Department of Health Care Policy and Financing
Strategic Plan
FY 2011-12 Budget Request

November 1, 2010

I. EXECUTIVE LETTER

November 1, 2010

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

Dear Representative Ferrandino,

The State of Colorado sits in a precarious position. In the midst of a prolonged economic downturn, revenues have declined and, at the same time, the demand for state-provided services has increased. This is particularly true for health care. To compound the issue, in March of 2010, the federal government approved legislation that makes sweeping changes to the current health care system over the next several years. While the federal government has committed to helping fund the transition, states are still expected to assume greater costs as a result of this health care reform.

Despite the pressure from declining revenues in the face of growing caseload and subsequent costs, Colorado has an opportunity to stand out as a leader during this transitional period. As a result of the Colorado Health Care Affordability Act (HB 09-1293), Colorado is already well ahead of schedule with eligibility expansion, one of the major elements of the federal legislation, with no General Fund impact.

Signed by the President on March 23, 2010, the Patient Protection and Affordable Care Act expands Medicaid eligibility to all citizens – including adults without dependent children – up to 133% of the federal poverty line by the year 2020. The Department estimates this eligibility expansion will add approximately 339,000 new clients to the State's Medicaid caseload; however, 194,000 (57%) of those new clients will already be covered due to the Colorado Health Care Affordability Act. Not many other states can make such a claim.

By partnering with licensed or certified hospital providers, the Colorado Health Care Affordability Act allows Colorado to generate up to approximately $600 million in additional funding per year through a hospital provider fee. This fee then draws down matching federal funds for health care services and administration, allowing the State to increase reimbursements to the hospitals while funding a multitude of Medicaid-related programs.

During FY 2009-10, the first year this fee system was implemented, the Department distributed approximately $300 million in fees from hospitals which combined with matching federal funds to fund health coverage expansions, payments to hospitals, the Department's administrative expenses, and also supported General Fund relief. In the first year of operation, the Colorado Health Care Affordability Act has demonstrated innovative success at allowing the State to improve its health care system without further budgetary strain. With this increased capacity, the Department is now focused on implementing a Medicaid Buy-In Program for People with

Disabilities and Adults without Dependent Children. The federal Patient Protection and Affordable Care Act requires coverage of both of these populations, further evidencing the State of Colorado as a leader in health care reform.

In an effort to better contain health care costs while improving the overall health and functioning of Medicaid clients served, the Department began implementation of the Accountable Care Collaborative in FY 2008-09. The Accountable Care Collaborative is 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 goals of these organizations are to provide a focal point of care for all Medicaid clients, develop statewide data and analytics capabilities, coordinate care across all programs and providers, and develop regional accountability for client health and cost containment. The Accountable Care Collaborative represents an innovative way to accomplish the Department's goals to improve health outcomes while also containing costs. As with many of the initiatives launched under the Colorado Health Care Affordability Act, the Accountable Care Collaborative represents yet another area in which Colorado is ahead of the curve in terms of implementing the Patient Protection and Affordable Act, which includes demonstration projects related specifically to Affordable Care Collaboratives as well as provisions supporting the coordination of care.

To this end, the Department has undergone a thorough reevaluation and revision to its Strategic Plan over the last three years. The Department has developed a 5-year Strategic Plan with overarching goals that better represent the Department's Mission and Goals related to cost-containment and improvement of health outcomes. These goals are more readily measurable and are a more comprehensive representation of all Department initiatives. The Department's Strategic Plan also meets all requirements of HB 10-1119, Performance-based budgeting.

Even in the face of economic uncertainty and administrative change, 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 in an effort to improve access to cost-effective, quality health care services for Coloradans.

Cordially,

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

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

- The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population.

- The 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.

- The School Health Services Program provides reimbursement to qualified school districts that provide health services to children enrolled in Medicaid.

- The Primary Care Fund, which is funded by taxes on tobacco products, provides an allocation of moneys to health care providers that provide basic health care services in an outpatient setting to residents of Colorado who are considered medically indigent.

Statutory Authority

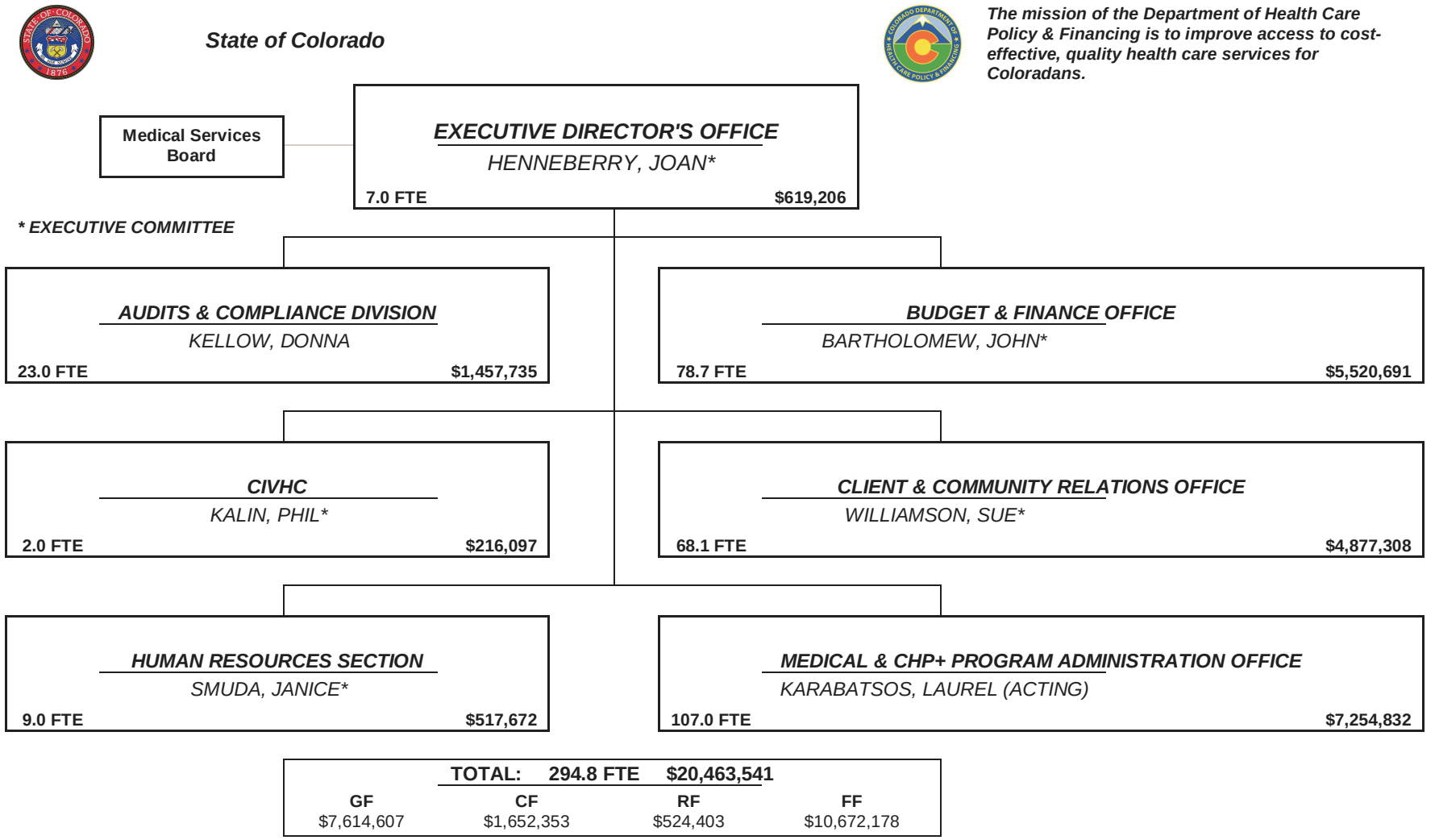
The statutory authority for the Department can be found at Title 25.5 of the Colorado Revised Statues, (2010).

