Department of Health Care Policy and Financing
Strategic Plan
FY 2012-13 Budget Request

November 1, 2011

I. 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 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.

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

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Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

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

II. 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 Governor Hickenlooper's health care reform initiatives corresponding with the federal Affordable Care Act (ACA). 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 2012-13 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
1. *Increase the number of insured Coloradans*: The Department aims to increase the number of insured Coloradans by increasing enrollment of individuals eligible for its Medicaid and CHP+ programs. Widening eligibility guidelines from the Colorado Health Care Affordability Act coincides with a federal mandate stemming from the Affordable Care Act and has allowed the Department to proactively prepare for federally mandated eligibility increases. With each fiscal year, the Department's goal is to have a higher percentage of the eligible population enrolled, which will improve health outcomes for an increasing number of Colorado's population.

2. *Improve health outcomes*: As a vital element of increasing the number of insured Coloradans, the Department intends to improve health outcomes for clients in the Medicaid and CHP+ programs. This effort will include reducing the number of dental carries in children, which has been shown to be linked to other physical health issues, as well as increasing the number of depression screenings in adolescents and reducing the obesity weight among both adults and children. As a measure to maintain cost-effective care, the Department plans to link an increasing percentage of Medicaid provider payments to value-based outcomes. These efforts should collectively improve health outcomes for Coloradans while combating cost increases.

3. *Increase access to health care*: Enrolling eligible clients is only effective in improving health outcomes if these individuals have access to high quality health care. As one of its goals, the Department intends to increase the percentage of Medicaid clients, both adults and children, who have a medical home or focal point of care. By having a medical home or focal point of care, these clients will receive the health care services they need in a timely manner, effectively preventing more expensive emergency treatment that comes as a result of neglected health conditions.

4. *Contain health care costs*: Increasing caseload is understood to carry an additional financial burden to the State, which is particularly concerning during an economic downturn. The Department has identified a number of areas where it can contain

health care costs while still providing health care services to its Medicaid and CHP+ clients. These cost-containment opportunities are made possible by an assortment of efforts to consolidate and streamline the delivery process, thus maximizing a number of potential efficiencies.

5. *Improve long-term supports and services*: As the population ages and costs increase, long-term care continues to serve as a difficult category in the arena of public health care. Long-term care services are expensive, however the Department believes there are efficiencies that can yet be attained, thus minimizing and perhaps containing cost increases while continuing to deliver the same level of care. Transitioning clients from facility-based care to community-based care and consolidating waiver programs are efficiency opportunities the Department plans to immediately pursue.

III. PERFORMANCE MEASURES

1. Increase the Number of Insured Coloradans

Objective: The Department aims to increase the number of insured Coloradans by increasing enrollment of individuals eligible for its Medicaid and CHP+ programs. Widening eligibility guidelines from the Colorado Health Care Affordability Act coincides with a federal mandate stemming from the Affordable Care Act and has allowed the Department to proactively prepare for federally mandated eligibility increases. With each fiscal year, the Department's goal is to have a higher percentage of the eligible population enrolled, which will improve health outcomes for an increasing number of Colorado's population.

Department Performance Measures by Fiscal Year					
Goal	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Increase the Number of Insured Coloradans	• 87% of eligible children are enrolled in Medicaid. • 64% of eligible children are enrolled in CHP+. • 76% of eligible parents are enrolled in Medicaid. • Determine annual benchmarks to measure enrollment of newly eligible populations under HB 09-1293 expansions.	• Meet timely processing requirements for 95% of all new applications for medical assistance. • Meet timely processing requirements for 95% of all redeterminations for medical assistance. • 89% of eligible children are enrolled in Medicaid. • 67% of eligible children are enrolled in CHP+. • 79% of eligible parents are enrolled in Medicaid. • Finalize plans to coordinate with the Colorado Health Insurance Exchange for public medical assistance.	• Maintain timely processing requirements for 95% of all new applications for medical assistance. • Maintain timely processing requirements for 95% of all redeterminations for medical assistance. • 91% of eligible children are enrolled in Medicaid.* • 70% of eligible children are enrolled in CHP+.* • 81% of eligible parents are enrolled in Medicaid.* **Enrollment benchmarks will be adjusted once estimates are finalized for expansion populations under the federal Affordable Care Act.*	• Maintain timely processing requirements for 95% of all new applications for medical assistance. • Maintain timely processing requirements for 95% of all redeterminations for medical assistance. • 93% of eligible children are enrolled in Medicaid.* • 73% of eligible children are enrolled in CHP+.* • 83% of eligible parents are enrolled in Medicaid.* **Enrollment benchmarks will be adjusted once estimates are finalized for expansion populations under the federal Affordable Care Act.*	• Maintain timely processing requirements for 95% of all new applications for medical assistance. • Maintain timely processing requirements for 95% of all redeterminations for medical assistance. • 95% of eligible children are enrolled in Medicaid.* • 75% of eligible children are enrolled in CHP+.* • 85% of eligible parents are enrolled in Medicaid.* **Enrollment benchmarks will be adjusted once estimates are finalized for expansion populations under the federal Affordable Care Act.*

***Strategy*:** While the Department has been successful in increasing the number of children enrolled in the program who were previously uninsured, the Department recognizes there are still many children who 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 Healthy 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 four 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 helps to 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, the Colorado Health Care Affordability Act, provides funding to expand eligibility in Medicaid and CHP+ over the next four 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 Disabled Buy-In Program for Working Adults and an Adults without Dependent Children (AwDC) program, both on March 2012, and a Medicaid Disabled Buy-In Program for Children approximately four to six months later. The Department anticipates that, once fully implemented, this legislation will provide health care coverage for more than 100,000 uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole.

On March 23, 2010, the President signed into law the Affordable Care Act (ACA), which 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 Health Care 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 Colorado 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: With the change in administration, the Department has revised its Strategic Plan effective FY 2011-12. This has resulted in the revision or replacement of many of the Department's previous goals. Because many of these strategic performance measures are new, the Department is not able to evaluate prior-year performance. The FY 2011-12 figures in the table are based on prior-year actuals and are used as a benchmark for goals in future fiscal years.

In FY 2010-11, an estimated 85% of all eligible children were enrolled in Medicaid, while an estimated 62% of all eligible children were enrolled in CHP+. In addition, the Department estimates that 76% of eligible parents were enrolled in Medicaid. These estimates are calculated from 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 evaluation of the 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*:** As a vital element of increasing the number of insured Coloradans, the Department intends to improve health outcomes for clients in the Medicaid and CHP+ programs. This effort will include reducing the number of dental carries in children, which has been shown to be linked to other physical health issues, as well as increasing the number of depression screenings in adolescents and reducing the obesity weight among both adults and children. As a measure to maintain cost-effective care, the Department plans to link an increasing percentage of Medicaid provider payments to value-based outcomes. These efforts should collectively improve health outcomes for Coloradans while combating cost increases.

Department Performance Measures by Fiscal Year					
Goal	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Improve Health Outcomes	• Reduce the percent of Medicaid children with dental caries experience from 57.2% to 55%. • Increase the percent of Medicaid children who receive a dental service from 49% to 51%. • Increase the percent of CHP+ children who receive a dental service from 44% to 46%. • Initiate development of a data strategy for long term integration of clinical and claims data.	• Maintain or improve the percent of Medicaid children with dental caries experience at <55%. • Increase the percent of Medicaid children who received a dental service in the last year from 51% to 53%. • Increase the percent of CHP+ children who received a dental service in the last year from 46% to 48%. • Develop baseline data for measuring the percentage of adult Medicaid clients who report being in excellent or very good physical health. • Increase the number of annual depression screenings for adolescents (age 11-20) on Medicaid/ CHP+ combined from 1,500 to 3,000. • 1.25% of Medicaid provider payments are linked to value-based outcomes. • Develop a plan to integrate systems of care for mental and physical health.	• Reduce the percent of female Medicaid clients who smoke during the last trimester of pregnancy from 19% to 15%. • Increase the percent of mothers on Medicaid who report that smoking is not allowed anywhere inside the home by 5% (from 2009 baseline, pending). • Decrease the percent of Medicaid adults who report using tobacco every day or some days from 29% to 23%. • 2% of Medicaid provider payments are linked to value-based outcomes. • Establish statewide Health Information Technology infrastructure for meaningful use under ARRA-HITECH.	• Improve effective management of acute depression in Medicaid adults from 53% to 58%. • 3.25% of Medicaid provider payments are linked to value-based outcomes.	• Decrease the percent of Medicaid/CHP+ children ages 0-14 who are overweight or obese from 30% to less than 25%. • Decrease the percent of Medicaid adults who are overweight or obese from 56% to less than 51%. • 5% of Medicaid provider payments are linked to value-based outcomes.

***Strategy*:** The Department aims to increase the number of Medicaid and CHP+ children who receive dental services and to reduce the number of Medicaid children with dental carries. Many studies link gum disease to serious health conditions, such as heart disease, stroke, and diabetes, and the Department believes a proactive effort to improve dental health in children will reduce future health care costs. Health outcomes are directly related to healthy lifestyles, and as such, the Department also intends to reduce tobacco use, particularly among pregnant women, in addition to reducing the obesity rate in both children and adults.

