the Department learned that provider rates for medical home related services were not adequate enough to ensure provider participation. Therefore, as part of the Department's effort to maximize the number of participating providers and the number of children enrolled, the Department initiated a pay-for-performance pilot program to evaluate the effectiveness and cost savings for a select number of

clients in an identified medical home and exceeded its goal of enrolling 15,000 clients in FY 2007-08.

3. Customer Satisfaction – Managed Care

Objectives: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Department-wide					
Survey customer satisfaction with managed care using the Consumer Assessment of Health Plans Survey (CAHPS).	Benchmark	N/A	Increase to at least the NCQA National Medicaid 80th percentile.	Increase all reportable rates to at or above national Medicaid average	Increase all reportable rates to at or above national Medicaid average
	Actual	6 of 13 reportable rates were at or above national Medicaid average = 46%	11 of 18 reportable rates were at or above national Medicaid average = 61% (Please see the Workload Reports section of the Department Description for full results)	Unknown	Unknown

*Strategy***:** Client satisfaction is a key component to understanding the efficacy of the delivery system. There are many known and unknown factors that influence the level of client satisfaction. The Department has implemented a number of policies in an attempt to positively influence client satisfaction rates. For instance, managed care organizations are using mailings and phone calls to encourage clients and their children to come in for their check-ups and chronic care visits. For the Primary Care Provider Program, the Department mails quarterly lists to the providers letting them know when clients need to come in for care. The Department hopes that these efforts to support providers in delivering primary care to clients will improve client satisfaction as the system becomes easier for clients to navigate and they will be more likely to receive recommended care.

Evaluation of Prior Year Performance: The Department's client satisfaction rates for managed care programs improved between FY 2006-07 and FY 2007-08. It is difficult to pinpoint which of the Department's efforts contributed to the increase in client satisfaction but some factors may include the following: the Colorado Children's Healthcare Access Program medical home pilot, where pediatricians and family practice providers provide a medical home approach to care for children and their families; and effective quality improvement interventions conducted by Denver Health Managed Care and Rocky Mountain Health Plans.

4. Health Plan Employer Data Information Set

Objectives: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Department-wide					
Improve access to and the quality of Medicaid health care as demonstrated through improvements in Medicaid Health plan scores on Healthcare Effectiveness Data Information Set (HEDIS) measures.	Benchmark	N/A	HEDIS National Medicaid 75th Percentile	All reported managed care HEDIS measures at or above national Medicaid average.	All reported managed care HEDIS measures at or above national Medicaid average.
	Actual	Managed care = 67% of reported measures were at or above national Medicaid average FFS = 28%	Managed care = 30% of reported measures were at or above national Medicaid average FFS = 10%*	Unknown	Unknown

**Please see the Workload Reports section of the Department Description for full results.*

*Strategy***:** The Healthcare Effectiveness Data Information Set (HEDIS) is a nationally recognized tool for measuring the quality of care for both public and commercial payers. It is comprised of a number of measures related to care for children, adults, and individuals with chronic illness. To maintain and increase the quality of care delivered to Medicaid clients, the Department will continue outreach efforts such as provider profiling, provider newsletters, and support for providers in the form of pediatric case workers and increased provider rates for preventive care. In addition, the Department will continue its effort to establish long-term baseline measures and health indicators for all Medicaid populations served.

Evaluation of Prior Year Performance: HEDIS scores decreased substantially from the prior year and the Department attributes part of this change to loss of managed care options. The Department will continue to assess its score in fee-for-service as well as the reason for the overall decline toward meeting this benchmark. Despite the overall decline, six measures improved from 2007 measures; most notably, the Childhood Immunization Status measure improved by 29% from calendar year 2007 to 2008. This improvement is the result of collaboration with the Colorado Immunization Information System (CIIS) to obtain immunization data not previously obtained via Medicaid claims data.

Currently, the Department is working with the Colorado Children's Healthcare Access Program to expand their medical home model for supporting the primary care provider. The Department works closely with the managed care organizations on their quality improvement efforts and the

Department aligns the managed care, fee-for-service, and the Children's Basic Health Plan quality improvement efforts as much as possible. In addition, the Department has partnered with Colorado Access managed care organization to develop an integrated care management program to improve the care of our highest cost and highest needs clients. The Department will continue to collaborate with providers to increase the quality of care delivered to clients.