25.5-4-104, C.R.S. (2010). 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. (2010). 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. (2010) 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 client experience of care with programs, services, and care. The Department's FY 2011-12 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.

Objectives

A. The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

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

C. Improve client experience of care with programs, services, and care. Support timely and accurate client eligibility determination. Provide accurate and consistent information to internal and external customers.

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

E. 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.

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

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

IV. PERFORMANCE MEASURES

1. Increase the Number of Insured Coloradans

Objective: The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Department-wide								
Increase the Number of Insured Coloradans	Benchmark	▪ Add 10,000 clients to CHP+.	▪ Add 7,000 clients to CHP+.	▪ 92% of Colorado children insured.	▪ 94% of Colorado children insured.	▪ 96% of Colorado children insured.	▪ 97% of Colorado children insured.	▪ 99% of Colorado children insured.
	Actual	▪ Added 3,882 clients to CHP+.	▪ Added 7,039 clients to CHP+.	Unknown	Unknown	Unknown	Unknown	Unknown
	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ 84% Coloradans insured.	▪ 86% of Coloradans insured.	▪ 89% Coloradans insured.	▪ 92% of Coloradans insured.	▪ 95% of Coloradans insured.
	Actual	N/A	N/A	Unknown	Unknown	Unknown	Unknown	Unknown
	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ 77% Colorado adults insured.	▪ 79% of Colorado adults insured.	▪ 81% Colorado adults insured.	▪ 83% of Colorado adults insured.	▪ 85% of Colorado adults insured.
	Actual	N/A	N/A	Unknown	Unknown	Unknown	Unknown	Unknown

***Strategy*:** While the Department 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 in Medicaid or the Children's Basic Health Plan (CHP+). The Department will continue to focus on targeted outreach through the implementation of the Health Communities initiative, which combines the best practices from the outreach and case management services performed through the Early and Periodic Screening, Detection, and Treatment program in Medicaid and those established over the last three years in CHP+. The Department conducted a household survey in FY 2008-09 which has provided 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 Medicaid and CHP+, as well as increase retention of individuals eligible for the programs.

HB 09-1293, or "Colorado Health Care Affordability Act," provided funding to expand eligibility in Medicaid and CHP+ over the next 4 years. Effective May 1, 2010, eligibility was increased to 250% of the federal poverty level for children and pregnant women in CHP+ and to 100% of the federal poverty level for parents of Medicaid eligible children. In addition, the legislation provided funding to establish a Medicaid Buy-In Program for Individuals with Disabilities up to 450% of the federal poverty level in summer 2011 and initiating coverage for adults without dependent children with incomes of up to 100% FPL through Medicaid in winter 2012. The Department anticipates that these expansions will extend coverage to 170,000 individuals who previously would have had no health care by 2014.

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA), which, along with the Health Care and Education Reconciliation Act of 2010, mandates broad, sweeping reform of the U.S. health care system that affects eligibility, administration, and delivery at both the federal and state levels. Among these changes are: requiring all citizens to carry health insurance; prohibiting health insurance providers from denying coverage for pre-existing conditions or having lifetime limits on coverage; expanding Medicaid eligibility to all citizens with incomes up to 133% of the federal poverty level effective January 1, 2014; and creating state-, multi-state, or regional-based Exchanges that allow individuals and small businesses to purchase health insurance. These changes are scheduled to take effect over a transition period spanning between the years 2010 and 2018. The Department estimates that this legislation will provide public coverage for another approximately 145,000 individuals by 2020, in addition to those covered under the Health Care Affordability Act.

Implementation of these two pieces of sweeping legislation will help the Department to meet its targets for ensuring that most Coloradans have access to health insurance.

Evaluation of Prior-Year Performance: In FY 2009-10, the Department met its target of enrolling 7,000 more clients in Children's Basic Health Plan, with an overall increase of 7,039. In order to transition to the revised benchmarks of children's insurance rates, the Department will use data provided by the Colorado Health Institute based on analysis of data regarding health insurance status from the American Community Survey. Based on this data, the Department estimates that 86% of Colorado children had health insurance in 2008. Due to the one-year lag in data available from the American Community Survey, the Department will use data from the most recent year available as a proxy for the new performance measures. This, however, may understate the number of individuals with access to health insurance in the measurement year, as the survey cannot account for increases in enrollment in Medicaid or CHP+ during the year.

2. Improve Health Outcomes

***Objective*:** The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Department-wide								
Improve Health Outcomes	Benchmark	▪ 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 average.	▪ 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 average.	▪ All reported managed care HEDIS measures at or above national Medicaid average.
	Actual	▪ 67% of managed care measures were at or above national Medicaid average.	▪ 67% of managed care measures were at or above national Medicaid average.	Unknown	Unknown	Unknown	Unknown	Unknown
	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ 0.75% of provider payments are linked to outcomes.	▪ 1.25% of provider payments are linked to outcomes.	▪ 2% of provider payments are linked to outcomes.	▪ 3.25% of provider payments are linked to outcomes.	▪ 5% of provider payments are linked to outcomes.
	Actual	N/A	N/A	Unknown	Unknown	Unknown	Unknown	Unknown

***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 2010 for data collected in 2009, the performance benchmark continues to be that all measures shall exceed the national average.

Historically, 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 began working on submitting the required codes beginning January 1, 2010, which will impact the Department's fee-for-service scores. While the FQHCs have made progress in submitting all the necessary data, not all codes were provided by all FQHCs in FY 2009-10. Once all data from the FQHCs are included in the fee-for-service rates, the Department anticipates that the majority of fee-for-service 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.

In FY 2010-11, the Department has begun to work with Managed Care Organizations, Behavioral Health Organizations, Non-Emergency Transportation services contractors, utilization management, enrollment broker, and other vendors to individually link payments to outcomes. The Department is determining baseline data and any reporting mechanisms required to properly tie payments to outcomes in FY 2010-11. If necessary, the Department will pursue legislative or budget actions to allow the Department greater flexibility in linking payments to outcomes to ensure that the Department is purchasing services in the most cost-effective manner possible.

