Department of Health Care Policy and Financing
Strategic Plan
FY 2010-11 Budget Request

November 6, 2009

I. EXECUTIVE LETTER

November 6, 2009

The Honorable Moe Keller
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Keller:

One of the recommendations of the Blue Ribbon Commission for Health Care Reform was that Medicaid program efficiency be improved and enhanced. In light of this recommendation, and the Department's commitment to health care reform as initiated in the Governor's Building Blocks to Health Care Reform, the Department offered a coordinated set of requests for FY 2009-10, including:

- DI-5 Improved Eligibility and Enrollment Processing
- DI-6 Medicaid Value-Based Care Coordination Initiative (Colorado Accountable Care Collaborative)
- BRI-1 Pharmacy Technical and Pricing Efficiencies
- BRI-2 Medicaid Program Efficiencies

Together, these requests streamline client navigation through the eligibility process of Medicaid and the Children's Basic Health Plan. In addition, these requests enable the Department to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado while improving the quality of services for clients. Other aspects of these requests include implementing an automated prior authorization system and changing the reimbursement rates of drugs using a state maximum allowable cost structure.

In alignment with these reform efforts for FY 2010-11, the Department requests authority for a set of requests that take into careful consideration the difficult economic decisions facing the State. These requests offer a net savings while improving the coordination of the Department's payment systems and still adhering to the principle of enhancing value through preventive care. Once implemented, the enhancements and programmatic changes contained in these requests will lead to a more affordable, coordinated system of care based on shared responsibility. Under this system, payers, providers, and clients each have responsibility for improving health and health outcomes for Colorado residents. The Department has focused on enhancing value and achieving efficiencies in its FY 2010-11 Budget Request, which includes the following:

- BRI-1 Prevention and Benefits for Enhanced Value
- BRI-2 Coordination of Payment and Payment Reform
- BRI-3 Expansion of a State Maximum Allowable Cost Reimbursement Rate Methodology
- BRI-4 Medicaid Program Efficiencies

At the heart of the Department's commitment to health care reform are the first two requests, BRI-1 and BRI-2.

BRI-1, "Prevention and Benefits for Enhanced Value" would allow the Department to generate service efficiencies while improving the quality of service for clients through a series of initiatives focused on enhancing quality and health outcomes. In order to achieve this outcome, the Department would implement:

- consolidation of current utilization review functions;
- expanded procedures for dental hygienists; and
- non-emergency medical transportation policies reform.

BRI-2, "Coordination of Payment and Payment Reform," proposes four practical and specific steps toward payment coordination. In the future, the Department may develop a proposal to implement payment reform initiatives as payment reform brings the economic incentives of the payment and rate structures into alignment with desired outcomes. For the time being, the Department is proposing the following initiatives that will result in cost savings by allowing the Department to:

- consolidate payment and billing processes for federally qualified health centers and behavioral health organizations;
- expand audits conducted by the Nursing Facilities Section;
- initiate a pilot audit of a community mental health center; and
- increase enrollment of Medicare-eligible clients into Medicare.

BRI-3, "Expansion of a State Maximum Allowable Cost Reimbursement Rate Methodology, and BRI-4, "Medicaid Program Efficiencies," seek to establish payment efficiencies through the establishment of reimbursement policies that maximize Department funding without compromising client care. Specifically, BRI-3 would allow the Department to save money on pharmaceutical drug expenditures by adding more drugs in the State Maximum Allowable Cost methodology. A portion of the savings created through expansion of this program would be used to perform necessary one-time changes to the Medicaid Management Information System. BRI-4 would allow the Department to realize cost savings by requiring a change in the way that home health agencies and providers bill for services. If approved, providers would be allowed to only bill for the time spent rendering service to a client, rather than the block time periods they're allowed to bill for now, which may be much longer than the time spent actually caring for clients.

The challenges posed by the global economic downturn have increased the importance of the Department's commitment to ensuring the delivery of appropriate, high quality health care in the most cost-effective manner possible. With the passage of HB 09-1293, "Colorado Health Care Affordability Act," the Department has begun taking steps toward reducing the number of uninsured Coloradans and increasing reimbursement rates for inpatient and outpatient care provided to Medicaid clients — all without General Fund impact. Further, in FY 2008-09, the Department was able to train 357 providers as medical home providers and provide access to a medical home for 162,315 children across Medicaid and the Children's Basic Health Plan.

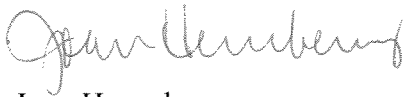
Additionally, in the face of rising caseload, and amid budget cuts affecting many of the Department's programs, the Department's General Fund expenditure for its Medical Services Premiums was 0.6% under the budgeted amount when contributions from the American Recovery and Reinvestment Act are taken into consideration.

The Department has also begun implementation of the Colorado Accountable Care Collaborative, an initiative for which funding was requested in DI-6, "Medicaid Value-Based Care Coordination Initiative," in the Department's November 3, 2008 FY 2009-10 Budget Request. Once in place, the Colorado Accountable Care Collaborative will consist of a statewide data organization and a number of regional care coordination organizations charged with offering care-coordination services and supporting providers and clients enrolled across each region. The Department anticipates that incentive structures for the regional care coordination organizations and providers participating in the Colorado Accountable Care Collaborative will reduce the incidence of unnecessary and more costly services, while maximizing the health, functioning, and self-sufficiency of Medicaid clients and providers.

The Department is in the process of implementing the initiatives requested in BRI-2, "Medicaid Program Efficiencies," in the Department's November 3, 2008 FY 2009-10 Budget Request. Once fully implemented, these initiatives will allow the Department to realize cost savings through a series of changes that include the definition of the amount, scope, and duration of Medicaid benefits, client-based evaluation of Medicaid clients on health outcomes, provision of a fluoride varnish benefit for children, and increased oversight of the Department's oxygen benefit program. Also a part of this initiative, the Department is taking steps toward implementing Executive Order D 005 09, "Medicaid Policy on Serious Reportable Events," which will require the Department to deny or reduce payments under Medicaid and the Children's Basic Health Plan for a specified list of medical events that should never happen during inpatient hospital stays. The objective of the order is to ensure patient safety and high quality care.

The Department remains committed to working with the General Assembly and all interested stakeholders in finding ways to improve care for its clients, advance health care reform, and realize cost efficiencies as the State's fiscal challenges continue.