The Department is committed to improving the health of its clients, staff and community. This focus on healthy living extends from healthy development during infancy and childhood through the life span to healthy aging. The Department's health improvement efforts are based in an understanding of the social determinants of health, and the importance of building healthy communities. To this end, the Department has launched the Healthy Living Initiatives, which concentrate on oral health, behavioral health, nutrition and fitness, and tobacco-free living. Through Healthy Living, the Department will ensure coordination with other Department initiatives for an efficient, cooperative approach to client health and wellness. The Department will collaborate with local community partners in health promotion and disease prevention efforts and promote a payment structure that encourages providers and clients to focus on health and wellness.

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 in the process of determining baseline data and any reporting mechanisms required to properly tie payments to outcomes. 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.

The Department continues to communicate with, educate, and support providers and contractors 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.

Evaluation of Prior-Year Performance: With the change in administration, the Department has revised its Strategic Plan effective FY 2011-12. This has resulted in the revision or replacement of many of the Department's previous goals. Because many of these strategic performance measures are new, the Department is not able to evaluate prior-year performance. The FY 2011-12 figures in the table are based on prior-year actuals and are used as a benchmark for goals in future fiscal years.

In federal fiscal year 2009-10, approximately 49% of Medicaid children and 44% of CHP+ children received a dental service. These estimates are calculated from data provided to the federal Centers for Medicare and Medicaid Services, and represent the number of children that have been continuously enrolled in Medicaid or CHP+ for at least 90 days and have received any dental service between October 1, 2009 and October 31, 2010. 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 evaluation of the performance measures. This, however, may understate the number of children receiving dental services in the measurement year, as the data cannot account for progress during the year.

3. Increase Access to Health Care

Objective: Enrolling eligible clients is only effective in improving health outcomes if these individuals have access to high quality health care. As one of its goals, the Department intends to increase the percentage of Medicaid clients, both adults and children, who have a medical home or focal point of care. By having a medical home or focal point of care, these clients will receive the health care services they need in a timely manner, effectively preventing more expensive emergency treatment that comes as a result of neglected health conditions.

Department Performance Measures by Fiscal Year					
Goal	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Improve Access to Health Care	• Increase the percent of adult Medicaid clients that have a medical home or focal point of care from 38% to 42%. • Increase the percent of Medicaid children that have a medical home or focal point of care from 78% to 80%. • Increase provider participation in Medicaid by 5% above the 27,336 providers in FY 2010-11. • Determine appropriate benchmarks to measure increases in provider participation to serve future expansion populations.	• Increase the percent of adult Medicaid clients that have a medical home or focal point of care from 42% to 52%. • Increase the percent of Medicaid children that have a medical home or focal point of care from 80% to 86%.	• Increase the percent of adult Medicaid clients that have a health home from 52% to 70%. • Increase the percent of Medicaid children that have a health home from 86% to 92%.	• Increase the percent of adult Medicaid clients that have a health home from 70% to 75%. • Increase the percent of Medicaid children that have a health home from 92% to 97%.	• Increase the percent of adult Medicaid clients that have a health home from 75% to 80%. • Increase the percent of Medicaid children that have a health home from 97% to 100%.

***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 are needed to assure delivery of appropriate, high-quality health care for all clients 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 such, the Department is focusing on expanding the number of Medicaid clients enrolled in a medical home as reflected as a percentage of the total Medicaid caseload in

each fiscal year. The number of Medicaid clients 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 clients with access to a medical home.

In order to meet the benchmarks, the Department must ensure there is an adequate network of primary care physicians who are willing to participate as medical homes. The Department anticipates 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.

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 Department has procured seven RCCOs as well as a Statewide Data and Analytic Contractor (SDAC) to assist RCCOs in coordinating care and collecting data. The ACC intends to enroll 123,000 clients by November 2011.

Evaluation of Prior-Year Performance: With the change in administration, the Department has revised its Strategic Plan effective FY 2011-12. This has resulted in the revision or replacement of many of the Department's previous goals. Because many of these

strategic performance measures are new, the Department is not able to evaluate prior-year performance. The FY 2011-12 figures in the table are based off prior-year actuals and are used as a benchmark for goals in future fiscal years.

In FY 2010-11, approximately 78% of Medicaid children were enrolled in a medical home. In addition, 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. Based on data provided to the federal Centers for Medicare and Medicaid Services, the Department estimates that 38% of adults in Medicaid were also enrolled in a medical home. The Department anticipates that these rates will increase in the next three years as the ACC is fully implemented and the Department finds new and innovative ways to ensure all Medicaid clients have a focal point of care.

4. Contain Health Care Costs

Objective: Increasing caseload is understood to carry an additional financial burden to the State, which is particularly concerning during an economic downturn. The Department has identified a number of areas where it can contain health care costs while still providing health care services to its Medicaid and CHP+ clients. These cost-containment opportunities are made possible by an assortment of efforts to consolidate and streamline the delivery process, thus maximizing a number of potential efficiencies. assure delivery of appropriate, high quality health care and expand and preserve health care services in the most cost-effective manner possible, as well as design programs that result in improved health status for clients served and improve health outcomes.

Department Performance Measures by Fiscal Year					
Goal	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Contain Health Care Costs	• Complete Phase I of the Accountable Care Collaborative. • Implement payment reform via the Benefits Collaborative, National Correct Coding Initiative, and Behavioral Health Organization rate reform. • Reduce the number of hospital readmissions within 30 days by 4% from FY 2010-11. • Initiate development of a data strategy for long-term containment of health care costs.	• Reduce Medical Services Premiums expenditures for clients enrolled in the Accountable Care Collaborative (ACC) by 7% compared to clients not enrolled in the ACC. • Audit Community Mental Health Centers. • Money Follows the Person: Reduce Medical Services Premiums expenditures for nursing facilities by 0.7% from FY 2011-12. • Implement the federal integrated care for dual eligibles contract.	• Implement integration findings through ACC and Behavioral Health Organization (BHO) contracts. • Develop a value-based reimbursement methodology for primary care providers / replace the current 'pay for volume' system. • Replace cost-based rate methodologies with acuity adjusted value-based payments.	• Reduce or stabilize utilization of the top 10 cost drivers* compared to "pre-health care reform" baseline in FY 2008-09. **Measured by units of events per 1,000.*	• Pay providers a prospective bundled payment based on the client-specific episode of care. • Reimburse Long Term Care services based on an improved/modified assessment tool.

***Strategy*:** The Department intends to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. The Accountable Care Collaborative (ACC) is Colorado's newest Medicaid program designed to improve health outcomes and control costs by providing coordinated care to fee-for-service clients. The ACC is comprised of Regional Care Collaborative Organizations (RCCOs), ultimately accountable for improving the health of our clients and reducing costs, Primary Care Medical Providers (PCMPs), responsible for providing comprehensive primary care, and the Statewide Data and Analytics Contractor. The ACC changes the incentives and health care delivery processes for providers from one that rewards a high volume of services, to one that focuses on the health outcomes of patients. The ACC controls costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources. Medicaid clients enrolled in the ACC receive services using the fee-for-service model, and also belong to a RCCO that provides care-coordination among providers and other community and government services. The

Department has procured seven RCCOs as well as a Statewide Data and Analytic Contractor (SDAC) to assist RCCOs in coordinating care and collecting data. The ACC intends to enroll 123,000 clients by November 2011.

The Department initiated the Benefits Collaborative pursuant to the Department's FY 2009-10 BRI-2 "Medicaid Program Efficiencies," which serves as the Department's formal benefit coverage policy development process. The overarching objective of the Benefits Collaborative is to ensure that benefit coverage policies are based on the best available clinical evidence while promoting the health and functioning of Medicaid clients. The Benefits Collaborative process is a transparent process that allows for stakeholders – including providers, clients, and client advocates – to collaborate with the Department to review draft coverage policies, which outline the appropriate amount, scope, and duration of Medicaid benefits.

Additionally, the Department will continue to identify baselines for current benefits and monitor data in an effort to track any changes or trends attributable to policy implementation. Reviewing utilization and expenditure data will help determine whether the goals of the Benefits Collaborative – defining clinical criteria, reducing inappropriate utilization, and promoting proper billing practices – have been met. The Department anticipates that these initiatives will not only result in cost savings but will also result in better health outcomes for clients as the Department begins to move the perception of Medicaid toward a commercial insurance product rather than a public benefit. As a result, the Department hopes to see fewer appeals for denial of non-medically necessary services and non-covered services and utilization data that aligns with the generally accepted best practices outlined in the benefit coverage policies.