Evaluation of Prior-Year Performance: The data collected reflects performance during calendar year 2009. The percent of HEDIS measures on which health plans scored equal to or better than the national average stayed constant 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 from 25% in FY 2008 to 56% in 2009, 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 beginning in FY 2008-09. Thirdly, greater focus is being placed on choosing measures that reflect current issues affecting Medicaid clients. The Department added various new measures including but not limited to weight assessment, medication management for depression and Chronic obstructive pulmonary disease (COPD), and appropriate treatment for back pain and bronchitis. Health plan performance exceeded the national average on 83% these new measures.

As discussed above, 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 will continue to work with the FQHCs to submit all required codes.

3. Increase Access to Health Care

Objective: The Department will increase the number of individuals eligible and enrolled in its programs, improve health outcomes for all clients, and ensure that the health care the Department purchases is medically necessary, appropriate to the population, and cost-effective. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Department-wide								
Increase Access to Health Care	Benchmark	▪ Add an additional 2,000 clients to targeted, integrated care management programs. ▪ Enroll 125,000 children in a medical home. ▪ Increase the number of clients with an identified focal point of care by 2% over FY 2007-08.	▪ Increase enrollment in targeted, integrated care management programs to approximately 3,800 clients. ▪ Medical home enrollment of 100% for CHP+ children and 49% for Medicaid children. ▪ Increase the number of clients with an identified focal point of care by 2% over FY 2008-09.	▪ 40% of Medicaid clients will have a medical home or focal point of care.	▪ 55% of Medicaid clients will have a medical home or focal point of care.	▪ 75% of Medicaid clients will have a medical home or focal point of care.	▪ 90% of Medicaid clients will have a medical home for focal point of care.	▪ 100% of Medicaid clients will have a medical home or focal point of care.
	Actual	▪ Added 308 clients to targeted, integrated care management programs. ▪ Added 162,135 clients (includes Medicaid and CHP+ children). ▪ 80,156 clients enrolled in viable managed care options (5% over FY 2007-08).	▪ Increased enrollment in targeted, integrated care management programs to 2,900 clients. ▪ Medical home enrollment of 100% for CHP+ children and 71% for Medicaid children. ▪ 85,170, clients enrolled in viable managed care options (6.3% over FY 2008-09).	Unknown	Unknown	Unknown	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 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 may be paid a per-member per-month fee or another form of incentive payment for care coordination or medical home services. 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.

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 client experience of care. Medical homes also improve client experience of care with programs, services, and care. As of the end of FY 2009-10, all children enrolled in CHP+ and 71% of children in Medicaid 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 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 2010-11 forward, the Department must ensure that there is an adequate network of primary care physicians who are willing to participate as medical homes. Despite the 4.5% rate cuts to physician services since FY 2009-10, the Department will continue to train and determine Medicaid and CHP+ providers as medical home providers. However, the Department anticipates that the budget reductions 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 CHP+ 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 CHP+ will help ensure that the highest quality care is being provided to the Department's youngest eligible clients.

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. In FY 2009-10, approximately 2,900 individuals were served in the CRICC program through Colorado Access and Kaiser Permanente. In FY 2010-11, the Department plans to increase enrollment in the program to 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, which is discussed below.

In seeking to shift toward a focal point of care model, the Department sought funding for the Colorado Accountable Care Collaborative (ACC) 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. The ACC Program plans to redesign the Medicaid program with the following goals:

- Provide a focal point of care/Medical Home for all clients;
- Develop statewide data and analytics capabilities;
- Coordinate care across all programs and providers; and,
- Develop regional accountability for client health and cost containment.

The ACC Program represents an innovative way to accomplish the Department's goals for Medicaid reform. The ACC Program differs from a capitated managed care organization by investing directly in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The ACC Program makes the people and organizations that actually provide the care accountable for the quality and cost of that care. Previous health care reform initiatives involved insurers and made them ultimately accountable. The fundamental premise of the ACC Program is that communities are in the best position to make the changes that will address the cost and quality problems resulting from the existing system of fragmented care, variation in practice patterns and volume-based payment systems. On August 20, 2010, the Department posted a Request For Proposals (RFP) to solicit competitive bids for the Regional Care Coordination Organizations (RCCOs), seeking experienced and innovative entities with a strong community presence that will be accountable for controlling costs and improving the health of Medicaid clients in one (or more) of seven regions statewide. The program 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 and the execution of the CRICC contract with Kaiser Permanente, the Department did not meet its goal of enrolling 3,800 clients into CRICC programs during FY 2009-10. Annual enrollment in the program was approximately 2,900 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.

The Department exceeded the benchmark for children enrolled in medical homes in FY 2009-10 as 205,000 children were enrolled in a medical home as of June 30, 2009, or 71%. In FY 2009-10, 69,369 or 100% of children enrolled in CHP+ were enrolled in a medical home. The Department has been able to enroll this number of children since each managed care organization that provides services through CHP+ is fully equipped to act as a medical home.

Enrollment of children into a medical home is dependent upon the availability of participating providers. By the end of FY 2009-10, 1,197 practices were trained and determined as medical home providers. Of this total, 184 practices accept only Medicaid clients and 821 accept clients enrolled in either Medicaid or CHP+. Since FY 2008-09, all participating Medicaid and CHP+ 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.

To transition to the new benchmarks in FY 2010-11, the Department has estimated the number of enrollees in Medicaid and CHP+ that had a focal point of care at the end of FY 2009-10 to be 314,458, or approximately 52.7% of all Medicaid and CHP+ enrollees. This includes clients enrolled in Managed Care Organizations, the CRICC Program, and children with an established medical home.

4. Contain Health Care Costs

Objective: The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Department-wide								
Contain Health Care Costs	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ Launch Hospital Quality Incentive Payments, Physician Payment Reform and Waiver Rate Reform. ▪ Implement the Evidence Guided utilization Review Contract. ▪ Reduce emergency room costs by 5% without reducing quality of care.	▪ Complete Phase I of Accountable Care Collaborative. ▪ Implement Benefits Collaborative, Correct Coding Initiative, and Behavioral Health Organization payment reform. ▪ Maintain emergency room savings of 5% without reducing quality of care. ▪ Achieve target for readmission reduction of 5% at 30 days.	▪ Scale Accountable Care Collaborative to entire state. ▪ Implement payment reform for Home Health agencies and Federally Qualified Health Centers. ▪ Audit Community Mental Health Centers. ▪ Maintain emergency room savings of 5% without reducing quality of care. ▪ Maintain target for readmission reduction of 5% at 30 days.	▪ Achieve community savings under the Accountable Care Collaborative; reprocure Behavioral Health Organization contracts. ▪ Establish statewide Health Information Technology Infrastructure. ▪ Maintain emergency room savings of 5% without reducing quality of care. ▪ Maintain target for readmission reduction of 5% at 30 days.	▪ Maintain emergency room savings of 5% without reducing quality of care. ▪ Maintain target for readmission reduction of 5% at 30 days. ▪ Reduce or stabilize utilization of the top 10 cost drivers form activities in FY 2010-11 through FY 2013-14 (as measured by units of events per 1,000 from FY 2008-09 baseline).
	Actual	N/A	N/A	Unknown	Unknown	Unknown	Unknown	Unknown

***Strategy*:** As discussed above, on August 20, 2010, the Department posted a Request For Proposals (RFP) to solicit competitive bids for the Regional Care Coordination Organizations (RCCOs), seeking experienced and innovative entities with a strong community presence that will be accountable for controlling costs and improving the health of Medicaid clients in one (or more) of seven regions statewide. The program is scheduled for implementation in FY 2010-11 and would provide a coordinated health care model for 60,000 Medicaid clients.