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

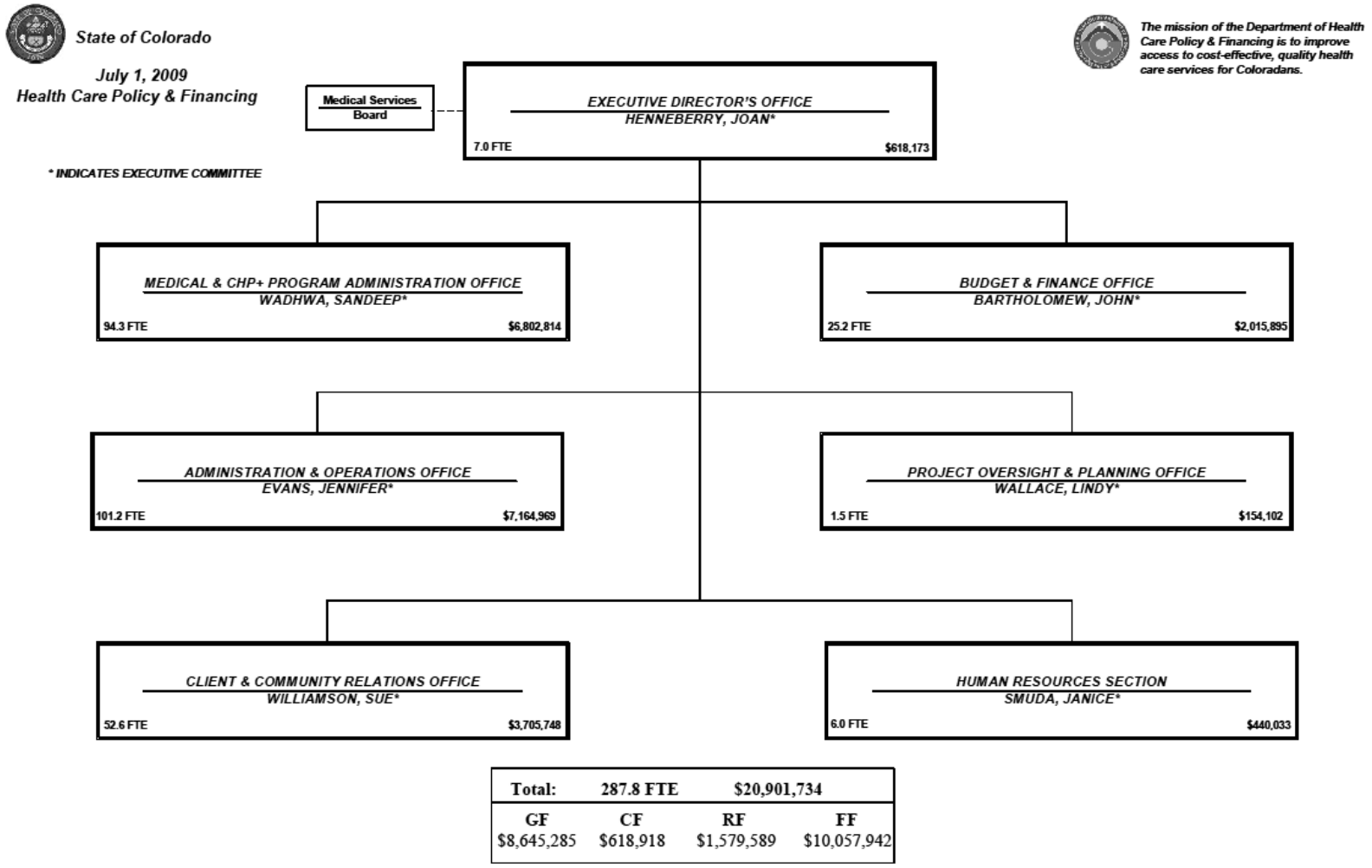
The statutory authority for the Department can be found at Title 25.5 of the Colorado Revised Statues, (2009).

25.5-4-104, C.R.S. (2009). 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. (2009). 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. (2009) 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



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 2010-11 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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Department-wide					
Increase the number of clients served through targeted, integrated care management programs.	Benchmark	Add 500 clients	Add an additional 2,000 clients	Increase enrollment to approximately 3,800 clients	Maintain enrollment of approximately 3,800 clients
	Actual	Added 2,000 clients	Added 308 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 clients 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.

During FY 2008-09, the Department negotiated with Colorado Access to expand from four counties to six. Denver County was successfully added in FY 2008-09 and Weld County was added in early FY 2009-10. In addition, the Department completed negotiations with Kaiser Permanente to add a second CRICC contract serving an additional 1,200 clients in Jefferson and Denver Counties. Enrollment in Kaiser started August 2009. The Department anticipates the addition of Kaiser Permanente, and the expansion of the Colorado Access services areas, will bring the total CRICC enrollment to approximately 3,800 clients in FY 2009-10.

In FY 2010-11, the Department plans to maintain enrollment in the program at approximately 3,800 clients. The Department will also evaluate the future direction of the program and apply lessons learned to other contracts where applicable. In addition, the Department will evaluate whether or not it would be appropriate to enroll some or all of these clients into the Colorado

Accountable Care Collaborative, a program that is scheduled for implementation in FY 2010-11 and would provide a coordinated health care model for 60,000 Medicaid clients.

Evaluation of Prior Year Performance: Despite expansion of the Colorado Access contract from four counties to six counties, the Department did not meet its goal of enrolling an additional 2,000 clients into CRICC programs during FY 2008-09. Actual enrollment as of June 2009 was 2,308 clients. The procurement and contracting process with Kaiser took longer than anticipated so this contract was put into place for FY 2009-10. In addition, the expansion of Colorado Access into Weld County did not occur in FY 2008-09 as expected, and was delayed into FY 2009-10. This has resulted in fewer than anticipated enrollments.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Department-wide					
Increase the number of children served through a dedicated medical home service delivery model.	Benchmark	Add 15,000 clients	Add 125,000 clients	Achieve the following access targets for medical home: Children's Basic Health Plan = 100% of enrolled children Medicaid = 49% of enrolled children	Achieve the following access targets for medical home: Children's Basic Health Plan = 100% of enrolled children Medicaid = 51% of enrolled children
	Actual	Added 15,865 Medicaid clients	Added 162,135 clients (includes Medicaid and Children's Basic Health Plan children)	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. As of the end of FY 2008-09, all children enrolled in the Children's Basic Health Plan have access to a medical home. As such, the Department is focusing on expanding the number of Medicaid children enrolled in a medical home as reflected as a percentage of the total caseload of Medicaid children in each fiscal year. The Department estimates that 49% of Medicaid children will have access to a medical home in FY 2009-10 and 51% will have access to a medical home in FY 2010-11.