5. Managed Care Options

Objective: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Department-wide					
Increase number of managed care options for clients enrolling in Medicaid.	Benchmark	N/A	Add one new option in the Denver-metro area	Add one new option in the state	Add three new options within the state
	Actual	Zero	Added one new option: Colorado Access CRICC Program	Unknown	Unknown

*Strategy***:** Currently, many clients lack a focal point for care and care coordination in the Medicaid program and the Department's goal is to increase enrollment in managed care. Therefore, it is important to increase the number of available programs to meet the diverse needs of the Medicaid population. The Department is working with organizations, including the Colorado Alliance for Health and Independence, Inc. as part of the Colorado Regional Integrated Care Collaborative to improve managed care options for clients. These efforts are expected to result in the creation of at least one new managed care option in FY 2008-09. In addition, a greatly modified managed care strategic plan was developed to complement the Building Blocks plan which impacted the overall managed care growth strategy. The Department is working to refine the managed care strategy in order to increase managed care options and enrollment.

Evaluation of Prior Year Performance: The Department met its benchmark of adding one new managed care option through its partnership with Colorado Access through the Colorado Regional Integrated Care Collaborative. The Colorado Access managed care program began enrolling high-need elderly and clients with disabilities effective May 2008. This performance measure is closely tied to the Department's first performance measure regarding integrated care management programs. For more detail regarding prior year performance, please see performance measure number 1, Integrated Care Management.

6. Managed Care Enrollment

Objective: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Increase the number of clients enrolled in viable managed care options.	Benchmark	N/A	Increase by 5% over FY 2006-07	Increase by 2% over FY 2007-08	Increase by 150% over FY 2008-09
	Actual	77,820 clients enrolled in viable managed care options	76,271 clients enrolled in viable managed care options	Unknown	Unknown

*Strategy***:** Currently, many clients lack a focal point for care and care coordination in the Medicaid program and the Department's goal is to increase enrollment in managed care. Therefore, it is important to increase the number of available programs to meet the diverse needs of the Medicaid population. The Department is working with organizations, including the Colorado Alliance for Health and Independence, Inc. as part of the Colorado Regional Integrated Care Collaborative to improve managed care options for clients, which will help increase client enrollment. In addition, a greatly modified managed care strategic plan was developed to complement the Building Blocks plan which impacts the overall managed care growth strategy.

Under the new strategy, to facilitate enrollment, the Department would expand its practice of passive enrollment for all regional plans to assure increased enrollment in managed care. If enrollment goals are not reached using passive voluntary enrollment, then the Department may file a State Plan amendment or file for a waiver in 2010 for mandatory enrollment. Each plan is assumed to enroll 3,000 clients per month, for a total of 15,000 clients being enrolled each month into the program. Because of the complexity required in providing clients access to such a wide array of benefits, the Department does not believe that faster enrollment will serve its clients better; if too many clients are enrolled at once, plans will be overwhelmed and clients may lose access to services rather than gain access.

Evaluation of Prior Year Performance: The Department was unable to meet its goal of increasing enrollment in managed care options by 5% over FY 2006-07. A new managed care program was added during the fiscal year but enrollment in that program did not begin until May, 2008 which limited the number of enrollees in FY 2007-08. In addition, total enrollment in the new managed care program is limited based on the number of elderly clients and clients with disabilities in its service area. In addition, "churn" in eligible Medicaid clients in existing managed care programs continues to offset passive enrollment activities resulting in minimal growth in new managed care enrollments.