The Department also received authority in FY 2010-11 to implement evidence guided utilization review (EGUR) that focuses on high-growth, high-cost medical spending categories, including radiology, hospital outpatient services, selected outpatient therapies, ancillary services, emerging technologies, and selected client groups such as high risk deliveries and pre-term newborns. The Department received funding to increase medical review hours to allow for expanded review by the Department's Quality Improvement Organization (QIO) contractor. In addition to additional prospective and retrospective review hours, EGUR funding allows for concurrent review selected activities such as inpatient outlier days.

The expansion of utilization review under EGUR involves continuing the work of the Benefits Collaborative and Accountable Care Collaborative. As provider panels and client and stakeholder sessions yield newly documented best practices and community standards, the Department will require its QIO to integrate these standards with evidence-based clinical guidelines – such as the Milliman Care Guidelines and McKesson's InterQual decision support criteria – and adjudicate its reviews based on those standards through the technology system. The expansion of utilization review is not only anticipated to yield savings, but also lead to enhanced quality and improved health outcomes.

In FY 2010-11, the Department plans to issue and award an RFP and execute a contract for to re-bid and enhance its current acute care utilization review structure. The RFP would position the Department for a comprehensive overhaul of its utilization review functions, following other states that in recent years have adopted advanced approaches to control medical costs and reduce unwarranted variation in care. The Department seeks to adopt best practices to address unnecessary medical expenditure. By more clearly defining benefit limits, and exceptions to those limits that require prior-authorizations, and by consolidating administrative functions for utilization and prior-authorization reviews, the Department can more efficiently guarantee access to care for its clients while ensuring that only medically necessary services are provided.

To address emergency room costs, the Department will continue to participate in the Emergency Room Reduction Work Group with broad staff representation. In addition, the Department submitted BRI-4 "Client Overutilization Program Expansion," which seeks to implement provider incentive payments for physicians willing to serve certain enrollees. Clients who meet the criteria for the Client Overutilization Program (COUP) demonstrate patterns of high-risk behavior such as excessive narcotic use enabled by having access to multiple Medicaid providers and the emergency room. Because these clients tend to exhibit inappropriate use of the emergency room, expansion of COUP is expected to reduce emergency room costs without compromising the quality of care. The Department is also investigating ways to implement interventions through managed care contractors where applicable.

Evaluation of Prior-Year Performance: Not applicable. These are new performance measures for FY 2010-11.

5. Improve the Long-Term Care Service Delivery System

Objective: The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

Improve client experience of care with programs, services, and care. Support timely and accurate client eligibility determination. Provide accurate and consistent information to internal and external customers.

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Department-wide								
Improve the Long-Term Care Service Delivery System	Benchmark	▪ Enroll 200 additional clients in the Consumer Directed Attendant Support Services (CDASS) Program.	▪ Enroll 324 additional clients in the CDASS Program.	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued
	Actual	▪ Enrolled 716 additional clients.	▪ Enrolled 432 additional clients.	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued
	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ Develop benchmarks for the Home and Community Based Services (HCBS) report card with client input. ▪ Identify baseline for nursing homes. ▪ Initiate new contracting requirements and oversight to make more efficient use of vendors.	▪ Complete development of benchmarks for HCBS report card, identification of baseline for nursing homes, and new contracting requirements. ▪ Audit Department of Human Services, Single Entry Points, and Community Centered Boards for financial accountability.	▪ Complete an interim report card on progress to date for nursing homes and HCBS. ▪ Competitively procure HCBS management organizations and address waiver inefficiencies (may include creating super waivers, one for adults and one for children).	▪ Eliminate the waiting list for HCBS.	▪ All HCBS case management organizations score at least 90% on the state quality report card. ▪ Every nursing home in Colorado scores in the top quartile of the Centers for Medicare & Medicaid Services National Report Card.
	Actual	N/A	N/A	Unknown	Unknown	Unknown	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.

Beginning in FY 2010-11, the Department will no longer be using CDASS enrollment as a performance measure. With the revision to the Department's objectives, the emphasis has shifted from enrolling more clients into specific programs within the Department to improving the cost-effectiveness, delivery systems, and the health outcomes of all clients in Long-Term Care. In FY 2010-11, the Department was awarded a planning grant to develop and submit the operational plan for the application for the Money Follows the Person Rebalancing (MFP) Demonstration Program, which provides funding to build systems and infrastructure needed to improve the quality of HCBS services, increase the availability of HCBS, and support the deinstitutionalization of several target populations. The Department is also working toward implementing Olmstead policy recommendations resulting from the Long-Term Care Advisory Committee to build a strategy towards improving upon the existing infrastructure of services for people with disabilities.

Evaluation of Prior-Year Performance: The Department exceeded its goals for client enrollment in the CDASS program in FY 2009-10. The CDASS program has been included on the Home and Community-Based Services (HCBS) waivers for Persons with Mental Illness and the Elderly, Blind and Disabled since FY 2008-09, which impacted total clients enrolled. Additionally, Single Entry Point (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 has been able to exceed the initial projections.

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 is currently working on revising Rules for the CDASS program to ensure proper use and oversight of the benefit, and will implement the State Plan benefit in FY 2010-11 upon approval of the revised rules.

6. Office of Client and Community Relations

Objective: The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

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

Improve client experience of care with programs, services, and care. Support timely and accurate client eligibility determination. Provide accurate and consistent information to internal and external customers.

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 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Office of Client and Community Relations								
Survey client experience of care with managed care using the Consumer Assessment of Health Plans Survey (CAHPS)	Benchmark	▪ Increase all reportable rates for managed care to at or above national Medicaid average. ▪ Increase all reportable rates for fee-for-service to at or above national Medicaid average.	▪ Maintain all reportable CAHPS rates for managed care and fee-for-service to at or above national Medicaid average.	▪ Increase or maintain all reportable CAHPS rates for managed care and fee-for-service to at or above national Medicaid average.	▪ Increase or maintain all reportable CAHPS rates for managed care and fee-for-service to at or above national Medicaid average.	▪ Increase or maintain all reportable CAHPS rates for managed care and fee-for-service to at or above national Medicaid average.	▪ Increase or maintain all reportable CAHPS rates for managed care and fee-for-service to at or above national Medicaid average.	▪ Increase or maintain all reportable CAHPS rates for managed care and fee-for-service to at or above national Medicaid average.
	Actual	▪ 18 of 28 reportable rates for managed care were at or above national Medicaid average = 64%. ▪ 5 of 11 reportable rates for fee-for-service were at or above national Medicaid average =45.5%.	▪ 20 of 30 reportable rates for managed care were at or above national Medicaid average = 67.8%. ▪ 8 of 17 reportable rates for fee-for-service were at or above national Medicaid average =47.1%.	Unknown	Unknown	Unknown	Unknown	Unknown