The number of Medicaid children able to enroll in a medical home is currently limited by the number that can be served by participating medical home providers. As such, increasing participation among medical home providers is prerequisite to the Department's ability to increase the total number of children with access to a medical home.

In order to meet the benchmarks for FY 2009-10 and FY 2010-11, the Department must ensure that there is an adequate network of primary care physicians who are willing to participate as

medical homes. Despite the 2% rate cut to physician services in FY 2009-10, the Department will continue to train and determine Medicaid and Children's Basic Health Plan providers as medical home providers. However, the Department anticipates that this budget reduction may result in fewer providers participating in the program. If a provider is determined as a medical home provider for one program, that provider is automatically determined for both. These efforts will include reaching out to providers that currently accept clients enrolled in Medicaid or the Children's Basic Health Plan as well as providers in the state who have previously been unwilling to participate. The Department believes that providing a medical home for children in Medicaid and the Children's Basic Health Plan will help ensure that the highest quality care is being provided to the Department's youngest eligible clients.

Evaluation of Prior Year Performance: The Department exceeded the enrollment benchmark for FY 2008-09 as 162,135 children were enrolled in a medical home as of June 30, 2009. By the end of FY 2008-09, 64,598 children, or 100% of children enrolled in the Children's Basic Health Plan were enrolled in a medical home. The Department was able to enroll this number of children since each managed care organization that provides services through the Children's Basic Health Plan is fully equipped to act as a medical home. In FY 2008-09, 97,537 children, or approximately 41% of Medicaid children were enrolled in a medical home. (November 6, 2009 FY 2010-11 Budget Request, Exhibit B, "Medicaid Caseload Forecast," page EB-1).

Enrollment of children into a medical home is dependent upon the availability of participating providers. By the end of FY 2008-09, 357 pediatricians were trained and determined as medical home providers. Of this total, 120 providers accept only Medicaid clients and 237 accept clients enrolled in either Medicaid or the Children's Basic Health Plan.

In FY 2008-09 all participating Medicaid and Children's Basic Health Plan pediatricians were certified as medical home providers. To increase the number of children in these programs with a medical home, additional specialties are now being certified. These include participating family practice, internal medicine, and other specialist types.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Department-wide					
Survey customer satisfaction with managed care using the Consumer Assessment of Health Plans Survey (CAHPS).	Benchmark	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	Increase all reportable rates to at or above national Medicaid average
	Actual	11 of 18 reportable rates were at or above national Medicaid average = 61%**	18 of 28 reportable rates were at or above national Medicaid average = 64%	Unknown	Unknown

** National Committee for Quality Assurance*

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

Strategy: Client satisfaction surveys are one way to get a sense of health care service quality. They can be used as an indicator of the quality of delivery of services, technical quality of care, cultural competency, communications, personal relationships between client and provider and other factors. Comparing these to the national reported benchmarks is helpful in identifying opportunities for improvements to operations, procedures, and changing benefits. At the very least, the measures increase awareness of the value in improving key components of medical services.

The Department has modified its managed care strategy to complement the Governor's Building Blocks to Health Care Reform. The new managed care strategy is reflected in the Medicaid reform efforts of the Colorado Accountable Care Collaborative, which is described in performance measures #3 and #5. The Colorado Accountable Care Collaborative, which the Department anticipates to implement in FY 2010-11, is expected to enroll 60,000 clients initially and if successful, to eventually enroll the vast majority of all Medicaid clients. The Department anticipates that the Colorado Accountable Care Collaborative will increase client satisfaction by creating a coordinated network of providers that are more focused and accountable for health outcomes of clients.

Evaluation of Prior Year Performance: A trend analysis was completed by the designated External Quality Review Organization, Health Services Advisory Group. Most plans and measures did not score statistically significantly higher or lower on any of the CAHPS measures. Compared to last year, a greater proportion of reportable rates were at or above the national Medicaid average reported rate for each measure. For children, there have been increased

satisfaction ratings over the last year for the Primary Care Physician Program for the measures "Rating of Personal Doctor" and "Rating of All Care," perhaps attributable to continuing efforts around the provision of a medical home for all children across Medicaid as well as changes to the Durable Medical benefit reducing Prior Authorizations for 66 wheelchair codes. Adults had increased satisfaction ratings for the measures "PCPP [Primary Care Physician Program] for Rating of All Health Care" and "Rating of Specialist Seen Most Often."

4. Healthcare Effectiveness Data and 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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 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 and Information Set (HEDIS) measures.	Benchmark	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	All reported managed care HEDIS measures at or above national Medicaid 75th percentile
	Actual	Managed care = 30% of reported measures were at or above national Medicaid average FFS = 10%*	Managed care = 67% of measures were at or above national Medicaid average FFS = 25%	Unknown	Unknown

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

Strategy: The Healthcare Effectiveness Data and Information Set (HEDIS) is a nationally recognized tool to measure performance on important dimensions of care and service for public and commercial payers. For Colorado Medicaid, an outside vendor calculates the final state averages with respect to the national Medicaid averages based on data from the health plans and participating fee-for-service providers. Measures change over time, as the Department selects measures based on the populations it serves as well as health plan performance. In selecting each year's measures, the Department substitutes measures that routinely show performance at the 75th or 90th percentile of national data with measures for which performance is not known or have been problematic in the past.

The HEDIS data reflect calendar year performance and are usually available eight months after the end of the year. Therefore the data to be reported in FY 2010-11 will reflect care provided January to December 2010 and changes in strategy effective prior to January 2010. Because a significant number of health plans achieved or exceeded the national average for the majority of measures reported in 2009, the performance benchmark will be raised from the national average to the national 75th percentile in FY 2010-11.

The federally qualified health centers (FQHCs) have not been submitting the types of codes needed to accurately calculate the HEDIS measures. However, FQHC clients are included in percentage denominators. As a result, some fee-for-service rates are artificially low. The

FQHCs are working on submitting the required codes beginning January 1, 2010, which will impact the Department's ability to meet its benchmark for FY 2010-11. Once data from the FQHCs is included in the fee-for-service rates, we anticipate the majority of rates will be at or above the national average.