7. Telemedicine

Objective: Assure delivery of appropriate, high-quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Improve access to health care, increase health outcomes and provide more cost effective services using information technology.	Benchmark	N/A	Serve 165 clients using telehealth / telemedicine technology	Serve 165 clients using telehealth / telemedicine technology	Serve 165 clients using telehealth / telemedicine technology
	Actual	N/A	145 clients were served using telemedicine technology	Unknown	Unknown

*Strategy***:** Due to the high cost of hospital visits and delays to see a physician, the telemedicine program provides clients the ability to coordinate with their doctors and nurses to manage their own care in their own home. The registered nurse care managers will continue to conduct outreach to new eligible people identified with high risk chronic obstructive pulmonary disease, heart failure and diabetes. Many of the individuals diagnosed with these high risk chronic conditions became ineligible soon after they were identified since they became eligible for Medicare and many others identified through claims data had invalid phone numbers and addresses. The community resource coordinator and the registered nurse care managers continue to search the internet, meet with local departments of human/social services offices and conduct community outreach to locate individuals who could benefit from the telemedicine program. For enrollees that lost eligibility for the program due to losing their landline telephone, U.S. Care Management collaborated with local departments of human/social services to enhance the process for telehealth services for these individuals. U.S. Care Management coordinated the implementation of new technology that will allow for the use of cell phones by utilizing an interactive voice response (IVR) process. This process allows the enrollees to answer very clear questions about the specific biometric reading by speaking into the phone. This process allows individuals to remain eligible for the program even if they do not have a landline telephone. Through outreach activities and ensuring individuals maintain eligibility, the Department anticipates it will meet its goal of enrolling 165 individuals in the program.

Evaluation of Prior Year Performance: The Department was unable to meet its goal of enrolling 165 individuals due to clients losing eligibility during the year. Many of the individuals identified with the high risk chronic conditions for this program became eligible for Medicare and therefore ineligible for this program. In addition, many clients lost their eligibility for the program due to losing their landline telephones. These issues will be addressed in the Department's strategy going forward and the Department expects 165 individuals will be enrolled in subsequent fiscal years.

8. Preferred Drug List

Objective: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Achieve Medicaid pharmaceutical cost avoidance for drug classes on the Preferred Drug List.	Benchmark	N/A	Cost avoid by 2%	Cost avoid by 7%	Cost avoid by 5%
	Actual	$7,778,706 (costs for drug classes on PDL)	Costs avoided by 10.88% (actual costs $6,932,302)	Unknown	Unknown

*Strategy***:** The Department will achieve its pharmaceutical cost avoidance benchmark by expanding the Preferred Drug List on a quarterly basis and negotiating supplemental rebate agreements for preferred drugs. As of November 3, 2008 the Department has implemented seven drug classes on the preferred drug list including: proton pump inhibitors, sedative-hypnotics, statins, antihistamines, antihypertensives, opioids and attention deficit hyperactivity disorder drugs. The Department anticipates adding three to four more drug classes by the end of FY 2008-09, and six to eight new drug classes in FY 2009-10.

The Department will continue selecting drug classes that offer opportunities to meet cost avoidance benchmarks. However, it is important to note two points. First, the drug classes added to the Preferred Drug List in FY 2007-08 were selected, in part, based on the likelihood of achieving significant cost avoidance. It is unlikely that the drug classes added in FY 2008-09 and FY 2009-10 will achieve cost avoidance to the same degree. Second, cost avoidance is generally greatest in the fiscal year that the drug classes are first added to the Preferred Drug List since that fiscal year is compared to the previous fiscal year in which no supplemental rebates were collected for drugs in those classes.

Evaluation of Prior Year Performance: The Department exceeded its FY 2007-08 benchmark by adding three drug classes which offered the greatest opportunities for cost avoidance through the Preferred Drug List.

9. Customer Satisfaction – Fee-for-Service

Objective: Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Survey client satisfaction with the fee-for-service program using the Consumer Assessment of Health Plans Survey (CAHPS).	Benchmark	N/A	Increase to at least the NCQA National Medicaid 80th Percentile	Increase all reportable rates to at or above national Medicaid average	Increase all reportable rates to at or above national Medicaid average
	Actual	5 of 12 reportable rates were at or above national Medicaid average = 42%	11 of 19 reportable rates were at or above national Medicaid average = 58%	Unknown	Unknown

Strategy**:** Client satisfaction is a key component to understanding the efficacy of the delivery system. There are many known and unknown factors that influence the level of client satisfaction. The Department has implemented a number of policies in an attempt to positively influence client satisfaction rates. For instance, the Department increased provider reimbursement rates for preventive care codes which may have improved access to care. The Department hopes that supporting providers in delivering primary care to clients will improve client satisfaction as the system becomes easier for clients to navigate and they will be more likely to receive recommended care.