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
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	▪ 90% satisfaction among internal customers.	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued
	Actual	▪ 89% satisfaction among internal customers.	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued
Actively audit expenditures to decrease fraud and abuse and increase recoveries	Benchmark	▪ 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.	▪ Increase total recoveries by 0.75% over FY 2010-11.	▪ Increase total recoveries by 0.75% over FY 2011-12.	▪ Increase total recoveries by 0.75% over FY 2012-13.	▪ Increase total recoveries by 0.75% over FY 2013-14.
	Actual	▪ $24.1 million in recoveries (1.63% under FY 2007-08).	▪ $35.9 million in recoveries (49.2% over FY 2008-09).	Unknown	Unknown	Unknown	Unknown	Unknown
Increase the Number of Insured Coloradans	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ 75% of eligibles are enrolled in Medicaid and CHP+	▪ 80% of eligibles are enrolled in Medicaid and CHP+	▪ 85% of eligibles are enrolled in Medicaid and CHP+	▪ 90% of eligibles are enrolled in Medicaid and CHP+	▪ 95% of eligibles are enrolled in Medicaid and CHP+
	Actual	N/A	N/A	Unknown	Unknown	Unknown	Unknown	Unknown

***Strategy*:** The Office of Client and Community Relations includes a diverse set of functions that promote the Department's mission of improving access to high-quality and cost-effective health care to Coloradans. Many of the activities focus on ensuring that those applying for state health care programs have the support and information they need to make the process as easy as possible. Understanding this, the Department has outlined a set of goals for the Office of Client and Community Relations that support the Department's objectives: improve overall customer experience through a client satisfaction survey; improve communication between the clients and the Office of Client and Community Relations; reduce fraud and abuse; and increase the number of insured Coloradans. While many of these goals represent the day-to-day operations of the Office, they are vital to the ability of the Department to meet its mission, vision, and goals.

To improve overall customer experience though a client satisfaction survey, the Office of Client and Community Relations will utilize the Consumer Assessment of Health Plans Survey (CAHPS), which allows clients who recently interacted with the Department to gauge their experience and provide input regarding satisfactory outcomes and suggested areas of improvement. The results of the survey will be analyzed, identifying opportunities to improve the client service experience, and appropriate changes will be implemented. The success of the Department to adapt and improve will be subsequently measured by further surveying of clients for satisfaction measurements. 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 #4. The ACC, 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

In FY 2008-09, Office initiated an internal Department survey to increase transparency and understanding of Department programs and initiatives. 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 Office, the Department found it extremely challenging to create one single survey to measure the level of client experience of care among internal Department customers. Each section or unit within the Office sought to identify the best approach and method to measure internal client experience of care. Due to increased workload within the Office and increasingly sparse staff resources, the survey was suspended after FY 2008-09. However, all sections and units continue to utilize the approaches identified during the FY 2008-09 process to improve upon internal communication, customer service, and satisfaction.

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 U.S. 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.

Finally, through its existing outreach network, the Office of Client and Community Relations will be involved in attaining the Department goal of increasing the number of insured Coloradans. The Office is well-positioned to lean on its experience and connections with community-based outreach opportunities to increase awareness of eligibility standards and emphasize the importance of preventative care. In addition to the existing outreach activities conducted by the Department and community-based organizations, the Department received grant funding to further outreach, enrollment, and retention activities:

- The federal Health Resources and Services Administration (HRSA) State Health Access Program (SHAP) awarded a 5-year, $42 million grant for the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). This grant program is providing funding for the Maximizing Outreach, Retention, and Enrollment (MORE) project, which aims to design, develop, and implement an enhanced outreach plan for expansion populations that generates awareness of the availability of health care coverage programs and the expanded eligibility and teaches families how to access health care in appropriate settings. The grant is also providing funding to further streamline the application process by replacing paper documentation with electronic data where possible, develop Web-based services for clients, and create interfaces to other state and federal systems to ease data exchange for expansion populations making it easier for clients to apply for public health insurance programs.

- The U.S. Department of Health and Human Services (HHS) is launching the "Get Covered. Get in the Game." initiative in seven pilot states across the country, including Colorado. The initiative is part of the *Connecting Kids to Coverage* effort, led by HHS Secretary Kathleen Sebelius, which calls on government and business leaders, health and human services providers, schools, the faith community, and those working with children in any setting to find and enroll roughly five million uninsured children in the U.S. who are currently eligible for Medicaid and the Children's Health Insurance Program (CHIP). This initiative will provide coaches with information about CHIP and Medicaid and how families can get their eligible children enrolled. Coaches and others in the school community can serve as a resource to families to help ensure that children are linked to vital health benefits. CMS will support events launching this initiative, outreach to news outlets across the pilot states, coaches' trainings, and the placement of promotional materials at select youth sports events to help direct families to enrollment assistance.

***Evaluation of Prior-Year Performance*:** In relation to the results of the CAHPS survey, a trend analysis was completed by the designated External Quality Review Organization, Health Services Advisory Group. Compared to last year, a greater proportion of

*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.

reportable rates were at or above the national Medicaid average reported rate for each measure. As can be seen in the chart below, the overall satisfaction ratings vary widely among the Department's Plans:

FY 2009-10 CAHPS Results

	Fee-For-Service	Primary Care Physician Program	Denver Health Medical Plan	Rocky Mountain Health Plan
Adult Medicaid				
Global Ratings				
Rating of Health Plan	★	★★	★	★★★★
Rating of All Health Care	★	★★★	★	★★★★★
Rating of Personal Doctor	★★★	★★★★	★★★★	★★★★
Rating of Specialist Seen Most Often	★★★★	★★★	★★	★★★
Composite Measures				
Getting Needed Care	★★★	★★★★	★	★★★★★
Getting Care Quickly	★★	★★★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★★	★★★	★★★★
Customer Service	NA	NA	NA	★★★★★
Shared Decision Making	★★★★	★★★★★	★★★★	★★★★★
★★★★★90th Percentile or Above ★★★★75th-89th Percentiles ★★★50th-74th Percentiles				
★★25th-49th Percentiles ★Below 25th Percentile **NA** Not Applicable				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health MP**	**Rocky Mountain Health Plan**
Child Medicaid				
Global Ratings				
Rating of Health Plan	★★	★★	★★	★★★★
Rating of All Health Care	★★	★★★	★	★★★★★
Rating of Personal Doctor	★★	★★★	★★★★★	★★★★★
Rating of Specialist Seen Most Often	★★	★★★	NA	NA
Composite Measures				
Getting Needed Care	★★	★★	NA	★★★★★
Getting Care Quickly	★★★	★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★★	★★	★★★★★
Customer Service	★	★★	NA	NA
Shared Decision Making	★★★★★	★★★★★	★	★★★★★
★★★★★80th Percentile or Above ★★★★60th-79th Percentiles ★★★40th-59th Percentiles				
★★20th-39th Percentiles ★Below 20th Percentile **NA** Not Applicable				