The Department continues to communicate with, educate, and support providers and contractors in order to improve provider and contractor performance on these measures. Support comes in the form of provider outreach meetings, regularly scheduled meetings, contract requirements, incentives where appropriate, and newsletters.

The Department anticipates that the Department's efforts to enroll children in either Medicaid or the Children's Basic Health Plan into a medical home will also improve the Department's ability to meet its stated benchmarks for this performance measure. For more information on the medical home concept, see performance measure #2, "Medical Homes."

Evaluation of Prior Year Performance: The data collected reflects performance during calendar year 2008. The percent of HEDIS measures on which health plans scored equal to or better than the national average increased substantially from the prior year. However, the majority of Medicaid clients receive care on a fee-for-service basis. While the percent of measures that scored near the national average more than doubled for the fee-for-service population, the percent below the average is too high.

It is important to note that the HEDIS measures selected for reporting each year change over time due to several factors. First, new measures become available for use with the Medicaid population. Secondly, contract changes in FY 2007-08 allowed more measures to be calculated in FY 2008-09. Thirdly, greater focus is being placed on choosing measures that reflect current issues affecting Medicaid clients. In comparison to the number of measures included in the FY 2007-08 report, three additional measures were included in the FY 2008-09 report. Health plan performance for these three measures exceeded the national average, increasing the percent of measures above national averages.

As discussed above, it was discovered that not all FQHCs submit the codes needed to accurately calculate some HEDIS measures, although FQHCs clients are included in percentage denominators. This means that some fee-for-service rates are artificially low. The Department is working with the FQHCs to submit the required codes.

5. Focal Point of 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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Department-wide					
Increase the number of options for clients enrolling in Medicaid to select a focal point of care.	Benchmark	Add one new option in the Denver-metro area	Add one new option in the state	Add two new options in the state	Implementation of Colorado Accountable Care Collaborative
	Actual	Added one new option: Colorado Access CRICC* Program	None added	Unknown	Unknown

**Colorado Regional Integrated Care Collaborative*

Strategy: Currently, many clients lack a focal point for care and care coordination in the Medicaid program. The Department's goal is to reduce enrollment in Medicaid fee-for-service and increase enrollment into medical care delivery models that provide clients with a focal point of care. Like managed care, a focal point of care provider is paid a per-member per-month fee. However, this fee is administrative in nature. Providers are paid fee-for-service rates for actual care provided. A portion of the administrative fee funds additional client care features like medical home, designated medical clinics, and client care coordination across specialists and other providers. The Department is shifting away from expanding the number of managed care options it offers clients and moving toward care models that offer a focal point of care as a means of providing more cost-effective, client-centered care that also improves outcomes.

In FY 2009-10, the Department anticipates it will add two new options for clients to enroll in a focal point of care. The Department is currently working with Colorado Access and Kaiser Permanente to increase participation in 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 clients by better coordinating physical health, mental health, and substance abuse services.

In early FY 2009-10, the Colorado Access contract was expanded to include Weld County. Kaiser Permanente began serving clients in August of 2009 in Denver and Jefferson Counties, and the Department anticipates that a total of 1,200 CRICC clients will be served by the end of FY 2009-10 (see performance measure #1, Integrated Care Management, for more information).

In seeking to shift toward a focal point of care model, the Department sought funding for the Colorado Accountable Care Collaborative program in DI-6, "Medicaid Value-Based Care Coordination Initiative," which was submitted in the Department's November 3, 2008 Budget Request for FY 2009-10. Funding for implementation, including client enrollment into the Colorado Accountable Care Collaborative program, was pushed into FY 2010-11 during final

balancing of the Long Bill, SB 09-259. The Department plans to spend FY 2009-10 working with stakeholders, contractors, and providers to ensure the successful implementation of the Colorado Accountable Care Collaborative in FY 2010-11.

In addition to continuing implementation of the Colorado Accountable Care Collaborative, 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 provide focal point of care options for clients, which is also discussed in performance measure #1 and performance measure #6.

Evaluation of Prior Year Performance: The Department did not meet its goal of adding one new managed care option in FY 2008-09. This addition was not made in FY 2008-09 due to delays in contract negotiation and execution with Kaiser Permanente. The Kaiser CRICC program became effective August 2009. This performance measure is closely tied to the Department's performance measure #1 regarding integrated care management programs.

6. Focal Point of 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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Medicaid Program Division					
Increase the number of clients with an identified focal point of care.	Benchmark	Increase by 5% over 2006-07	Increase by 2% over FY 2007-08	Increase by 2% over FY 2008-09	Increase by 150% over FY 2009-10
	Actual	76,271 clients enrolled in viable managed care options (2% under FY 2006-07)	80,156 clients enrolled in viable managed care options (5% over FY 2007-08)	Unknown	Unknown

Strategy: Currently, many clients lack a focal point for care and care coordination in the Medicaid program. The Department's goal is to increase enrollment into health care delivery models offering a focal point of 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 (CRICC) to improve managed care options for clients, which will help increase client enrollment into these programs. Based on the expansion of the CRICC program into Jefferson, Denver, and Weld Counties in FY 2009-10, the Department anticipates a 2% increase, approximately 1,600 clients, in the number of clients with access to a focal point of care.

In addition, a greatly modified managed care strategic plan was developed to complement the Governor's Building Blocks to Health Care Reform, which impacts the overall managed care growth strategy. The new managed care strategy is reflected in the Medicaid reform efforts of the Colorado Accountable Care Collaborative, described in performance measures #3 and #5. These efforts will introduce a new managed care program in FY 2010-11, a program which is expected to enroll 60,000 clients initially and if successful, to eventually enroll the vast majority of all Medicaid clients.

This performance measure is closely tied to the Department's performance measure #5 regarding focal point of care options.

Evaluation of Prior Year Performance: The Department was able to exceed its goal of increasing enrollment in managed care programs by 2% for FY 2008-09. Managed care enrollments increased by 5%, from 76,271 to 80,156. This increase reflects the overall Medicaid caseload increase of over 10% during this same period.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Medicaid Program Division					
Improve access to health care, increase health outcomes and provide more cost effective services using information technology.	Benchmark	Serve 165 clients using telehealth / telemedicine technology	Serve 165 clients using telehealth / telemedicine technology	N/A – program eliminated	N/A – program eliminated
	Actual	145 clients were served using telemedicine technology	131 clients were served using telemedicine technology	N/A	N/A

Strategy: In response to the high cost of hospital stays and delays experienced by some Medicaid fee-for-service clients when wishing to see a physician, the Department initiated the Colorado Medicaid Telehealth Pilot Program (CMTPP) in 2007. Participation in the CMTPP is limited to Medicaid clients with heart failure, chronic obstructive pulmonary disease, or diabetes. Clients who have been enrolled in the program for at least six months have shown an increase in adherence to physician visits, stabilized biometrics, and reduced emergency room visits.