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 its FY 2012-13 budget, the Department is also proposing to reform its fee-for-service payment system through a series of initiatives that will better align provider incentives with delivering quality, efficient care. Most of the initiatives involve an element of gainsharing, which is a payment methodology whereby providers receive a percentage of savings that result in other service categories from greater care management of their clients. Gainsharing puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against

benchmarks in predetermined service areas, so the gainsharing reforms are guaranteed to be either budget neutral or negative. The Department has identified payment reforms that are ready to be implemented in physical and behavioral health in FY 2012-13. In addition, the Department is proposing to study other potential reforms that would be implemented in a later fiscal year, particularly in the long-term care delivery system. For more information, please see FY 2012-13 R-5 "Medicaid Fee-for-Service Reform" in the Department's November 1, 2012 Budget Request.

Evaluation of Prior-Year Performance: With the change in administration, the Department has revised its Strategic Plan effective FY 2011-12. This has resulted in the revision or replacement of many of the Department's previous goals. Because many of these strategic performance measures are new, the Department is not able to evaluate prior-year performance. The FY 2011-12 figures in the table are based off prior-year actuals and are used as a benchmark for goals in future fiscal years.

In FY 2010-11, the Department procured seven RCCOs as well as a Statewide Data and Analytic Contractor (SDAC) to assist RCCOs in coordinating care and collecting data. By the end of the fiscal year, the Department had enrolled approximately 30,000 clients into the ACC.

One of the Department's benchmarks for FY 2011-12 is to reduce the number of hospital readmissions within 30 days by 4% from FY 2010-11. In FY 2010-11, there were a total of 4,995 readmissions within 30 days of discharge. This represents a 9.4% 30-day readmission rate. The highest rate of 30-day readmissions was 23.0% among the 45-64 age group (age 65 and older are not calculated as dual eligibles are excluded because of limited hospitalization data from Medicare, which is the primary payer).

5. Improve the Long-Term Care Service Delivery System

Objective: As the population ages and costs increase, long-term care continues to serve as a difficult category in the arena of public health care. Long-term care services are expensive, however the Department believes there are efficiencies that can yet be attained, thus minimizing and perhaps containing cost increases while continuing to deliver the same level of care. Transitioning clients from facility-based care to community-based care and consolidating waiver programs are efficiency opportunities the Department plans to immediately pursue.

Department Performance Measures by Fiscal Year					
Goal	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Improve Long-Term Supports and Services	• Develop a 5-year strategy to increase the number of dually eligible long-term care clients who have a health home. • Develop a 5-year strategy to improve long-term care population outcomes. • Develop a roadmap for waiver consolidation.	• Enroll 60% of the dual-eligible population into the Accountable Care Collaborative for a focal point of care. • Transition 100 persons from facility-based care to community-based care. • Implement the roadmap for waiver consolidation.	• Enroll 70% of the dual-eligible population into the Accountable Care Collaborative for health homes. • Transition 100 additional persons from facility-based care to community-based care.	• Maintain 70% of the dual-eligible population in the Accountable Care Collaborative for health homes. • Transition 100 additional persons from facility-based care to community-based care. • Increase the number of Colorado nursing homes in the top quartile of the Centers for Medicare & Medicaid Services' National Report Card by 9% from the prior fiscal year. • Improve the average performance of Home and Community Based Services providers and case management organizations by 10% from the prior fiscal year.	• Maintain 70% of the dual-eligible population in the Accountable Care Collaborative for health homes. • Transition 100 additional persons from facility-based care to community-based care. • Increase the number of Colorado nursing homes in the top quartile of the Centers for Medicare & Medicaid Services' National Report Card by 4% from the prior fiscal year. • Improve the average performance of Home and Community Based Services providers and case management organizations by 10% from the prior fiscal year. • Reduce the total number of waivers to 6 or less. • Reduce the number of people on waiver waitlists by 10% from the prior fiscal year.

***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.

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 is designed to provide enhanced transition services to clients currently living in nursing facilities in order to transition them to the community. Clients residing in nursing facilities for greater than 90 days are eligible for the program and can receive MFP services for 365 days. Colorado Access to Community-Based Transitions & Services (CO-ACTS) is Colorado's MFP initiative for which the Department received $22 million for five years from CMS in February 2011. The vision for this grant is to transform long-term care services and support from institutionally-based and provider-driven care to person-centered, consumer-directed and community-based. The Department anticipates 100 clients per year will receive services and transition to the community setting starting in July 2012. With the ability to provide additional services through the grant, the Department intends to improve clients' quality of life and realize savings as clients move from nursing facilities. Colorado's LTC system will become more person-centered, navigable, and integrated, making it easier to coordinate between agencies, providers, consumers and families, so that the elderly and adults with disabilities have greater access to home and community services instead of facing institutionalization, and can continue to successfully transition into the community.

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. Over the past several years, expenditures through these waivers have increased much more rapidly than the number of Developmental Disability (DD) clients being served. In January 2011, the legislative Joint Budget Committee (JBC) requested that the departments work together with Community Centered Boards and submit a report with recommendations regarding whether the DHS Division for Developmental Disabilities should be transferred from DHS to the Department. Governor Hickenlooper redirected the departments to instead cooperate with each other in efforts to improve efficiencies in the delivery of services to the developmentally disabled and to inform the JBC and General Assembly in writing as efforts progressed. The departments are working together to develop a plan for implementing the Governor's direction in a manner that would entail stakeholder participation, assessing existing processes and frameworks, and seeking solutions for effectively and efficiently meeting the diverse needs of various affected groups.

Evaluation of Prior-Year Performance: With the change in administration, the Department has revised its Strategic Plan effective FY 2011-12. This has resulted in the revision or replacement of many of the Department's previous goals. Because many of these strategic performance measures are new, the Department is not able to evaluate prior-year performance. The FY 2011-12 figures in the table are based on prior-year actuals and are used as a benchmark for goals in future fiscal years.

In FY 2010-11, the Department secured the MFP grant and has begun to host a series of workgroups, stakeholder meetings, public forums to solicit information regarding opportunities and barriers to community transition, as well as input on benefits and services to be provided to MFP clients.

IV. OPERATIONAL PLANS

Introduction

In past years, the Strategic Plan included five overarching objectives tied to its core business as well as division-specific objectives that related to the Department's vision in accordance with direction from the Office of State Planning and Budgeting. Beginning with this submission, the Department is including its internal operational plans for each applicable office, division, or section as a replacement for the division-specific objectives. The Department believes that this transparency allows for the operational plans for each office, division, and section to be both viewed on its own and be tied directly to the Department's vision, Strategic Plan, and its 5 objectives. The following crosswalk shows the relationship between each of the operational plans that follow and the Department's Strategic Plan.

Operational Plan to Strategic Plan Crosswalk					
Operational Plan	**Increase the Number of Insured Coloradans**	**Improve Health Outcomes**	**Increase Access to Health Care**	**Contain Health Care Costs**	**Improve Long-Term Supports and Services**
EDO - Audits & Compliance Division	X	X	X	X	X
EDO - Human Resources Section	X	X	X	X	X
EDO - Legislative Liaison	X	X	X	X	X
EDO - Public Information Officer	X	X	X	X	X
FASO - Budget Division	X	X	X	X	X
FASO- Controller Division	X	X	X	X	X
FASO - Safety Net Programs Section	X		X	X	X
FASO - Provider Operations Division	X	X	X	X	X
FASO - Strategic Performance Unit	X	X	X	X	X
MCPAO - Medicaid & CHP+		X	► 3a, 3b	► 4a, 4b, 4c	
MCPAO - Quality & Health Improvement Unit		► 2a, 2b, 2c	X	X	X
MCPAO - Long-Term Care Benefits Division	X	X	X	X	► 5a, 5b, 5c, 5d
MCPAO - Pharmacy Section		X	X	X	
MCPAO - Data Analysis Section		► 2d		► 4d	X
MCPAO - Fee for Service Rates		X		► 4c	► 5b, 5c
MCPAO - Managed Care Rates		► 2d	► 3a	► 4a, 4b, 4c	
OCCR - Office of Client & Community Relations	► 1a, 1b, 1c, 1d		► 3c, 3d	X	

X = Operational plan supports the Strategic Goal

► = Operational Plan directly impacts Strategic Plan Performance Measures

Increase the Number of Insured Coloradans	*Improve Health Outcomes*	*Increase Access to Health Care*	*Contain Health Care Costs*	*Improve Long-term Supports and Services*
• 1a) 87% of eligible children are enrolled in Medicaid. • 1b) 64% of eligible children are enrolled in CHP+. • 1c) 76% of eligible parents are enrolled in Medicaid. • 1d) Determine annual benchmarks to measure enrollment of newly eligible populations under HB 09-1293 expansions.	• 2a) Reduce the percent of Medicaid children with dental caries experience from 57.2% to 55%. • 2b) Increase the percent of Medicaid children who receive a dental service from 49% to 51%. • 2c) Increase the percent of CHP+ children who receive a dental service from 44% to 46%. • 2d) Initiate development of data strategy for long term integration of clinical & claims data.	• 3a) Increase the percent of adult Medicaid clients that have a medical home or focal point of care from 38% to 42%. • 3b) Increase the percent of Medicaid children that have a medical home or focal point of care from 78% to 80%. • 3c) Increase provider participation in Medicaid by 5% above the 27,336 providers in FY 2010-11. • 3d) Determine appropriate benchmarks to measure increases in provider participation to serve future expansion populations.	• 4a) Complete Phase I of the Accountable Care Collaborative. • 4b) Implement payment reform via Benefits Collaborative, NCCI, and BHO rate reform. • 4c) Reduce the number of hospital readmissions within 30 days by 4% from FY 2010-11. • 4d) Initiate development of a data strategy for long-term containment of health care costs.	• 5a) Develop 5-year strategy to increase # of dually eligible LTC clients who have a health home. • 5b) Develop a 5-year strategy to improve long-term care population outcomes. • 5c) Develop a roadmap for waiver consolidation.