In order to identify performance differences in client satisfaction between the four Colorado Medicaid plans, the results for fee-for-service, Primary Care Physician Plan, Denver Health Medical Plan, and Rocky Mountain Health Plan were compared to the State Medicaid average using standard tests for statistical significance.[1] For purposes of this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results for the Colorado Medicaid plans were case-mix adjusted for general health status, educational level, and age of the respondent.[2] Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

Statistically significant differences are noted in the tables below by arrows. A plan that performed statistically better than the State average is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically worse than the State average is denoted with a downward (↓) arrow. A plan that did not perform statistically different than the State average is denoted with a horizontal (↔) arrow. If a plan does not meet the requirement of 100 respondents, the plan's question summary rate or global proportion for that measure is denoted as Not Applicable (NA). The tables below present the question summary rates and global proportions results of the plan comparisons analysis for Adult Medicaid and Child Medicaid.

Adult Medicaid Plan Comparisons				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health Medical Plan**	**Rocky Mountain Health Plan**
Global Rating				
Rating of Health Plan	44.50% ↓	54.40% ↔	45.90% ↔	60.40% ↑
Rating of All Health Care	42.40% ↔	50.80% ↔	37.00% ↓	54.10% ↑
Rating of Personal Doctor	59.80% ↔	65.10% ↔	65.40% ↔	64.80% ↔
Rating of Specialist Seen Most Often	65.40% ↔	61.90% ↔	56.50% ↔	60.90% ↔
Composite Measure				
Getting Needed Care	48.20% ↔	53.10% ↔	32.80% ↓	58.30% ↑
Getting Care Quickly	53.10% ↔	58.50% ↑	39.30% ↓	61.40% ↑
How Well Doctors Communicate	65.40% ↔	68.60% ↔	67.00% ↔	68.20% ↔
Customer Service	NA	NA	NA	69.30% ↑
Shared Decision Making	59.20% ↔	63.50% ↔	55.20% ↔	65.90% ↔
Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the state average.				

The plan comparisons revealed the following statistically significant results for Adult Medicaid:

[1] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.
[2] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008.* Rockville, MD: US Department of Health and Human Services, July 2008.

- Colorado Medicaid fee-for-service scored significantly lower than the Colorado Medicaid State average on one CAHPS measure, Rating of Health Plan.
- Colorado Medicaid Primary Care Physician Plan scored significantly higher than the Colorado Medicaid State average on one CAHPS measure, Getting Care Quickly.
- Denver Health Medical Plan scored significantly lower than the Colorado Medicaid State average on three CAHPS measures: Rating of All Health Care, Getting Needed Care, and Getting Care Quickly.
- Rocky Mountain Health Plan scored significantly higher than the Colorado Medicaid State average on five CAHPS measures: Rating of Health Plan, Rating of All Health Care, Getting Needed Care, Getting Care Quickly, and Customer Service.

Child Medicaid Plan Comparisons				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health Medical Plan**	**Rocky Mountain Health Plan**
Global Rating				
Rating of Health Plan	60.70% ↔	64.80% ↔	60.10% ↔	66.90% ↔
Rating of All Health Care	58.60% ↔	60.50% ↔	53.50% ↔	64.50% ↔
Rating of Personal Doctor	67.60% ↓	70.60% ↔	73.20% ↔	77.70% ↑
Rating of Specialist Seen Most Often	64.10% ↔	70.30% ↔	NA	NA
Composite Measure				
Getting Needed Care	52.60% ↔	52.60% ↔	NA	63.70% ↑
Getting Care Quickly	71.10% ↑	68.80% ↔	45.10% ↓	75.30% ↑
How Well Doctors Communicate	73.10% ↔	76.00% ↔	71.70% ↔	79.60% ↑
Customer Service	48.50% ↔	56.70% ↔	NA	NA
Shared Decision Making	68.90% ↔	70.70% ↔	61.20% ↔	72.40% ↔
Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the state average.				

The plan comparisons revealed the following statistically significant results for Child Medicaid:

- Colorado Medicaid fee-for-service scored significantly lower than the Colorado Medicaid State average on one CAHPS measure, Rating of Personal Doctor.
- Colorado Medicaid fee-for-service scored significantly higher than the Colorado Medicaid State average on one CAHPS measure, Getting Care Quickly.
- Colorado Medicaid Primary Care Physician Plan did not score significantly higher or lower than the Colorado Medicaid State average on any of the CAHPS measures.
- Denver Health Medical Plan scored significantly lower than the Colorado Medicaid State average on one CAHPS measure, Getting Care Quickly.
- Rocky Mountain Health Plan scored significantly higher than the Colorado Medicaid State average on four CAHPS measures: Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate.

The Department exceeded its benchmark for FY 2009-10 related to recoveries, with the amount increasing by 49.2% over FY 2008-09. The Department had anticipated a relatively low level of post-pay insurance recoveries were depressed due to economic hardship resulting from high unemployment, which lowers the number of individuals with access to private insurance. In addition, post-pay recoveries were also affected by better Department processes to cost-avoid claims, which eliminate the need to chase after a recovery. One of the major reasons for the large recovery amount in FY 2009-10 was the completion of a project in which the Department retroactively recouped capitation payments made to various managed care organizations for Medicaid clients after their date of death. This project looked back several years, and will be a one-time recovery.

7. Medicaid and CHP+ Program Administration Office

Objective: The Department will increase the number of individuals eligible and enrolled in its programs, 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. Assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes.

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

Improve client experience of care with programs, services, and care. Support timely and accurate client eligibility determination. Provide accurate and consistent information to internal and external customers.

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 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Medicaid and CHP+ Program Administration Office								
Achieve Medicaid pharmaceutical cost avoidance for drug classes on the Preferred Drug List (PDL)	Benchmark	▪ Cost avoid by 7%.	▪ Cost avoid by 5%.	▪ Cost avoid by 3%.	▪ Cost avoid by 3%.	▪ Cost avoid by 3%.	▪ Cost avoid by 3%.	▪ Cost avoid by 3%.
	Actual	▪ Costs avoided by 6.70%.	▪ Costs avoided by 10.6%.	Unknown	Unknown	Unknown	Unknown	Unknown
Conduct nursing facility audits (both change of ownership or risk based audits) to recoup patient payment (third party liabilities)	Benchmark	▪ Recover approximately $1.5 million.	▪ Recover $683,879.	▪ Recover $593,477*.	▪ Recover $796,081*.	▪ Recover $796,081*.	▪ Recover $796,081*.	▪ Recover $796,081*.
	Actual	▪ $1,138,828 in recoveries.	▪ $618,250 in recoveries.	Unknown	Unknown	Unknown	Unknown	Unknown