The CMTPP provides clients the ability to coordinate with their doctors and nurses to manage their own care from their homes using biometric feedback technology. Once a client enrolls into the program, they are provided with in-home tele-monitoring equipment that allows for the use of on-site health technologies including glucometers, weight scales, blood pressure monitors, pulse oximeters, and spirometers, as appropriate for the condition being managed. Client measurements are transferred to a nurse station through the telephone line to allow remote evaluation of the client's condition. Measures determined to be outside client-specific parameters set by the client's physician prompt follow-up from a registered nurse and physician notification.

As a part of ES-2 "Medicaid Program Reductions," submitted on August 24, 2009, the Department proposed a combination of rate reductions, service restrictions, elimination of certain programs, increased cost-sharing, and financial efficiencies to reduce Medicaid program expenditures by approximately $17 million net General Fund in FY 2009-10. The Department's Telehealth Disease Management Program was a part of this proposal. As a result, the Department's contractor stopped offering services on September 1, 2009. The Department estimates that the proposed restrictions will reduce expenditure by approximately $317,000 total funds and $159,000 General Fund in FY 2009-10. This reduction is permanent; therefore, the Department will not be offering this program in FY 2010-11.

Evaluation of Prior Year Performance: The Department was unable to meet its goal of enrolling 165 individuals due to the following:

- fluctuating program enrollment resulting from loss of Medicaid eligibility during the year;
- client ineligibility resulting from Medicare eligibility determinations;
- delayed contractor outreach due to manual client eligibility verifications performed by Department staff as a result of inconsistencies in system-generated client eligibility files; and
- suspension of client enrollment into the program in January and February while the Department evaluated whether or not the program would be eliminated to help balance the state's budget. Client enrollment into the program resumed in March for the remainder of the fiscal year, but not without impacting the program's enrollment targets.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Pharmacy Section					
Achieve Medicaid pharmaceutical cost avoidance for drug classes on the Preferred Drug List (PDL).	Benchmark	Cost avoid by 2%	Cost avoid by 7%	Cost avoid by 5%	Cost avoid by 3%
	Actual	Costs avoided by 10.88% (actual costs for drug classes on PDL were $6,932,302)	Costs avoided by 6.70% (actual costs for drug classes on PDL were $24,242,166)	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 2009 the Department has implemented ten additional drug classes on the Preferred Drug List including: antiemetics, oral bisphosphonates, oral anti-diabetic agents, growth hormones, intranasal corticosteroids, leukotriene modifiers, ophthalmic allergy medications, respiratory inhalants, skeletal muscle relaxants, and triptans. The Department anticipates adding three to four more drug classes by the end of FY 2009-10, and four new drug classes in FY 2010-11. Other future focuses for cost avoidance will fall into three major areas: analysis of potential cost savings in mental health drugs (antidepressants); increasing generic utilization; and the pursuit of higher supplemental rebates in existing classes.

The Department will continue selecting drug classes that offer opportunities to meet cost avoidance benchmarks. However, it is important to note three points that could limit the cost avoidance. 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. The Department considered it unlikely that cost avoidance would continue at the same rate. It is also unlikely that the drug classes added in FY 2009-10 and FY 2010-11 will achieve cost avoidance to the same degree. Third, cost avoidance is generally greatest in the fiscal year that the drug classes are 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 estimates that cost avoidance falls short of projections by 0.3%. The benchmark for FY 2008-09 was set high in response to the outstanding cost avoidance achieved in FY 2007-08. As the Preferred Drug List expands, the potential percentage of cost avoidance derived from adding new drug classes continues to fall due to lower overall expenditures for the new classes. The increased caseload had a significant impact on cost measures as well.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Health Outcomes and Quality Management Unit					
Survey client satisfaction with the fee-for-service program using the Consumer Assessment of Health Plans Survey (CAHPS).	Benchmark	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	Increase all reportable rates to at or above national Medicaid average
	Actual	11 of 19 reportable rates were at or above national Medicaid average = 58%	5 of 11 reportable rates were at or above national Medicaid average =45.5%	Unknown	Unknown

**National Committee for Quality Assurance*

Strategy: Client satisfaction surveys are one way to get a sense of health care service quality. They can be used as an indicator of the quality of delivery of services, technical quality of care, cultural competency, communications, personal relationships between client and provider and other factors. Comparing these to the national reported benchmarks is helpful in identifying opportunities for needed improvements to operations, procedures, and changing benefits. At the very least, the measures increase awareness of the value in improving key components of medical services.

The Department has modified its managed care strategy to complement the Governor's Building Blocks to Health Care Reform. The new managed care strategy is reflected in the Medicaid reform efforts of the Colorado Accountable Care Collaborative, which is described in performance measures #3 and #5. The Colorado Accountable Care Collaborative, which the Department anticipates to implement in FY 2010-11, is expected to enroll 60,000 clients initially and if successful, to eventually enroll the vast majority of all Medicaid clients. The Department anticipates that the Colorado Accountable Care Collaborative will increase client satisfaction by creating a coordinated network of providers that are more focused and accountable for health outcomes of clients.

Evaluation of Prior Year Performance: The Department's Medicaid fee-for-service program did not score significantly higher or lower on any of the CAHPS measures. It is recognized that this population has the least service uniformity and oversight while comprising the largest population served. There are ample opportunities for improvement in several individual satisfaction elements. The Department believes that the medical home initiative impacted parents' increased satisfaction with their children's care.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
CHP+ Division					
Expand coverage in the Children's Basic Health Plan.	Benchmark	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 clients to the Children's Basic Health Plan	Add 12,839 clients to the Children's Basic Health Plan
	Benchmark	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	Maintain the FY 2009-10 number of 200 enrollees in the CHP+ at Work Program
	Actual	Added 11,148 clients to the Children's Basic Health Plan	Added 3,882 clients to the Children's Basic Health Plan	Unknown	Unknown
	Actual	Total 151 enrollees in the CHP+ at Work program	Total 157 enrollees in the CHP+ at Work program	Unknown	Unknown

*Strategy***:** While the Children's Basic Health Plan has been successful in 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 2009-10. The Department conducted a household survey in FY 2008-09 which will provide valuable information on the most effective ways to reach the eligible but not enrolled populations. In addition, the Department received grant funding from the federal Health Resources and Services Administration, State Health Access Program for the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). This grant will help fund the State's strategies to expand access to affordable health care including enrollment in the Children's Basic Health Plan.