Evaluation of Prior Year Performance: Our client satisfaction rates for the fee-for-service program improved between FY 2006-07 and FY 2007-08. It is difficult to pinpoint which of the Department's efforts contributed to the increase in client satisfaction but some factors may include the following: increasing provider reimbursement rates for preventive care codes and the Colorado Children's Healthcare Access Program medical home pilot, where pediatricians and family practice providers provide a medical home approach to care to children and their families.

10. Children's Basic Health Plan

Objective: Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Expand coverage in the Children's Basic Health Plan.	Benchmark	N/A	Add 9,000 clients to the Children's Basic Health Plan	Add 10,000 clients to the Children's Basic Health Plan	Add 7,000 to the Children's Basic Health Plan
	Benchmark	N/A	Increase number of enrollees in the CHP+ at Work Program to 150	Maintain number of enrollees at 150 in the CHP+ at Work Program	Add 50 new enrollees and one new employer group to the CHP+ at Work Program
	Actual	N/A	Added 11,148 clients to CBHP	Unknown	Unknown
	Actual	One employer participated in the CHP+ at Work Program and 106 children were enrolled	151 enrollees in the CHP+ at Work program	Unknown	Unknown

*Strategy***:** While the Children's Basic Health Plan has been successful increasing the number of children enrolled in the program who were previously uninsured, the Department recognizes that there are still many children that are eligible yet not enrolled. The Children's Basic Health Plan strategy for meeting its benchmarks will be to continue to focus on marketing and outreach with targeted outreach based on initiatives the Department will pursue during FY 2008-09. The Department will be conducting a household survey which will provide valuable information on the most effective ways to reach the eligible population. In addition, the Department has applied for a grant that will help fund retention strategies for the Children's Basic Health Plan.

Legislation passed during the 2008 session will also assist the Department in meeting its benchmarks for the Children's Basic Health Plan. SB 08-160 expanded eligibility for children and pregnant women in the Children's Basic Health Plan to 225% of the federal poverty level, or up to 250% if funding permits. SB 08-161 allows for self-declaration of income for individuals applying for Medicaid and the Children's Basic Health Plan, and requires the Department to verify income through records from the Department of Labor and Employment.

Evaluation of Prior Year Performance: The Children's Basic Health Plan was able to meet the FY 2007-08 benchmarks based on a combination of efforts. The continued efforts in both marketing and outreach through the Maximus contract have helped increase the enrollment numbers. Several legislative initiatives also helped the program meet the growth targets set for FY 2007-08. SB 07-211 added presumptive eligibility for children, SB 07-097 increased

eligibility to 205% of federal poverty level, SB 07-036 increased the mental health benefits, and SB 07-004 added early intervention services.

11. Office of Client and Community Relations

Objectives: Assure delivery of appropriate, high-quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Improve internal and external communication and customer service to increase transparency and understanding of Department programs and initiatives.	Benchmark	N/A - New Measure	N/A - New Measure	90% satisfaction in internal customers	95% satisfaction in both internal and external customers
	Actual	N/A - New Measure	N/A - New Measure	Unknown	Unknown

Strategy: In order to ensure optimum customer satisfaction, the Department will conduct surveys to measure internal and selected external customer service satisfaction with services provided through the Office of Client and Community Relations (OCCR). FY 2008-09 will be the first year of the surveys and will be used to establish a benchmark that will be instrumental for improving satisfaction with programs, services, and care.

The sections within the OCCR have not consistently used surveys to gather information or measure outcomes. For example, while surveys are a best practice for customer service call centers, they have been used inconsistently in the past. OCCR recognizes the value of learning from customers and implementing suggestions when applicable to increase transparency and understanding of Department programs and initiatives. The outcomes of the surveys will be improved policies and processes, and improved communication, outreach, and training. The surveys will allow OCCR to identify and target needed areas of improvement in order to increase or maintain customer satisfaction. The first year of the surveys will be an opportunity to establish a benchmark with a goal to achieve 90% customer service satisfaction for internal customers and in FY 2009-10, the surveys will be expanded to selected external customers.

Evaluation of Prior Year Performance: Not applicable as this is a new performance measure.