Performance Measure	Outcome	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
		Actual	Actual	Approp.	Request	Goal	Goal	Goal
Medicaid and CHP+ Program Administration Office								
Improve Health Outcomes	Benchmark	N/A - New Benchmark for FY 2010-11	N/A - New Benchmark for FY 2010-11	▪ Establish baseline data for the performance measures in FY 2011-12 through FY 2014-15.	▪ Reduce the proportion of children with dental caries to <50%.	▪ Reduce the proportion of children regularly exposed to tobacco smoke to <25%. ▪ Maintain the proportion of children with dental caries to <50%.	▪ Reduce the proportion of clients with obesity to <20%. ▪ Reduce tobacco use during pregnancy from 19% to 2%. ▪ 70% of adult population reports being in excellent or very good physical health. ▪ Maintain the proportion of children regularly exposed to tobacco smoke to <25%. ▪ Maintain the proportion of children with dental caries to <50%.	▪ Increase the percentage of the non-smoking population from 63% to 82%. ▪ Move out of the bottom quartile for adolescent depression (Colorado ranks 50th among other states) to a ranking that is 37th or better. ▪ Maintain the proportion of clients with obesity to <20%. ▪ Maintain tobacco use during pregnancy from 19% to 2%. ▪ 70% of adult population reports being in excellent or very good physical health. ▪ Maintain the proportion of children regularly exposed to tobacco smoke to <25%. ▪ Maintain the proportion of children with dental caries to <50%.
	Actual	N/A	N/A	Unknown	Unknown	Unknown	Unknown	Unknown

*See Exhibit H, "Long Term Care – Class I Nursing Facilities Request, Footnotes, and Calculation of General Fund Cap," page EH-7 of the Department's November 1, 2010 FY 2011-12 Budget Request for more information.

***Strategy*:** The Medicaid and CHP+ Program Administration Office designs, implements, and administers Medicaid, CHP+, and the Long-Term Care Medicaid Programs, aiming to improve the health status of all clients, achieve efficiencies in scarce health care resource utilization, and promote effective partnerships with providers and contractors to achieve improved health and functioning of clients. While many of these goals represent the day-to-day operations of the Office, they are vital to the ability of the Department to meet its mission, vision, and goals.

Drug classes on the Preferred Drug List (PDL) are drugs that have been identified as effective in terms of both treatment and cost and are preferred over more expensive drugs that show little to no greater effectiveness in treatment of the ailment for which it is prescribed. The practice of purchasing PDL drugs comparable to non-PDL drugs is called cost avoidance, which is the first goal of the Medicaid and CHP+ Program Administration Office. An initial benchmark of increasing cost avoidance by 7% was met in FY 2008-09, followed by an additional 5% for FY 2009-10. A goal of 15% (an additional 3%) was set for FY 2010-11, and that standard of an additional 3% is the target for the next few years through FY 2014-15, at which point the cost avoidance goal will be 33% of the original base. Eventually, the savings will plateau and reach an equilibrium that has yet to be determined.

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 estimates that, on average, each audit recovers approximately $30,000.

The projected drop in recoveries beginning in FY 2009-10 is because the Department anticipates a reduction in the number of audits the Department can complete on an annual basis. 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. The Department completed 13 audits in FY 2009-10 and anticipates completing 20 in FY 2010-11.

Finally, coinciding with one of its broader objectives, the Medicaid and CHP+ Program Administration Office is tasked with improving overall health outcomes for both Medicaid and CHP+ through a number of initiatives. These initiatives include: reducing the proportion of children with dental caries; reducing the proportion of children exposed to tobacco smoke; reducing obesity rates; reducing tobacco use; and combating adolescent depression. Each of these initiatives has a corresponding benchmark, as depicted in the table above, many of which were presented to the Hospital Provider Fee Oversight and Advisory Board regarding recommended performance measures for the Hospital Quality Incentive Payments established in HB 09-1293. As each goal is met, additional goals may be introduced that will continue to improve health outcomes for clients.

Evaluation of Prior-Year Performance: The Department estimates that the FY 2009-10 cost avoidance for the PDL exceeded the benchmark, with savings of 10.6%. The Department added 7 new drug classes to the PDL in the last half of FY 2009-10, which increased the savings beyond the benchmark. In addition, the increased caseload had a significant impact on cost measures as well, as the less expensive alternatives are utilized.

Recoveries from Nursing Facility audits were slightly below the benchmark. The Department completed 13 audits in FY 2009-10 compared with an estimate of 20 when the benchmark was set. While the total amount of recoveries was approximately 9.6% lower than the benchmark, the Department was able to perform 35% fewer audits than anticipated. This implies that the Department actually recovered 39% per audit than the benchmark level. In addition, a facility with a large audit finding completed the audit process at the end of FY 2009-10 and has yet to complete an appeals process. Any recovery from this audit completed in FY 2009-10 will be incurred in FY 2010-11.

8. Budget and Finance Office

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

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

Performance Measure	Outcome	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Budget and Finance Office								
Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medical Services Premiums.	Benchmark	▪ Expenditures within 1% of final appropriation.	▪ Expenditures within 0.75% of final appropriation.	▪ Expenditures within 0.75% of final appropriation.	▪ Expenditures within 0.75% of final appropriation.	▪ Expenditures within 0.75% of final appropriation.	▪ Expenditures within 0.75% of final appropriation.	▪ Expenditures within 0.75% of final appropriation.
	Actual	▪ General Fund expenditure was 0.06% below the budgeted amount.	▪ Total expenditure was 1.8% below the appropriation. General Fund expenditure was 4.2% under the appropriation.	Unknown	Unknown	Unknown	Unknown	Unknown

***Strategy*:** The Budget and Finance Office is comprised of a number of divisions which work in unison handling financial matters and budgetary responsibilities of the Department. One of these responsibilities is to estimate future years' expenditures, which is then used as the appropriation request. Because of the number of variables and uncertainty involved, the Budget and Finance Office's estimates can have varying degrees of accuracy. The goal set for the Budget and Finance Office is for its expenditures estimate to fall within 0.75% of the final appropriated amount. 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. While many of these goals represent the day-to-day operations of the Office, they are vital to the ability of the Department to meet its mission, vision, and goals.

Evaluation of Prior-Year Performance: The Budget Division did not meet its performance measure for FY 2009-10, total with expenditures being 1.8% below the appropriation. This is largely due to the delay in the last two weeks of fee-for-service payments from the Medicaid Management Information System, which was required to avoid a State General Fund overexpenditure. The June 21, 2010 Legislative Council Revenue indicated that the FY 2009-10 tax collections would be insufficient to support the FY 2009-10 appropriations. As a result, the Department was directed to delay the last two weeks of fee-for-service payments in June 2010 until July 2010. Without the impact of this payment delay, the Department's total expenditures would have been 0.64% higher than the appropriation, with a 0.53% overexpenditure in General Fund.