Legislation passed during the 2009 session will also assist the Department in meeting its benchmarks for the Children's Basic Health Plan. "The Colorado Health Care Affordability Act," HB 09-1293 expanded eligibility for children and pregnant women in the Children's Basic Health Plan to 250% of the federal poverty level. This expansion has an expected April 2010 implementation date. Additionally, in February 2009, Congress passed the Children's Health Insurance Program Reauthorization Act which expanded access and funding for states. The legislation increases Colorado's federal funding by 36% to $97.5 million in the 2009 federal fiscal year. The reauthorization allows Colorado to continue its current program and allows the State to continue efforts to enroll eligible but not enrolled children and pregnant women into the Children's Basic Health Plan.

Evaluation of Prior Year Performance: The Children's Basic Health Plan was not able to meet the FY 2008-09 benchmarks. While the Children's Basic Health Plan did see a continued increase in enrollment during FY 2008-09, the Department believes that the benchmark was not fully met because a higher number of children migrated to Medicaid who were previously eligible for the Children's Basic Health Plan. This migration was the result of a drop in the incomes of families who initially qualified for the Children's Basic Health Plan, thus making their children eligible for Medicaid. The increased enrollment numbers in Medicaid support this trend. The Department expects this trend to continue until the economy improves.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Office of Client and Community Relations					
Improve internal and external communication and customer service to increase transparency and understanding of Department programs and initiatives.	Benchmark	N/A - New Measure for FY 2008-09	90% satisfaction among internal customers	90% satisfaction among internal customers	90% satisfaction among both internal and external customers
	Actual	N/A - New Measure for FY 2008-09	89% satisfaction among internal customers	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).

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. The 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 the OCCR to identify and target needed areas of improvement in order to increase or maintain customer satisfaction. In FY 2009-10, the surveys will be expanded to selected external customers.

For FY 2009-10, the OCCR plans to expand the pilot survey to include all of its sections and units. The questionnaire will be modified to capture uniform measurements with a goal of achieving a 90% favorable customer satisfaction rating among internal customers in FY 2009-10. In addition, OCCR staff will develop a process and a survey instrument to assess external customer satisfaction.

The OCCR has identified several proven customer service strategies that will be implemented to meet the FY 2009-10 and FY 2010-11 benchmarks. First, excellent customer service requires training staff and constantly reinforcing the message that customers come first. We will offer training to all of the OCCR staff on providing excellent customer service so the message is reinforced that customer service is a priority. For internal customer service, OCCR managers will be encouraged to develop and foster good working relationships with colleagues and ask

staff what they need from OCCR staff to be more productive and successful in their jobs. The OCCR has identified the following key messages to ensure that the level of customer satisfaction is met: 1) respond to customer service inquiries in a timely manner; 2) offer solutions to problems and think "outside the box"; 3) provide accurate information in response to inquiries; and 4) communicate in a respectful and positive manner. If these key messages are reinforced and rewarded, OCCR can meet the benchmarks for FY 2009-10 and FY 2010-11.

Evaluation of Prior Year Performance: FY 2008-09 was the first year of the surveys, and the information gathered will be used to establish a benchmark that will be instrumental for improving satisfaction with programs, services, and care. Because of the diversity of activities within the OCCR, the Department found it extremely challenging to create one single survey to measure the level of customer satisfaction among internal Department customers. Each section or unit within the OCCR sought to identify the best approach and method to measure internal customer satisfaction. However, certain sections and units within the OCCR have greater interaction with other Department staff than others; therefore, the Department focused its efforts on pilot testing a survey with only one section within the OCCR – the Business Analysis Section (BAS). The mission of BAS is to work with Department staff to provide accurate analyses which enable program staff to make informed decisions in the administration of their programs. The BAS developed a set of questions meant to measure internal customer satisfaction for those Department staff for which BAS staff had performed specific data analysis. Based on 66 total responses received, other Department staff rated the overall experience with BAS as either very good (47%) or exceeded expectations (42%), both favorable, for a total favorable customer satisfaction rating of 89%.

12. Budget Division

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

Performance Measure	Outcome	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Budget Division					
Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medical Services Premiums.	Benchmark	1%	1%	0.75%	0.75%
	Actual	Expenditures were 1.74% above the final spending authority	General Fund expenditure was 0.06% below the budgeted amount	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 2008-09, the accuracy of expenditure forecasts was limited by rapidly changing caseload and per capita costs. In FY 2008-09, the Department overexpended General Fund by $11,980,431, or 1.07%. Total funds overexpenditure was $30,621,734, or 1.23%. However, this overexpenditure is overstated, as the final amount budgeted differs from the Department's official spending authority. Due to the American Recovery and Reinvestment Act of 2009 (ARRA), the Department's General Fund spending authority was restricted by $166,933,935, based on the actual account of funding received. However, the additional federal funds that were included in budget balancing for Medical Services Premiums totaled $154,373,964.[1] When the estimated amount of ARRA funding is considered in evaluating expenditure, the Department can be said to have underexpended Medical Services Premiums by $579,540, or 0.06%.

General Fund Expenditure	Spending Authority	Expenditure	Overexpenditure/ (Underexpenditure)
With Actual ARRA	$955,762,112	$967,742,543	$11,980,431
With Estimated ARRA	$968,322,083	$967,742,543	($579,540)

[1] See the Long Bill Narrative, "FY 2008-09 General Fund Overview," page 1. Note that the Long Bill Narrative did not break out individual reductions by Long Bill Group; however, the Department has confirmed the figure for Medical Services Premiums with Joint Budget Committee staff.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Human Resources Section					
Provide job specific training to each employee. Complete and implement a comprehensive orientation and training curriculum for new staff.	Benchmark	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	Train 75% of Department managers and work leaders on coaching, mentoring, and employee assessment
	Benchmark	Job specific training will be provided to 90% of all staff	Reduce employee turnover rate to 15%	Maintain employee turnover rate at or below 11.1%	Maintain employee turnover rate at or below 11.1%
	Actual	All employees received orientation training within 60 days of employment	Professional development training was provided to 45% of Department staff	Unknown	Unknown
	Actual	Job specific training was provided to 91% of staff	Turnover rate reduced to 6.84%	Unknown	Unknown

Strategy: Providing training for Department staff will help ensure that the Department reduces turnover rates, and retains a knowledgeable and skilled staff. For FY 2009-10, the Department will continue the internal training that it received approval for in FY 2008-09 from DI-8, "Training for Department Staff" (November 1, 2007 FY 2008-09 Budget Request) which requested funds for each employee to receive professional development and training. In addition, last year the Department provided $200 per employee to take additional trainings not offered within the department. In FY 2009-10, the Department will provide $150 per employee for additional trainings.