12. Budget Division

Objective: Monitor expenditures for programs managed by the Department to ensure accurate financial reporting at all times.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medical Services Premiums.	Benchmark	N/A	1%	1%	0.75%
	Actual	Expenditures were 0.17% above the final spending authority	Expenditures were 1.74% above the final spending authority	Unknown	Unknown

Strategy: In order to assure that the Department's final appropriation for Medical Services Premiums is as accurate as possible, the Department submits a total of four Budget Requests per year to account for changes to base caseload and costs-per-client (excluding any additional Decision Items or Supplemental Budget Requests). The Department's final request, in February of the current budget year, incorporates actual caseload and expenditure for the first six months of the fiscal year in order to minimize the amount of projected caseload and expenditure before the Department's final supplemental appropriation.

Evaluation of Prior Year Performance: In FY 2007-08, Medicaid caseload increased substantially in the second half of the year. These increases were not anticipated in either the Department's Budget Request or the projections of the Joint Budget Committee. By June 2008, caseload had reached the level of 409,640, which was a total of 25,984 clients above the final caseload used in the calculations for the appropriation of 383,656. This unanticipated caseload was the primary factor in the Department's overexpenditure.

13. Human Resources

Objective: Value Department personnel through effective recruitment, hiring, training, and retention. Allocate its staff and resources in ways that ensure that the Department's priorities are met.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Provide job specific training to each employee. Complete and implement a comprehensive orientation and training curriculum for new staff.	Benchmark	N/A	New orientation training will occur within the first 60 days of employment	Professional development training will be provided to at least 95% of all staff	Professional development training will be provided to at least 95% of all staff
	Benchmark	N/A	Job specific training will be provided to 90% of all staff	Reduce employee turnover rate to 15%	Maintain employee turnover rate at 15%
	Actual	N/A	All employees received orientation training within 60 days of employment.	Unknown	Unknown
	Actual	N/A	Job specific training was provided to 91% of staff	Unknown	Unknown

*Strategy***:** Providing training for Department staff will help ensure that the Department reduces turnover rates, and retain a knowledgeable and skilled staff. For FY 2008-09, the Department submitted and received approval for Decision Item #8, "Training for Department Staff" which requested funds for each employee to receive professional development and training. This funding will allow the Department to enhance trainings currently offered and broaden training opportunities. The Department also intends to offer some Department-wide trainings in the upcoming fiscal year. These trainings are essential in order to create a safe and respectful work environment and to provide the appropriate level of protection of client specific information. The trainings include: 1) Privacy and Security, including the Health Insurance Portability and Accountability Act of 1996; 2) Violence in the Workplace; 3) Preventing Sexual Harassment; and 4) Creating a Respectful Workplace. In addition, the Department intends to expand its current orientation training to include a quarterly event for new employees to meet with Office Directors of the Department to get a better idea of the overall operations of the agency.

In order to improve the Department's retention rate (or decrease the turnover rate) the Human Resources Section will create a solid retention plan to encompass high quality recruitment and hiring practices, work life policies, training and education, employee recognition, improved employee relations and succession planning. In order to identify retention issues a survey was developed and will be administered to employees during FY 2008-09. The survey will allow the Human Resources Section to develop retention strategies, some of which already include offering flex-time for employees, salary equity policies, tuition reimbursement opportunities and employee recognition.

Evaluation of Prior Year Performance: Beginning in FY 2006-07, a new Individual Performance Objective regarding training was added to the employee Performance Evaluation and Planning document. Through the annual employee performance review, the manager and employee discuss individual training needs and professional development while keeping in mind the goals and objectives of their respective division, section or unit. The Department believes these efforts may: 1) increase employee and programmatic productivity; 2) enhance cost-effectiveness; 3) improve quality; and 4) reduce costly staff turnover. The Department continued this practice of including training performance objectives in the employee Performance Evaluations in FY 2007-08 and the Department was able to meet its goal of ensuring at least 90% of employees received job specific training. Some examples of training offered during FY 2007-08 include training for managers in supervision, coaching and mentoring, and multi-generational issues.