Executive Director's Office

Audits & Compliance Division

Purpose: Promote improvement and efficiencies through the sharing of audit/review findings. Establish accountability and efficiency of state and federal funds paid to Medicaid enrolled providers for covered items or services to eligible clients.

Strategic Goal/s Supported: The Audits & Compliance Division supports all of the Department's strategic goals by working to improve the accuracy of internal business processes. Business processes that are audited and targeted for improvement by this division include eligibility determinations, claims payments, cost allocation plans, federal funds reporting, and recoveries.

Staffing Resources:
Total FTE appropriated to organizational unit: 25.0 FTE

Assumptions: It is assumed that the Audits & Compliance Division will be fully staffed. That staff and fraud and abuse detection tools planned for are funded. That our CMS partners and their Contractors meet project timeline deadlines.

Objective	Action Plan	Measurement Plan
1. Improve the accuracy of claims payments and eligibility determinations.	a. The Audit Section will begin work with Program Staff to identify cost-effective actions that will achieve desired corrections by September 2011. b. The Audit Section will submit final corrective action plan by due date set by CMS of February 2012. c. The Audit Section will work with Program Staff to implement the plan – June 2012. d. The Audit Section will monitor progress in plan - beginning June 2012.	• PERM corrective action plan is developed and ready to implement by February 2012.
2. Develop an internal audit plan by September 15, 2011.	a. The Audit Section will research other states' methods for risk assessment and audit plans by July 15, 2011. b. The Audit Section will identify Department programs and procedures by July 31, 2011. c. The Audit Section will identify the type of risk based on previously noted Department programs and procedures. Accomplished by August 15, 2011. d. Rank areas of risk by August 30, 2011. e. Audit Section will develop a draft risk plan by September 15, 2011.	• Develop Draft audit plan by September 15, 2011.
3. Formulate a plan to assess internal controls of the Department by January 2012.	a. The Audit section will do flowchart of duties of Internal Audit staff to establish process and learn software by August 2011. b. Audit Section will complete an Internal Control Questionnaire for Internal Audit staff by August 2011. c. Complete written plan for internal control assessment by January 2012.	• Complete written plan for internal control assessment by January 2012.
4. Devise a method to audit county cost allocation plans by May 2012.	a. The Audit Section will research all rules, regulations, laws and agency letters regarding cost allocation planning by October 2011. b. The Audit Section will devise a plan to audit county-wide cost allocation plans by May 2012. c. The Audit Section will audit two plans by May 2012. d. The Audit Section will report results to appropriate Department staff by May 2012.	• Report findings in writing to appropriate Department personnel by May 2012.

Objective	Action Plan	Measurement Plan
5. Works toward decreasing the number of repeat audit findings by 5%.	a. The Audit Section will develop a ranking system for prior year audit recommendations to assess their criticality by August 2011. b. The Audit Section will identify one outstanding audit recommendation based on method identified above by September 2011. c. The Audit Section will work with Department staff to assist in audit recommendation implementation by November 2011. d. Draft of ranking system for prior year audit recommendations to assess their criticality by August 2011. e. Identification and management approval of one outstanding audit recommendation for initial focus by September 2011. f. Work toward assistance of Department staff in audit recommendation implementation by November 2011.	• Draft of ranking system for prior year audit recommendations to assess their criticality by August 2011. • Identification and management approval of one outstanding audit recommendation for initial focus by September 2011. • Work toward assistance of Department staff in audit recommendation implementation by November 2011.
6. Work toward improving the administrative eligibility processes by conducting two eligibility audits by June 30, 2011.	a. MEQC staff will develop pilot proposals by August 2011 and February 2012. b. MEQC staff will conduct pilot by March 2012 and September 2012. c. MEQC staff will submit final reports to CMS and the Department by May 2012 and November 2012.	• Pilot proposals approved by August 2011. • Conduct pilot reviews by September 2012. • Pilot reports submitted by May and November 2012.
7. Increase the number of Program Integrity cases opened by 10% over current baseline.	a. 10% quarterly increase to the benchmark numbers will be the result of the cumulative efforts of the Claims Investigation Unit, two Contingency Contractors and the contract manager, Investigative Liaison, Section Manager and the three (3) Data Analysts. Fiscal quarterly numbers will be logged no later than: • October 10, 2011 • January 10, 2012 • April 10, 2012 • July 10, 2012	• Use Benchmark Numbers from FY 2010-11
8. Conduct a minimum of two "data-only" projects each quarter during FY 2011-12.	a. The PI Section will identify "data-only projects and a minimum of one data-only project will be finalized by each individual PI Data Analyst each quarter. b. PI Data Analysts will partner with each policy manager to devise the data query criteria for each data review and to identify pertinent rules, policy guidelines, Provider Bulletins and/or Billing Manual instructions. c. With the conclusion of each data-only review, findings that result in NO overpayment identification but indicate improper billing practices will be provided to policy managers for follow up with providers. d. A finalized data-only project will be logged when overpayment demand letters are sent each fiscal quarter.	• The Program Integrity section has documented the completion of at least eight *data-only projects by June 30, 2012. *"Data-only" projects use data to identify overpayment. These projects do not require provider records.

Objective	Action Plan	Measurement Plan
	e. Case summary documentation will include policy manager involvement in development of the data-only projects each fiscal quarter. f. All data-only project summaries will be provided to the policy managers as a feedback loop for awareness of review findings, education given to providers and for dollar amounts of overpayments involved for recovery action each fiscal quarter.	
9. Work toward recovering $10 million in provider overpayments by June 30, 2012.	a. PI develops a specific plan for obtaining recoveries by August 15, 2011. b. Implement RAC portion of work plan according to RAC contract. c. Present plan to Division Director by September 1, 2011. d. PI Recovery Officer tracks PI recoveries. e. Plan completed for obtaining recovery by August 15, 2011. f. RAC recovery plan completed per timeline in RAC contract. g. Plan presented to Division Director by September 1, 2011.	• Recoveries are $10 million by June 30, 2012.

Human Resources Section

Purpose: The Human Resources Section guides managers through the hiring process to hire the right applicants into the right positions while complying with all State personnel rules and regulations. In addition, this section supports managers throughout the personnel evaluation and planning process, which is designed to incent successful performance and make improvements where needed. The Human Resources section focuses on training and retraining Department employees, and develops or leads special projects where HR expertise is needed.

Strategic Goal/s Supported: Because the Department depends on high-performing employees to reach all of its strategic goals, this section provides essential internal support to increase the number of insured Coloradans, improve health outcomes, increase access to health care, contain health care costs, and improve long-term supports and services.

Staffing Resources:
Total FTE appropriated to organizational unit: 10.0 FTE.

Assumptions: The assumptions outside of the organizational unit's direct control necessary to achieve the operational plan are working with DPA training schedules to ensure managers are trained within 60 days of hire. Also the DORA system can only be implemented if DORA is prepared to go live by September 1, 2011.

Comments: The department needs to maintain a low turnover rate through the next performance year and to provide trainings. These trainings are primarily targeted at management in supervisory classes, but will also identify strengths and weaknesses of pilot employees for a 360 program. There will be a 360 assessment study over the next 9 months by March 2012 to assist in this assessment. The office or Division that have signed up for the Pilot must complete their 360 assessments and supervisory trainings by allotted time frames.

Objective	Action Plan	Measurement Plan
1. Complete the implementation of the online personnel PAR personnel and position request forms system PEAT by September 1, 2011.	a. The HR Office Manager will work with DORA administrators to implement the PEAT system. b. All managers will receive their monthly topical trainings according to the HR training needs.	• PEAT is ready for Department use by September 1, 2011.
2. Require all Department managers to attend DPA's training on the Nuts and Bolts of Supervising State Employees.	a. The training Specialist will work with Benefit Manager to ensure New Employee Orientation (NEO) attendees are ear marked for supervisor trainings presented from DPA. b. The training specialist will compile a list of all existing supervisors and document if/when they received this training in the past. c. Managers who received this training in the past but not within the last three years will be given instructions to take a refresher training. d. The training specialist will develop a system for adding new supervisors to the list on a go-forward basis and will review the list once a year to ensure compliance.	• The training specialist has documented by June 30, 2012 that all supervisors have received this training, or a refresher version, within the last three years.
3. Procure and utilize a 360 feedback tool to identify areas of strength, and areas for growth and development of department employees.	a. Purchase 360 tool from CSU. Provide the tool to sections that have opted in for the pilot. b. Chart responses and submit to CSU for interpretation. c. Draft decision and submit to Executive Committee for performance outcomes. d. Identify training needs	• Assessments are completed in increments of 33% for each remaining quarter of the performance year. • Evaluate appropriate tools to accomplish 360 review by March 31, 2012.