The Department also intends to offer some Department-wide trainings in the upcoming fiscal year such as coaching and mentoring; performance management; writing and communicating; and workplace violence. 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. In addition, the Department intends to expand its current new employee 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.

The average turnover rate for agencies across the State of Colorado is 11.1%. Through the enhanced training efforts, and despite the lifting of the hiring freeze, the Department hopes to maintain its turnover rate at or below the state level in FY 2009-10 and FY 2010-11.

Evaluation of Prior Year Performance: In FY 2008-09, the Department made $200 available for each employee to attend one training session during the fiscal year. Approximately 120 employees, or 45% of the Department, took advantage of this training opportunity. Employees attended trainings on Excel proficiency, leadership, improved management, and communication skills.

In addition, the Human Resources Section offered mandatory trainings on sexual harassment and workplace violence. Employees also attended mandatory trainings specific to the Health Insurance Portability and Accountability Act.

In September of 2008, Governor Ritter issued a hiring freeze across state government in response to the global economic slowdown. As a result, the Department could not fill vacant positions. Further, since turnover at the Department derives in part from staff going to other state agencies, the Department's retention rate improved significantly.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Community-Based Long-Term Care Section					
Increase number of clients enrolled in community based settings.	Benchmark	N/A - New Measure for FY 2008-09	Enroll 200 additional clients in the Consumer Directed Attendant Support Services Program	Enroll 324 additional clients in the Consumer Directed Attendant Support Services Program	Enroll 324 additional clients in the Consumer Directed Attendant Support Services Program
	Actual	N/A	Enrolled 716 additional clients	Unknown	Unknown

*Strategy***:** Medicaid-funded long term care services include both institutionally-based 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. In the middle of FY 2007-08, the CDASS program was added to the Home and Community-Based Services (HCBS) waivers for Persons with Mental Illness and the Elderly, Blind and Disabled.

The Department will continue to expand the CDASS Program into FY 2009-10 and FY 2010-11. The expansion of the program is dependent upon several factors. First of all, the Department submitted a Medicaid State Plan Amendment to add the CDASS Program as a State Plan benefit, which was approved by the federal Centers for Medicare and Medicaid Services in June 2009. The Department anticipates that the approval of this benefit will increase the number of clients that will enroll in the CDASS program.

Secondly, the Department is currently transitioning to a new fiscal management agency, which acts as the employer of record for attendants caring for clients participating in the CDASS program. The Department anticipates that the new fiscal management agency will be fully operational by the end of April 2010. By the end of FY 2009-10, as a result of the new fiscal management agency's operations, the Department anticipates that services offered through the CDASS program will be offered to clients on the following waivers: the two HCBS waivers

mentioned above; the Children's waiver; the HCBS waiver for Persons with Brain Injury; the HCBS Children's Extensive Support waiver; the Persons with Developmental Disabilities waiver; and the Supportive Living Services waivers for persons with developmental disabilities. Through coordination and outreach with contracted case management agencies, the Department anticipates it will meet its benchmarks for enrolling new individuals in FY 2009-10 and FY 2010-11.

Evaluation of Prior Year Performance: The Department far exceeded its goals for client enrollment in the CDASS program in FY 2008-09. First of all, the CDASS program was included on the Home and Community-Based Services (HCBS) waivers for Persons with Mental Illness and the Elderly, Blind and Disabled for all of FY 2008-09, which impacted total clients enrolled. Secondly, in February 2008 the case management of this program was transitioned to the Single Entry Point (SEP) agencies. The SEP agencies administer many of the waiver programs and provide extensive outreach activities for the consumer directed services program. As a result of the increased outreach performed by the SEP agencies, the Department was able to exceed the initial projection.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Nursing Facilities Section					
Conduct nursing facility audits (both change of ownership or risk based audits) to recoup patient payment (third party liabilities).	Benchmark	Increase by 0.1% over FY 2006-07	Recover approximately $1.5 million	Recover $683,879*	Recover $872,026*
	Actual	$1.8 million in recoveries (approximately 17% over FY 2006-07)	$1,138,828 in recoveries	Unknown	Unknown

**See Exhibit H, "Long Term Care – Class I Nursing Facilities Request, Footnotes, and Calculation of General Fund Cap," page EH-2 of the Department's November 6, 2009 FY 2010-11 Budget Request for more information.*

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. Once the Department's auditors have determined the amount due, they issue demand letters to the nursing facilities for these amounts.

The Department anticipates that recoveries in FY 2009-10 will be lower than in past years because staff resources are needed on other projects. In FY 2009-10, staff will be preparing two requests for proposals for two contracts for FY 2010-11. Also, in FY 2009-10, staff will be heavily involved in the continued rollout of the new nursing facilities rate methodology, which was authorized by HB 08-1114. Staff resources are estimated to be fully re-allocated to audits in FY 2010-11.

Another reason for the projected drop in recoveries is that the Department anticipates a reduction in the number of audits the Department can complete in FY 2009-10 and FY 2010-11. Nursing facilities can now elect to have Department audits performed on 100% of billing records rather than using a sampling approach. When using a sampling approach, the Department utilizes statistical techniques to review a portion of billings that infer conclusions on the total billings for the facility. Nursing facilities are increasingly electing to have audits performed on 100% of billing records, which requires much more Department resources, but generally results in the same amount recovered on a per-audit basis.

Evaluation of Prior Year Performance: The Department's Nursing Facilities Section issued approximately $1.6 million in demand letters in FY 2008-09, with $600,000 of that total coming from one provider. Total collections by October 2009 approximated $1,138,828. The amount of

collections can vary widely, making it difficult for the Department to estimate how much the Department will recover 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.