14. Long Term Care Benefits

Objectives: Assure delivery of appropriate, high-quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Increase number of clients enrolled in community based settings.	Benchmark	N/A New Measure	N/A New Measure	Enroll 200 additional clients in the Consumer Directed Attendant Support Services Program	Enroll 350 additional clients in the Consumer Directed Attendant Support Services Program
	Actual	N/A	N/A	Unknown	Unknown

*Strategy***:** Medicaid-funded long term care services include both institutionally-based nursing facility care and home and community-based waiver services. In aggregate, providing home and community-based care is more cost-effective and is often rated with a higher satisfaction level by clients. In certain regions of the state, the number of community-based service providers is more limited, with commensurate limitations on remaining in the community for clients with long term care needs. The Consumer Directed Attendant Support Services (CDASS) benefit expands options for community-based services delivery mechanisms, allowing the opportunity for greater numbers of clients with long term care needs to remain in the community. The Department will continue to expand the CDASS Program. The CDASS program has been added to the Home and Community Based Services (HCBS) waivers for Persons with Mental Illness and the Elderly, Blind and Disabled. In addition to these two HCBS waivers, the Department has proposed to the Centers for Medicare and Medicaid Services to add the CDASS Program to the HCBS waiver for Persons with Brain Injury and the Children's HCBS waiver. In addition, the Department anticipates it will add the CDASS Program to the HCBS waivers for persons with developmental disabilities when those waivers are renewed in 2009. The Department has also submitted a Medicaid State Plan Amendment to add the CDASS Program as a State Plan benefit. Through coordination and outreach with contracted case management agencies, the Department anticipates it will meet its benchmark for enrolling new individuals though current and expanded options.

Evaluation of Prior Year Performance: Not applicable as this is a new performance measure.

15. Nursing Facility Audits

Objective: Audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Conduct nursing facility audits (both change of ownership or risk based audits) to recoup patient payment (third party liabilities) currently used in personal needs accounts.	Benchmark	N/A	Increase by 0.1% over FY 2006-07	Recover approximately $1.5 million	Increase by 0.1% over FY 08-09
	Actual	Approximate monthly recoupment was $82,000 (approximately $984,000 total)	$1.8 million in recoveries (approximately 17% over FY 2006-07)	Unknown	Unknown

*Strategy***:** The Department is statutorily required to audit costs as reported by Medicaid nursing facilities and any overpayments to providers must be recovered. The Department conducts billing audits each year of facilities to ensure the patient personal needs allowance and the patient payment amount are calculated properly. In addition, the auditors review the Post Eligibility Treatment of Income calculation which allows clients to pay for medically necessary items that are not covered by Medicaid. The Department's auditors evaluate these items to identify inaccuracies and determine the amount of recoveries due. In order to continue recoveries from nursing facility providers, the Department will continue to conduct audits in accordance with all applicable rules and regulations.

Evaluation of Prior Year Performance: The Department far exceeded its goal for recoveries in FY 2007-08 due to unexpectedly large recoveries from some nursing facilities. The amount of collections can vary widely, making it difficult for the Department to estimate how much recoveries will be in any given year. In addition, due to the timing of the collection of recoveries, some recoveries can be demanded in one fiscal year, but not collected until the next fiscal year. The Department experienced some unusually large collections in FY 2007-08, but does not anticipate the same number of unusually large collections in the upcoming fiscal year. For this reason, the benchmark for FY 2008-09 reflects a fixed dollar amount instead of growth over the prior fiscal year.

16. Program Integrity

Objective: Audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Conduct provider post payment audits to decrease fraud and abuse and increase recoveries.	Benchmark	N/A	$10 million in total recoveries	$10 million in total recoveries	$12 million in total recoveries
	Actual	Nearly $10 million	$7.1 million in total recoveries	Unknown	Unknown

Strategy: There are currently many successful avenues for monitoring provider compliance and recovering funds for provider fraud, waste and abuse. However, opportunities exist for improving the manner in which recoveries are identified, recovered and tracked. The Department is committed to continuous improvement and is working toward ways to report the cumulative comprehensive results of all provider integrity efforts. The Department is undertaking new initiatives to increase provider recoveries as well as increase cost avoidance so that recoveries are not necessary. Beginning in FY 2008-09, Colorado will voluntarily begin participating in the Centers for Medicare and Medicaid Services-sponsored Provider Enrollment System (PES) pilot program. PES is a Medicaid-Medicare enrollment system for all fee-for-service providers and for managed care entities. The program combats fraud by running the enrollment information across multiple databases and information sources, including national crime information, the Internal Revenue Service, the Fraud Investigations Database, the Social Security Administration, licensing data through the Colorado Department of Regulatory Agencies, and other exclusionary databases. The goal of PES at the national level is for all states to have an online Medicaid and Medicare provider application process. In this manner, one national repository of all Medicare and Medicaid provider information will be created that will allow program integrity programs nationwide to track trends, monitor migration of fraudulent providers, and increase provider accountability for submitted claims.