Legislative Liaison

Purpose: Provides accurate, candid and timely information to the public and the General Assembly on Department initiatives and legislation in order to increase awareness and understanding. In so doing, enhances the Department's opportunities for success with regard to its strategic goals.

Strategic Goal/s Supported: The Legislative Unit drives progress on all Department strategic goals by collaborating with internal and external partners to maximize awareness and consensus on legislation and initiatives.

Staffing Resources:

Total FTE appropriated to organizational unit: 2.0 FTE.

Assumptions: Coordination with the Governor's policy and budget office is critical, as is the technical expertise provided by staff.

Objective	Action Plan	Measurement Plan
1. Work towards passage of all of the Department's legislative agenda items.	a. Engage an internal team to review proposals and provide input to Executive Committee b. Ensure all proposals receive appropriate vetting from internal staff. c. Work with legislators, legislative staff and stakeholders to gain support on Department initiatives. d. Educate and prepare staff on the legislative process e. Work with program staff to build support of impacted stakeholders	Success in meeting the objective will be measured by: 90% of the Department's bills are passed and signed by the Governor.
2. Work towards passage of all of the Department's Budget requests.	a. Coordinate with Department staff as needed to provide background on coordination of legislative and budget initiatives b. Work effectively with members of the JBC	Success in meeting the objective will be measured by: 90% of budget requests are agreed to by the JBC.
3. Work towards passage of bills whose appropriations are consistent with Department fiscal notes.	a. Prepare staff on the legislative process b. Work with lobbyists, stakeholders or legislators as needed c. Communicate between Department staff and Governor's and Legislative staff to reconcile differences of opinion regarding estimates of fiscal impact.	Success in meeting the objective will be measured by: All bills passed during the 2012 session have fiscal notes and appropriations consistent with the Department's estimate of fiscal impact.
4. Work towards on-time legislation implementation for bills passed in 2011.	a. Coordinate internally with the implementation lead to review progress of statutory deliverables b. Communicate with stakeholders and legislators as needed c. Update bill implementation spreadsheet with timely information.	Success in meeting the objective will be measured by: All bills passed in 2011 that require Department implementation beginning in FY 2011-12 will be reported as "on track" by June 30, 2012.
5. Develop communications plan.	a. Build relationships with legislators and stakeholders b. Communicate regularly with internal staff on updates from the General Assembly c. Develop a scheduled communication with legislators on Department Initiatives d. Develop a Legislator packet with information about Department's initiatives and strategic goals	Success in meeting the objective will be measured by: The Legislative Office has an Executive Director-approved communications plan in effect by January 1, 2012.

Public Information Officer

Purpose: Distribute accurate and timely information about the Department through media, internal communications, Department publications, and materials to enable a well-informed public to provide informed consent of Department-proposed initiatives and legislation..

Strategic Goal/s Supported: The Public Information Office impacts all Department strategic goals. It provides support to all sections on communication plans.

Staffing Resources:
Total FTE appropriated to organizational unit: 2.0 FTE.

Assumptions: The Public Information Office is informed by Department staff about initiatives, progress, program changes, and potential crises.

Comments: "Public" includes staff, advocates, press, CBMS workers, clients, community-based organizations, legislators, and providers.

Objective	Action Plan	Measurement Plan
1. Develop a strategic Department communication plan.	a. Work with Asst. PIO to assemble information for the plan. b. Draft the plan. c. Receive ED approval. d. Edit and finalize the plan and communicate to staff.	• Final strategic communication plan to ED by December 15, 2011
2. Work toward interagency communication and collaboration	a. Create Interagency communication committee- CDPHE, DHS b. Develop goals and objectives	• Committee formed by October 30, 2011 • Goals and objectives developed by December 15, 2011
3. Work toward improving client health literacy.	a. Develop a plan to incorporate education into all Departmental client communication to include measurements b. Collaborate with MCPAO to assess existing educational materials and strategies c. Evaluate all materials sent to clients d. Collaborate with advocacy organizations	• Gather baseline information by June 30, 2012 to set a measurable target for health literacy in FY 2012-13
4. Work toward changing the image of Medicaid	a. Work with MCPAO to select names for Accountable Care Collaborative, AwDC, Medicaid by March 12, 2012 b. Begin marketing new Accountable Care Collaborative and AwDC name by February 1, 2012 c. Engage the services of a PR firm to assist with a new name for Medicaid if the budget allows by March 15, 2012	• Names selected by March 12, 2012 • Marketing of names beginning February 1, 2012 • Plan received by PR firm as to how to roll-out new Medicaid name June 30, 2012
5. Improve stakeholder's perception of effective Department communication by 5% over existing levels.	a. Survey stakeholder groups to obtain baseline by November 15,2011 b. Conduct second survey for rate of improvement by June 30, 2012	• Increase in stakeholder perception of effective communication by 5% by June 30, 2012

Objective	Action Plan	Measurement Plan
	c. Finalize distribution lists for all stakeholder groups. d. Assess all Department publications. e. Evaluate all publications for effectiveness. f. Streamline publications where applicable. g. Develop new publications as applicable.	
6. Implement social media.	a. Develop social media policy b. Set up Twitter account. c. Publish weekly tweets. d. Measure number of retweets to establish baseline. e. Research capability and reasonability of other social media, (e.g., blogs)	• Evidence of Twitter account by October 15, 2011. • Evidence of weekly providing baseline for measurement. • Tweets by June 30, 2012. • Research conducted by May 15, 2012.
7. Increase the use and the usability of the Web site	a. Continue to work with Colorado.gov to receive Google Analytics to develop a baseline of users. b. Analyze data and make changes. c. Research testing tools for usability. d. Obtain testing tool by March 15, 2012 e. Hire a webmaster by February 1, 2012	• Determine baseline data one month after Colorado.gov releases the tool

Financial & Administrative Services Office

Budget Division

Purpose: The Budget Division exists to develop, manage, and defend the Department's budget. The division seeks to maximize the value of Department funding resources by maintaining high standards of accuracy, gaining approval of Department requests for funding, and providing effective and timely reports that support the needs of Department staff, its partners, and the people of Colorado. The division provides high-quality information to the public, policy-makers, partners, and stakeholders transparently, honestly, and respectfully, fostering trust and confidence.

Strategic Goal/s Supported: The Budget Division serves a vital supporting role, helping the Department achieve its goal of containing health care costs. This then enables the Department to more efficiently reach the goals of increasing the number of insured Coloradans, as well as increasing access to health care.

Staffing Resources:
Total FTE appropriated to organizational unit: 17.0 FTE.

Assumptions: The Budget Division will implement activities necessary to meet its operational plan objectives in FY 2011-12. The operational plan represents a large-scale blueprint highlighting key structures and supports needed to fulfill the Budget Division's goal and the mission of the Department; it is not inclusive of all activities to be undertaken by the Budget Division in meeting its objectives. Although individual units within the Budget Division may have specific responsibilities listed in the Operational Plan, all members of the Budget Division play an important role in its implementation.

Comments: The Budget Division provides high-quality information to the public, policy-makers, partners, and stakeholders transparently, honestly and respectfully, fostering trust and confidence. To achieve its goal, the Budget Division must engage in effective communication and information-sharing within the Department and critically examine and challenge the information it receives. A collaborative work environment is needed to enhance understanding of budget documents and processes and increase the accuracy and flow of information between Department programs and the division. In addition, effective forecasting, planning, and managing of expenditures is needed by the Budget Division to help the Department avoid inefficient over- and under-expenditures, unanticipated changes in funding for its programs, and enable Department leaders and governing authorities to make informed and effective policy decisions. Strong subject-matter expertise attained through various methods of training and development is a fundamental trait desired among division staff. Internal consensus indicates that improvement in this particular area is needed.