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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Program Integrity Section					
Conduct provider post payment audits to decrease fraud and abuse and increase recoveries.	Benchmark	$10 million in total recoveries	$10 million in total recoveries	$12 million in total recoveries	$12 million in total recoveries
	Actual	$7.1 million in total recoveries	$7.2 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 program integrity efforts. The Department is undertaking new initiatives to increase provider recoveries as well as increase cost avoidance so that recoveries are not necessary. The Unified Provider Enrollment Process (UPEP) is a Medicaid-Medicare online 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 UPEP 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. During FY 2009-10, the Department plans to launch the MEDI-MEDI data matching project. Currently, Department data is being provided to the MEDI-MEDI contractor. Estimates on the effectiveness of the MEDI-MEDI program have not been forecast yet, but performance of the program in the current 10 pilot states have identified fraud schemes and duplicate billing of claims to Medicare and Medicaid for the same services rendered to the same clients on the same dates of service.

With the collaboration of multiple sections in the Department and fiscal agent staff, the Program Integrity Section led the way to successful installation and implementation of a surveillance utilization reporting system for fraud and abuse detection called Enterprise Surveillance

Utilization Reporting and Fraud Detection System. Section staff received training on this software in July 2009, after which the system was put into use. The system is being used to generate high probability cases of provider overuse, abuse, and fraudulent use of State and federal taxpayer's funds. Recoveries are anticipated to increase as the result of using this cutting-edge fraud and abuse detection technology. This program fulfills one of the Government Efficiency and Management Review initiatives for which the Program Integrity Section received 5.0 FTE and funds to purchase the technology.

In addition to these national initiatives, the Department also intends to begin tracking recoveries internally in a centralized manner. Up through the end of FY 2008-09, recoveries were recorded in several different sections of the Department. The Department has centralized these functions in order to provide more complete information regarding the amount of provider recoveries each year. Beginning July 1, 2009, all dollars from all recovery efforts conducted throughout the Department will be reported by the Program Integrity Section.

Evaluation of Prior Year Performance: The Department did not meet its benchmark of $10 million in recoveries through its Program Integrity Section. Much of the fiscal year was spent hiring and training new staff, as well as purchasing and implementing new fraud and abuse technology.

In addition, 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, the State Attorney General's Office or the Assistant U.S. Attorney's Office. In FY 2008-09 a total of 22 cases were referred to these other agencies and 18 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 10-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 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Benefits Coordination Section					
Actively audit expenditures to decrease fraud and abuse and increase recoveries.	Benchmark	Increase recoveries to $25 million	Increase total recoveries by 2% over FY 2007-08	Increase total recoveries by 2% over FY 2008-09	Increase total recoveries by 0.75% over FY 2009-10
	Actual	$24.5 million in recoveries	$24.1 million in recoveries (1.63% under FY 2007-08)	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 and its contractors recover a large portion of funds from estates and places liens on real property held by Medicaid clients in nursing facilities or clients who are over the age of 55. The Department pays the contractor a contingency fee and the remainder of the recoveries offset costs in the Medical Services Premiums line. Since the Department primarily recovers residential real estate and sells the property, recovery amounts depend in part on the value of the state's residential real estate market.

The Department anticipates that the real estate market will improve slightly in Colorado in FY 2009-10 as Colorado was ahead of the national curve, and will result in higher recoveries. Other recovery programs, such as tort & casualty and trust recoveries, will also increase slightly due to increased focus on potential recoveries. Tort & casualty recoveries could be hurt if additional case law relating to the US Supreme Court decision in Ahlborn* further limits this area's recovery potential. Post-pay recoveries will continue to lag because of the high unemployment rate which results in fewer individuals with access to private insurance. Also, larger recoveries are not anticipated due to increased cost-avoidance 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.

*United States Supreme Court decision for Arkansas Department of Health and Human Services v. Ahlborn ("Ahlborn"). The Ahlborn decision only allows states to have a lien on the medical portion of the judgment, award, or settlement. With the passage of HB 09-1191, Colorado's recovery practices are consistent with this federal decision.

Evaluation of Prior Year Performance: The Department did not meet its benchmark for FY 2008-09 because forecasted post-pay insurance recoveries were depressed due to economic hardship resulting from high unemployment. High unemployment lowers the number of individuals with access to private insurance. These post-pay recoveries were also affected by better Department processes to cost-avoid claims, which avoids the need to chase after a recovery. Estate recovery, trust recovery, and tort & casualty recovery all saw increases this past fiscal year.

18. American Recovery and Reinvestment Act

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

Performance Measure	Outcome	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.	FY 2010-11 Request
Department-wide					
Advance the Department's support of Health Information Technology by coordinating with stakeholders and providers to maximize the funding to be made available by the Health and Information Technology for Economic and Clinical Health Act (HITECH).	Benchmark	N/A - New Measure for FY 2010-11	N/A - New Measure for FY 2010-11	N/A - New Measure for FY 2010-11	Facilitate one provider education seminar on adopting Health Information Technology under HITECH.
	Actual	N/A - New Measure for FY 2010-11	N/A - New Measure for FY 2010-11	N/A - New Measure for FY 2010-11	Unknown

*Strategy***:** The Department is the entity responsible for monitoring compliance with the meaningful use provisions contained within the federal American Recovery and Reinvestment Act of 2009 (ARRA) and the Health and Information Technology for Economic and Clinical Health Act (HITECH). As such, the Department has a responsibility to ensure that its providers are educated in the HITECH provisions as well as the considerations and responsibilities in adopting Health Information Technology (HIT) into their practices.

The Department, in conjunction with its information technology partners, including the Colorado Hospital Association, the Colorado Regional Health Information Organization and the Department's fiscal agent, Affiliated Computer Systems, is uniquely positioned to facilitate a provider education seminar. While final decisions have not been made on the details surrounding this seminar, the Department must explore costs and logistics regarding not only the facilitation but the seminar delivery methodology. Options include but are not limited to: facilitating and hosting a seminar; partnering with another entity that has HIT background to co-host a seminar; facilitating an in-person seminar; and designing and conducting a webinar or a series of webinars. The Department anticipates having these decisions made before the start of FY 2010-11.

In order to meet this benchmark by the end of FY 2010-11, the Department will consider these and other options in the context of available resources.

Evaluation of Prior Year Performance: Not applicable as this is a new performance measure for FY 2010-11.