Another initiative is the Medicare-Medicaid Data Matching Project (MEDI-MEDI) which is a federal initiative that arose from the Deficit Reduction Act of 2005. The program seeks to identify fraud by comparing data patterns occurring in Medicaid and Medicare that previously went undetected in either program. Providers submitting aberrant claims in one program are found to be doing the same in the other. The Department will become a MEDI- MEDI state with a scheduled implementation of the project in FY 2008-09. Estimates on the effectiveness of the MEDI- MEDI program have not been forecast yet, but performance of the program in the current ten pilot states have identified duplicate billing of claims to Medicare and Medicaid for the same services rendered to the same clients on the same dates of service.

In addition to these national initiatives, the Department also intends to begin tracking recoveries internally in a centralized manner. Currently, recoveries are recorded in several different sections of the Department. The Department will centralize these functions in order to provide more complete information regarding the amount of provider recoveries each year.

Evaluation of Prior Year Performance: The Department did not meet its benchmark of $10 million in recoveries through its Program Integrity Section. Many of the Department's cases are referred for criminal and civil investigations to the Medicaid Fraud Control Unit, Health and Human Services Office of the Inspector General (HHS-OIG), the State Attorney General's Office or the Assistant U.S. Attorney's Office (AUSA). In FY 2007-08 a total of 19 cases were referred to these other agencies and all cases are still open and active. When cases are referred to other investigative entities, the Department does not make any recoveries so as not to interfere with the ongoing investigations. While the Department may not directly make recoveries related to the cases it refers, the cases can still result in significant recoveries or criminal penalties. One referral case has the potential to reach $7 million in false claims, penalties and interest. Another case resulted in a conviction and a ten year jail sentence with $1 million in restitution.

17. Payment Recoveries

Objective: Audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.

Performance Measure	Outcome	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.	FY 2009-10 Request
Actively audit expenditures to decrease fraud and abuse and increase recoveries.	Benchmark	N/A	Increase recoveries to $25 million	Increase total recoveries by 2% over FY 07-08.	Increase total recoveries by 2% over FY 08-09.
	Actual	$25.8 million in recoveries (this amount includes a one-time payment of approximately $1.6 million from a class action lawsuit)	$24.5 million in recoveries	Unknown	Unknown

Strategy: Frequently Medicaid unnecessarily pays for health and long-term care services because another party is liable for the services. Some third parties or clients, who should be the primary payer, abuse or misuse the system through fraudulent activities or inaccurate eligibility information. The Department anticipates that the real estate market will improve slightly in Colorado (Colorado was ahead of the national curve) and that other recovery programs, such as post-pay third party insurance recoveries, tort & casualty and trust recoveries, will also increase slightly due to increased focus on potential recoveries. Larger increases are not anticipated because the Department is able to cost avoid more and more in these cases (for example, discovering when someone has third party insurance before the claim is paid avoids the need to chase after a recovery). Through HB 08-1407, the Department will be able to increase cost avoidance because the bill provides additional incentives for third parties to not unreasonably deny or delay payment of claims.

Evaluation of Prior Year Performance: The Department did not meet its benchmark for FY 2007-08 because forecasted estate recovery was depressed due to economic hardship in the real estate market. The Department primarily recovers residential real estate under estate recovery and sells the property. The Department has a large portfolio of properties but it has been difficult to sell these properties to convert them into cash recoveries. This difficulty will continue until the real estate market recovers, especially the secondary investment real estate market which includes those who buy and repair homes and resell them. The typical buyer of Department properties obtained through Department estate recoveries purchase the properties as a secondary investment rather than a personal residence.