Objective	Action Plan	Measurement Plan
1. The Budget Division will provide good customer service as measured by its annual department survey.	a. All Budget staff will adhere to the established code of conduct at all times. b. The Budget Director will encourage a spirit of expenditure accountability among EC members and Department managers at monthly managers meetings. c. Budget staff will demonstrate customer-service by responding to all inbound	The Budget Division annual department-wide survey indicates that at least 70% of respondents rate Budget Division staff in the top two

Objective	Action Plan	Measurement Plan
	inquiries within 24 hours. d. Budget staff will act as a resource for any staff person requesting training or assistance understanding details falling within their budget related purview. e. Budget staff will proactively solicit status updates from relevant external staff for all lines in which they possess oversight responsibility at least monthly and be prepared to report as needed/requested at Unit Staff Meetings and/or one-on-ones. f. Budget analysts will help program staff understand and manage spending authority for their line items by initiating periodic dialog to discuss details and status of the projects and initiatives affecting their areas of responsibility. g. Budget Leadership will establish clear expectations for their employees pertaining to managing and monitoring line items. h. The Budget Division's Annual Survey will be evaluated, adjusted, and issued (one for distribution within the Division and one for distribution throughout the Department) and the results analyzed to measure the perceived level of success of the Division's customer service efforts.	quintiles on questions related to customer service. Specific aspects within the survey that comprise customer service include: • Communication • Professionalism • Collaboration • Courtesy • Information-sharing
2. The Budget Division will work toward eliminating errors in deliverables it submits to OSPB	a. Budget analysts will utilize an established analyst self-check review system to identify and resolve potential technical errors in their work. b. Where no self-check review yet exists, the Division will evaluate and consider developing. c. Budget analysts will utilize the established peer review system to critically examine OSPB-related deliverables to identify and resolve potential errors or weaknesses prior to submission. d. After peer review has been completed (above), a member of Budget Leadership will review all deliverables for quality prior to submission to the Budget Director. e. Budget Leadership will ensure follow-up coaching is provided to staff whose actions or omissions result in the need to submit avoidable change requests. f. Budget Leadership will evaluate for common mistakes and develop processes to minimize their occurrence in the future.	Division Leadership believes strongly in the necessity to provide accurate, lucid information of highest professional quality to OSPB. The Division recognizes and believes that certain objectives are essential, yet not measurable within conventional constructs.
3. The Budget Division will conduct two training/educational classes for departmental employees and three for division employees	a. Budget staff will identify areas where division-wide training is required or desired and will proactively take steps to ensure training is available. b. Budget staff will offer three training sessions for Budget staff. c. Budget staff will provide two training courses for Departmental staff	1) Two Departmental trainings will be provided by Budget Division staff. 2) Three trainings will be provided for Division staff by Division staff.
4. As part of a multi-year objective, the Budget Division will complete an assessment of all of its existing reports. NOTE: The larger multi-year	a. Budget staff will compile a comprehensive list of all reports it currently produces. b. Each report will be evaluated for possible revision, simplification, consolidation, or discontinuation. c. Each report will be further evaluated for content and form with particular emphasis on identifying opportunities for effectively addressing/integrating unmet needs.	By June 30, 2012, the Division will have a final comprehensive list of all existing reports deemed necessary for supporting the Department's management of appropriations. As predicate to a future year objective toward meeting the larger

Objective	Action Plan	Measurement Plan
objective is: The Division produces reports that help managers manage their programs.	d. Budget Leadership will produce recommendations for all reports from "b" and "c", above.	objective (see note in first column), the Division will possess recommended actions to be taken related to existing reports.
5. The Budget Division will work toward creating a Utilization Tracking/Mgmt. system.	a. Budget staff will define what Utilization Tracking/Mgmt is. b. Budget staff will determine what the Division hopes to accomplish as the result of employing a Utilization Tracking/Mgmt. system c. Budget Leadership will determine appropriate next steps for continuation of progress toward accomplishing the overall objective d. Budget staff will establish timeframe for the completion of next steps created in "c" above e. Budget Leadership will assign next step duties to appropriate Budget Staff	By June 30, 2012, the Budget Division will possess a definition of what Utilization Tracking/Mgmt is, as well as what will be accomplished through its implementation. The Budget Division will determine and assign next step duties related to the creation of a Utilization Tracking/Mgmt system.

Controller's Division

Purpose: The goal is to ensure the proper recording and reporting of financial events that occur in the Department in compliance with generally accepted accounting principles and State and federal rules and regulations.

Strategic Goal/s Supported: The Controller's Division goal is to continually assess and evaluated the quality of our work and provide complete and honest information to the public and each other and to ensure taxpayers are confident that dollars appropriated to the Department are spent wisely and consistently within the mission and goals of the Department.

Staffing Resources:
Total FTE appropriated to organizational unit: 20.0 FTE.

Assumptions: The Controllers Division will implement activities to meet its operational plan objectives in FY 2011-12, including development of collaborative performance plans that support the Controller Division's Operational Plan objectives. Objective 1 & 5 are to develop data in order to measure accuracy of reporting in future years.

Comments: Unanticipated audit requests and supporting documentation as well as the economic environment have continued to impact staff regularly throughout the past few fiscal years. ARRA and the Governor's restrictions have been areas which required the Controller's Division to shift its resources in order to meet its objectives in the most effective and efficient manner possible.

Objective	Action Plan	Measurement Plan
1. Develop base line data to asses accounting error rates.	Will invite and involve staff from other offices, divisions, and sections in the following efforts: a. Participation of Budget and Finance Office, Contracts/Purchasing Section, Contracts and Monitoring Section, Legal Division and Audits Section in Controller Division meetings b. Participation of Department staff in Controller Division meetings to provide training on Department's programs, Open/ Close Training and Travel Training.	a. Each quarter compile listing of revision to federal reports and reason why report was revised. b. Annually review year end exhibit and record number of times modified and why. c. Annually list any Accounts payables that were not recorded and why.
2. Document 75% of the processes being performed within the Controller's Division in an approved format by March 31, 2012.	a. Identify all of the programs and related processes within the Controllers Div. These will be reviewed on a quarterly basis. b. Document position procedures within the Controller's Div. in approved format by March 31, 2012.	a. List of procedures by position is posted to the shared drive and reviewed with the Controller and Accounting Manager. b. Individual Desk Procedures and a Master Procedure Manual are created and reviewed by Unit Supervisors, the Accounting Manager and the Controller.
3. Require Controller Division staff to cross-train on 3 procedures outside of their responsibility by March 31, 2012.	a. Meet with Controller Div staff to identify their areas of interest by August 30, 2011. b. Create a cross-training plan for the Controller Div by September 30, 2011.	Performance Evaluations conducted in April show that all staff members are cross-trained on 3 procedures by March 31, 2012.
4. Increase the use of Journal Voucher upload process.	a. Identify all manual transactions within the Controllers Div by September 30, 2011. b. Determine which manual COFRS Journal Vouchers could be eliminated by making changes to MMIS and purpose of each entry.	A listing of each transaction and documentation of the purpose of these transactions will be identified by position in each of the units in the Accounting Section. This will be completed by September 30, 2011.
5. Develop matrix to ensure accurate reporting on Federal reports.	a. Review the CMS approved State Plan and the CMS-64 to ensure that expenditures are being reported appropriately. b. Involve staff from program to review coding, expenditures and state plan by line of the CMS64. c. Meetings are scheduled to take place at least monthly.	A federal reporting matrix is approved by the Controller Division Director by June 30, 2012.

Safety Net Programs Section

Purpose: The Safety Net Programs Section exists to administer, allocate and establish funding to qualified medical providers who serve the indigent population, and to research methods for leveraging federal funds, and funds from other sources, to offset the expenditure of State General Funds to maintain or increase reimbursement levels to qualified medical providers.

The Section administers the Colorado Indigent Care Program, the Primary Care Fund, the Old Age Pension State Medical Program, the Medicaid School Health Services Program, the Hospital Provider Fee Model and the Hospital Provider Fee Advisory and Oversight Board, and the Nursing Facility Provider Fee Model.

Strategic Goal/s Supported: The Safety Net Programs Section supports the Department's strategic goals to Increase the Number of Insured Coloradans, Increase Access to Health Care, Contain Health Care Costs, and Improve Long Term Supports and Services through developing and administering the following:

- Financing models that fund expansions to Medicaid and CHP+ enrollment,
- Financing models that fund the Hospital Quality Incentive Payments and the nursing facility pay for performance payments
- Financing models for Supplemental Medicaid and Disproportionate Share Hospital payments to reduce uncompensated care costs for community health centers, hospitals, nursing facilities, and school districts. (Reducing uncompensated costs supports access to care for Medicaid clients and low-income, uninsured Coloradans.)
- Financing mechanisms to draw additional federal funds into the Department's budget without expending state General Funds.

Staffing Resources:
Total FTE appropriated to organizational unit: 12.2 FTE

Assumptions: The objectives in this operational plan are predicated on maintaining current staffing and funding levels, receiving timely approval of State Plan Amendments from CMS, having cooperation from providers and other stakeholders, including advisory boards, and having a consistent federal regulatory environment.

Comments: The Colorado Indigent Care Program provides funding to participating hospitals and clinics to offset their uncompensated care costs for services provided to low-income Coloradans who are not eligible for Medicaid or CHP+. Expanded Medicaid coverage under the Colorado Health Care Affordability Act (hospital provider fees) and federal health care reform under the Affordable Care Act will reduce the number of uninsured Coloradans and the number of persons eligible for discounted services under the CICP.

The School Health Services Program provides federal Medicaid funds to participating school districts, funded by the districts' Certified Public Expenditures or uncompensated costs. In FY 2008-09, CMS required that the Department change its State Plan such that the districts must complete a cost report, participate in a time study, and submit claims through the MMIS. The Department reconciles its payments to districts following each fiscal year to the districts' allowable and certified costs. The new federal requirements substantially increased the administrative burden for the districts, and the cost reconciliation process results in many districts owing funds back to the Department each year. This has resulted in a significant loss in district participation from 93 in FY 2007-08 to approximately 54 in FY 2011-12.