9. Human Resources Section

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 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Human Resources Section								
Provide job specific training to each employee. Complete and implement a comprehensive orientation and training curriculum for new staff.	Benchmark	▪ 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.	▪ Train 75% of Department managers and work leaders on coaching, mentoring, and employee assessment.	▪ Train 75% of Department managers and work leaders on coaching, mentoring, and employee assessment.	▪ Train 75% of Department managers and work leaders on coaching, mentoring, and employee assessment.	▪ Train 75% of Department managers and work leaders on coaching, mentoring, and employee assessment.
	Actual	▪ Professional development training was provided to 45% of Department staff.	▪ Professional development training was provided to at least 75% of Department staff	Unknown	Unknown	Unknown	Unknown	Unknown
	Benchmark	▪ Reduce employee turnover rate to 15%.	▪ Maintain employee turnover rate at or below 11.1%.	▪ Maintain turnover rate at or below the statewide average.	▪ Maintain turnover rate at or below the statewide average.	▪ Maintain turnover rate at or below the statewide average.	▪ Maintain turnover rate at or below the statewide average.	▪ Maintain turnover rate at or below the statewide average.
	Actual	▪ Turnover rate was 6.84%.	▪ Turnover rate was 6.00%.	Unknown	Unknown	Unknown	Unknown	Unknown

***Strategy*:** The Human Resources Section provides the full range of human resource services to all employees of the Department. This is a decentralized personnel function, which includes recruitment, testing, selection, classification, salary administration, diversity, training, rules interpretation, work force development, employee/manager counseling, corrective and disciplinary actions, separation analysis, dispute resolution, and maintaining personnel records within the confines of the State personnel rules. This section also provides advice, guidance, counseling, and technical assistance to Department managers and staff on the workings of the State personnel system. For the Human Resources Section, its assigned goal is to maintain a certain level of training and to minimize turnover rate within the Department. While many of these goals represent the day-to-day operations of the Section, they are vital to the ability of the Department to meet its mission, vision, and goals.

To maintain a certain level of training, the Human Resources Section has been tasked with ensuring at least 75% of Department managers and work leaders are trained on coaching, mentoring, and employee assessment. This training will enable these individuals

to become more effective leaders in terms of delegating assignments and encouraging their employees to work more efficiently. In addition, providing training for Department staff will help ensure that the Department reduces turnover rates, and retains a knowledgeable and skilled staff.

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.

To minimize turnover rate within the Department, the Human Resources Section has a target rate of 11.1% or below. While a stagnant economy has aided in keeping this number low, the section is looking at ways to creative incentives to keep employees with the Department, including pay raises, greater benefits packages, and interdepartmental mobility.

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 8.4%[*]. Through the enhanced training efforts, the Department hopes to maintain its turnover rate at or below the state level in FY 2010-11 and beyond.

Evaluation of Prior-Year Performance: The Department exceeded its benchmark with a turnover rate of 6.0% in FY 2009-10, only slightly higher than FY 2008-09 when a hiring freeze was in place and 2.4 percentage points lower than that the statewide average across agencies. The Department believes that the availability of training and career development opportunities, as discussed below, are partially responsible for maintaining a low turnover rate.

In FY 2009-10, the Department made $150 available for each employee to attend one training session during the fiscal year. Approximately 100 employees, or 40% of the Department, took advantage of this training opportunity. Employees attended trainings on Excel proficiency, leadership, improved management, and communication skills. In addition, over 53 of the Department's managers were trained in coaching and mentoring programs, or 72% of management. The Department concentrated a majority of the training budget on the Supervisory Certificate trainings offered through the Department of Personnel and Administration for managers and team leads.

In addition, the Human Resources Section offered training on Coaching for Commitment, which was a free course offered to all employees and was very widely attended. Section staff also conducted mandatory trainings on sexual harassment and workplace violence, and trainings specific to the Health Insurance Portability and Accountability Act.

[*] All turnover rates from the Annual Workload Report published by the Department of Personnel and Administration, Division of Human Resources.

10. Audits & Compliance Division

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 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Approp.	FY 2011-12 Request	FY 2012-13 Goal	FY 2013-14 Goal	FY 2014-15 Goal
Audits & Compliance Division								
Conduct provider post payment audits to decrease fraud and abuse and increase recoveries.	Benchmark	▪ $10 million in total recoveries.	▪ $12 million in total recoveries.	▪ $7 million in total recoveries.	▪ $8 million in total recoveries.	▪ $9 million in total recoveries.	▪ $10 million in total recoveries.	▪ $11 million in total recoveries.
	Actual	▪ $7.2 million in total recoveries.	▪ $6.2 million in total recoveries.	Unknown	Unknown	Unknown	Unknown	Unknown

***Strategy*:** The Audits and Compliance Division consists of the Program Integrity Section, Medicaid Eligibility Quality Control Unit, and the Internal Audit Unit. The primary goals of the Division are to ensure compliance with state and federal law as well as identifying and recovering improper Medicaid payments, establishing accountability and efficiency of state and federal funds paid to Medicaid enrolled providers for covered items or services to eligible clients, and promoting improvement and efficiencies through the sharing of audit/review findings. In the Program Integrity Section, the audits are conducted to identify cases of fraud, abuse, and waste. Overpayments are recovered as appropriate. The Medicaid Eligibility Quality Control unit assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays. The internal Audit unit is new to the Department and is an independent, objective assurance activity designed to add value and improve an organization's operations and assist with compliance with federal and state laws and regulations. While many of these goals represent the day-to-day operations of the Division, they are vital to the ability of the Department to meet its mission, vision, and goals.

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. The Centers for Medicare and Medicaid Services (CMS) halted efforts on this project during the development of the Patient Protection and Affordable Care Act of 2010, and the Department is currently awaiting notification from CMS whether this initiative will move forward in the future.

On July 1, 2010 Program Integrity launched its first ever work plan to dedicate focused monitoring of Medicaid provider activities by and with the assistance of our federal partners, Department contingency contractors and internal Program Integrity staff.

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. 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 System (ESURS). ESURS is a software program that conducts provider peer group analysis to determine the normal billing patterns and to identify aberrant billers that are two or more statistical deviations from the norm. In this manner Program Integrity is able to better focus the limited reviewer resources on the most probable aberrant billers to better identify fraud, waste and abuse. Currently there are currently 52 users of ESURS including Program Integrity staff, Department policy personnel, fiscal agent, and software support staff monitoring provider activities. 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.

The Program Integrity Section continues to conduct other activities to reduce fraud abuse in waste, including but not limited to data mining and analysis and record review.

In addition to national initiatives, the Department began 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 are reported by the Program Integrity Section.

Evaluation of Prior-Year Performance: The Department did not meet its benchmark of $1 2 million in recoveries through its Program Integrity Section. The federal programs, MEDI-MEDI and the Medicaid Recovery Contractors have currently not yielded the recoveries that were anticipated. In addition, the Section spent part of the fiscal year hiring and training new staff, as well as purchasing and implementing new fraud and abuse technology. By December 2010, the PI Section will be fully staffed and new technology has been successfully implemented.

After initial review from the Program Integrity, several cases were 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 200 9 - 10 a total of 9 cases were referred to these other agencies and 20 cases are still open and active. In cooperation with external investigative entities, the Department will often defer recovery actions 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.