Objective	Action Plan	Measurement Plan
1. The Safety Net Programs Section will update CICP policies and rules by February 28, 2012.	a. Review policies and rules to identify barriers to facilitate the transition of eligible clients from CICP to the Adults without Dependent Children Medicaid expansion program Solicit Stakeholders' input on proposed changes. b. Collaborate with Medicaid Expansion staff. c. Prepare applicable rules for revision and Medical Services Board review. d. Revise procedures and update program manual. e. Solicit stakeholders' feedback on impact of changes through annual provider meeting and stakeholder forums.	Success in meeting the objective will be measured by: • Proposed rule changes approved by Medical Services Board • Revised process reduces or eliminates gap in coverage for clients pending Medicaid eligibility determinations • Provider and Stakeholder's feedback reflects an overall approval of revised process
2. The Safety Net Programs Section will achieve 95% on-time submission rates for provider audits and data summary January 31, 2012.	a. Train new providers on data requirements and submission timelines b. Update provider data/ audit tracking files with current contact information of all participating providers c. Work with providers to determine timeline for audits d. Review requests for due date waivers. Approve as appropriate e. Use Stakeholder Forum, Newsletters and email to inform and remind providers of due dates f. Weekly monitoring of providers' due dates and overdue data/audits g. Provide consistent follow-up through calls and or email to providers who miss due dates	Success in meeting the objective will be measured by: • End of review period (March 31, 2012) analysis of Provider Audit Compliance Reports received on or before dates due indicates 95% or above overall compliance rate • End of review period (March 31, 2012) analysis of Provider Billing Data Summaries received on or before dates due indicates 95% or above overall compliance rate
3. The Safety Net Programs Section will increase School Health Services (SHS) district participation by 15% over 55 districts that have currently agreed to participate in FY 2011-12. *NOTE: this supports the section's longer term goal of returning the participating number of districts to FY 2007-08 levels or higher, e.g., at least 93 participating districts*.	a. Survey SHS provider community to gather feedback on program b. Develop and prioritize a list of districts/BOCES/ stakeholders to target c. Review and prioritize survey results for action and development of communications d. Develop method and schedule for outreach and communication efforts e. Develop materials and tools for outreach and information f. Reach out to provider community through email, newsletter, phone calls and mail for participation g. Implement and monitor the 1/12 interim payment change to the SHS Program reimbursement methodology. h. Implement a process whereby the Department (or its vendor) conducts the Medicaid Eligibility Rate determination process, alleviating the districts of a time-consuming process. i. Explore other mechanisms to reduce the districts' administrative burden in this program, such as alternative time-study methodologies.	Success in meeting the objective will be measured by: • Providers' participation attrition trend stabilizes or declines • A minimum of seven previously participating or new providers indicate an intent to enroll in the SHS Program, for a total of 62 districts.
4. The Safety Net Programs Section will present a	a. SNP staff will meet with the eligibility section and the AWDC team to learn how to identify those OAP clients that will remain in OAP	Success in meeting the objective will be measured by:

Objective	Action Plan	Measurement Plan
comprehensive analysis and projections of the OAP Health and Medical Care Program's caseload, utilization and expenditures for FY 2011-12 and FY 2012-13.	after implementation of AWDC b. Staff will model caseload, utilization and expenditures using various statistical techniques in making final recommendations to Budget.	• Staff will present findings and recommendations in a memo to section management. • Staff will submit approved information to Budget in time for the November Budget request.
5. The Safety Net Programs Section will construct and implement a plan to improve outcomes for the FY 2007-08 DSH Audit	a. The DSH Audit Team will present improvement recommendations to management prior to May 2011. b. Staff will train the Internal Audits section on the CMS 2552-96 cost report. c. Staff will compile the following data and submit it to the auditor by June 30, 2011. Hospital cost reports, hospital working papers, COFRS data and MMIS data relevant for the FY 2007-08 audits. d. Staff will work with targeted hospitals to provide Non-CICP uninsured data, Medicaid out-of-state data and Medicaid managed care data for FY 2007-08. e. Staff will survey all DSH hospitals regarding the OB requirement. f. Staff will research ways to demonstrate to CMS' satisfaction, that hospitals are permitted to retain their DSH payments. g. The DSH Audit Team will develop and enforce a timeline with the auditor that complies with deadlines prescribed in the purchase order. h. Staff will develop a process for verifying data entry into the DSH Limit spreadsheets.	Success in meeting the objective will be measured by: • DSH Audit Team will create an SOP based on this plan that will be used to guide future DSH Audits, by March 1, 2012. • DSH Audit Team will compare the findings and results of the FY 2007-08 audit over the findings of audits for previous years to document improvements that have been achieved
6. The Safety Net Programs Section will establish a calendar to meet budgetary and accounting needs.	a. Safety Net Financing Team will create a draft calendar by August 1, 2011. b. Calendar will be reviewed by Budget and Accounting by September 1, 2011. c. Final calendar will be reviewed monthly during the Financing Unit's Team weekly meetings.	Success in meeting the objective will be measured by: • Final calendar will be posted in the shared drive by September 15, 2011.
7. The Safety Net Programs Section will achieve federal approval of SPAs to increase supplemental reimbursements to providers	a. Staff will submit a SPA to create a physician supplemental payment for Memorial. b. Staff will work with CMS to finalize SPA 10-038 (IP CPE payments for Denver, University and Memorial)	Success in meeting the objective will be measured by: • SPA for Memorial will be submitted by September 30, 2011, and be approved by March 31, 2012. • SPA10-038 will be approved by CMS such that the funds are drawn before FYE.
8. The Safety Net Programs Section will implement SB 11-125, modifying reimbursement under the nursing facility model.	a. Staff will submit a SPA to CMS by July 30, 2011, for approval by December 31, 2011. b. Staff will present rules to the Medical Services Board for adoption by January 1, 2012. c. Staff will attend all nursing facility advisory meetings held by the	Success in meeting the objective will be measured by: • The SPA is approved by December 31, 2011. • Rules are adopted and effective January

Objective	Action Plan	Measurement Plan
	Department and provide updates on the modeling process. d. Staff will attend meetings as requested by the nursing facility associations. e. Staff will mail information in writing to nursing facilities describing the fee and payment calculations and due dates prior to changes in implementation.	1, 2012. • Reimbursement letters were mailed at least two weeks prior to implementation of any changes in fees or payments.

Provider Operations Division

Purpose:

The Provider Operations Division is responsible assisting the Department in maintaining and implementing policy. The Claims System and Operations Division is responsible for the execution of system contracts and the execution of projects related to the Department's strategic initiatives, Fiscal Agent operations, and systems compliance. The Purchasing & Contracting Services Section is responsible for the timely and effective execution of solicitations and contracts for the Department.

Strategic Goal/s Supported:

The Provider Operations Division provides support to the policy groups in actuating Department objectives in actuating Department objectives, contract management, project management and software development methodologies and practices. This Division provides support to the policy groups. Division Customers include the Department staff, as well as Centers for Medicare and Medicaid Services, and the provider community. The Purchasing & Contracting Services Section is assists the policy goals of the Department by drafting solicitations and contracts and then by the timely and effective execution of solicitations and contracts for the Department.

Staffing Resources:

Claims Systems and Operations Division; Total FTE appropriated to organizational unit: 38.0 FTE
Purchasing and Contracting Services Section; Total FTE appropriated to organizational unit: 12.0 FTE

Assumptions:

- The Division is fully staffed and Project Manager's are hired in a timely fashion;
- Centers for Medicare and Medicaid Services approves contracts within the initial 60-day review period;
- System projects have sufficient Department staff committed and actively involved;
- Business Analysts have the tools and resources (i.e., access to policy staff) that are necessary to complete their responsibilities;
- Solicitations are released and contracted completed within deadlines;
- Solicitation and contract priorities are clearly provided and supported;
- Statement of Works are developed sufficiently for contracts to be placed into the contract clearance process; and
- Solicitations have sufficient Department staff committed and actively involved.

Comments:
This Division relies heavily on cooperation from / coordination with other sections to be efficient and effective in executing Department solicitations and contracts. Because improvement in these areas is critical to the Purchasing and Contracting Services Section's ability to support the Department's strategic goals, making improvements to internal customer service ratings is the only objective for this year's Purchasing and Contracting Services Section's operational plan.

Objective	Action Plan	Measurement Plan
1. Full compliance with HIPAA 5010 federal regulations by June 30, 2012.	a. Complete Final Assessment (with contractor) b. Complete Remediation Plan (with contractor) c. Test in MMIS (with contractor)	Remediation plan has been implemented and signed off by Claims Systems and Operations Division.
2. Claims Systems and Operations Division complete and improve customer service scores for client satisfaction by 25% over previous survey results by December 31, 2012.	a. Completed internal client satisfaction survey b. Measure results and their relation to business process c. Implement associated changes based on metrics	a. Completed internal client satisfaction survey by December 31, 2011. b. Within 12 months, increase the internal client satisfaction scores by 25% over the baseline established in December 31, 2011.
3. Implement National Correct Coding Initiative edits into the MMIS by March 3, 2012.	a. Complete requirements with contractor b. Complete Test Plans with contractor c. Complete Post-Implementation testing	a. Executed contract with ACS b. Requirements, design and test documents completed c. Post-Implementation results achieve 98% success rate.
4. Purchasing and Contracting Services Section customer service survey results correspond to an improvement from below standard to above standard in client satisfaction scores (as compiled from Department Managers).	a. Completed internal client satisfaction survey (June 2011 , December 2011 and June 2012) b. All staff in the Section will receive two Customer Service Trainings in the Fiscal Year c. Customer service and communications Core Competencies in performance plans will receive a higher weight that other Core Competencies	The improvement is that a majority (over 50%) of the responses will rate the Section as Above Standard or Meets Standard, rather than Meets Standard or Below Standard.

Strategic Performance Unit

Purpose: The Strategic Performance Unit coordinates strategic planning projects such as annual benchmark-setting, performance measurement, and operational planning. Staff in this unit also comprise the Bridge Team, which brings resources and ideas together to help managers and staff solve strategic and operational problems. The Bridge Team also assists project leads with implementation planning, and monitors and reports to Leadership Team and Executive Committee on implementation progress for enacted bills and budget projects.

Strategic Goal/s Supported: The Strategic Performance Unit enhances the Department's ability to achieve all of its strategic goals by helping managers define strategic and operational objectives that are specific, measurable, assigned, realistic and time-bound. In addition, the unit's Bridge Team provides assistance to sections experiencing short-term strategic and operational needs. By assisting project leads with implementation planning, monitoring and reporting for enacted bills and budget projects, this unit facilitates executive prioritization of resources consistent with the Department's strategic goals.

Staffing Resources:
Total FTE appropriated to organizational unit: 2.0 FTE

Assumptions: The Strategic Performance Unit has no authority to enforce Department policies or recommendations. In its work to help managers and staff make progress on projects that support strategic goals, this unit relies on internal cooperation, persuasion and influence.

Comments:
There is currently little Department policy linking strategic and operational plan goals to employee performance evaluations or incentives. It is a long-term goal of the Strategic Performance Unit to coordinate with managers to explore opportunities to standardize employee performance evaluation plans and incentives in a way that links performance to strategic and operational plans.

Objective #2: The due date for submission of all Operational Plans is June 30, 2011. The July 31 evaluation cutoff date for this objective allows one month for managers to make final revisions. *Action Plan item e):* A "positive response" rate on training evaluation equals a response of "some" or "a lot" vs. "a little" or "none" on the automatically generated survey questions sent to all attendees via GoSignMeUp.

Objectives #4 & #5: "Green", "yellow" and "red" status indicators are defined on Bridge Team implementation reports. *Objective #4:* "Special bills" is a legislative term referring to enacted bills that are neither long appropriations nor supplemental funding bills.

Objective	Action Plan	Measurement Plan
1. Work toward achieving 100% of benchmarks in the Department's strategic plan for FY 2011-12.	a. Unit to work with the Budget Division to get OSPB approval of *revised* strategic plan benchmarks by November 1, 2011. b. Unit to evaluate strategic plan progress YTD by December 31, 2011 based on a review of JBC briefing and hearing responses. c. Unit to develop recommendations for action by January 15, 2012 to address progress delays toward strategic plan benchmarks. d. Unit lead to present recommendations for action based on YTD progress to Leadership Team on January 25, 2012. e. Bridge Team to assist as needed in implementing approved recommendations for action from February-June 2012.	• FY 2011-12 Strategic Plan performance evaluation reports 100% of benchmarks achieved. *This report is due in September 2012 from the Budget Division to OSPB as part of the Department's FY 2013-14 Budget Request.*

Objective	Action Plan	Measurement Plan
	f. Bridge Team to collaborate with the Budget Division to complete performance evaluation of FY 2011-12 Strategic Plan by September 30, 2012.	
2. Work toward achieving 90% "SMART quality" on all Department Operational Plan objectives submitted by September 1, 2011.	a. Unit lead to develop a scoring tool to evaluate "SMART quality" for Operational Plan objectives by October 1, 2011. b. Bridge Team to score all Operational Plans by October 31, 2011. c. Unit lead to request approval of an incentive award for Operational Plan leads with the top-3 SMART scores by December 1, 2011. d. Unit lead to present at least 3 Operational Plan training workshops per year. e. Unit lead to achieve a "positive response" rate of at least 90% on training evaluations from workshop attendees.	• Department-wide evaluation of FY 2011-12 Operational Plans using new scoring tool reports 90% of objectives meet "SMART quality" criteria by October 31, 2011. • Scores to be based on Operational Plans revised and submitted to the Strategic Performance Manager by September 1, 2011.
3. Report to Leadership Team on the outcomes of at least four Bridge Team projects by June 30, 2012.	a. Bridge Team to maintain tracking sheet of projects on SharePoint. b. Unit lead to assess progress on projects at least quarterly. c. Unit lead to report to Leadership Team on progress as needed.	• Bridge Team reports to Leadership Team on at least four projects by June 30, 2012.
4. Work toward implementing all FY 2011-12 requirements for 2011 "special bills."	a. Bridge Team to maintain on SharePoint the "2011 Legislative Session - Implementation and Planning Report" which defines project leads, summarizes implementation plans and reports on progress. b. Bridge Team to meet regularly with the Legislative Liaison and Legislative Analyst to discuss implementation status, potential political implications, and coordinate on bill-related projects as needed to meet objective #4. c. For bills experiencing implementation delays, Bridge Team to ensure budget analysts are involved in policy and implementation discussions to enable Budget Division to provide additional guidance and assistance or submit additional change requests.	• The Bridge Team's final report on implementation status of 2011 bills shows no bills in red status as of June 30, 2012.
5. Work toward implementing all approved "budget projects" with changes in funding for FY 2011-12.	a. Bridge Team to maintain the "New Funding by Project Report for FY 2011-12" which defines "budget projects" and provides benchmarks. b. For projects experiencing implementation delays, Bridge Team to ensure budget analysts are involved in policy and implementation discussions to enable Budget Division to refine budget estimates and submit additional change requests.	• The Bridge Team's final report on implementation status of budget projects for FY 2011-12 shows no projects in red status as of June 30, 2012.

Medical & CHP+ Program Administration Office

Medicaid & CHP+ Programs Division

Purpose: Medicaid & CHP+ Program Division is responsible for the administration and performance of Medicaid acute care services and programs that include both physical health and behavioral health and span the managed care continuum from fee-for-service to fully capitated risk programs.

Strategic Goal/s Supported: The division plays an important role in working toward the Department's mission to improve access to cost-effective, quality health care services for Coloradans by providing indirect support in the form of administrative and program assistance including policy research and other functions that strengthen the Department's ability to achieve strategic goals. This support includes monitoring utilization of services to reduce avoidable, duplicative, and inappropriate use of health care resources, while simultaneously developing and implementing programs that enhance care-coordination and patient satisfaction.

Staffing Resources:
Total FTE appropriated to organizational unit: 34.0 FTE

Assumptions: Several of the programs rely upon maintenance of current funding or staffing levels, statutory authority, timely cooperation from federal/other agencies in order to be successful. All objectives are assumed to be fulfilled within the FY 2011-2012, unless otherwise stated.

Comments: The division was recently reorganized in June 2011, with new positions to be filled during FY 2011-2012. In addition, Balanced Scorecard measures and tracking is now incorporated into the division operational plan, as well as individual performance plans.

Objective	Action Plan	Measurement Plan
1. Access a) Increase the number Medicaid clients with a medical home or focal point of care: • Adults from 38% to 42%; and • Children from 78% to 80%	a. Implement procedures to attribute and passively enroll clients in programs with PCPs, Medical Homes and Health Homes (e.g. ACC) b. Develop a plan to attribute Medicaid clients by working with Managed Care Rates Section to identify clients c. Formalize the attribution methodology process and transition to SDAC d. Initiate activities to integrate long-term care, behavioral and physical health programs such as: e. Establish a cross-section, cross-division workgroup that meets at least once per quarter f. Develop and submit the 2703 State Plan Amendment	Success in meeting the objective will be measured by: • 42% of adult Medicaid clients have a medical home or focal point of care. • 80% of children Medicaid clients have a medical home or focal point of care.

Objective	Action Plan	Measurement Plan
	(SPA) g. Develop and submit the Duals strategy to CMS	
b) Complete Phase I of the Accountable Care Collaborative (ACC) by executing and putting into operation 7 Regional Care Collaborative Organization (RCCO) contracts.	a. Negotiate 7 RCCO contracts that align with the goals of the ACC b. Work with the RCCOs to execute Primary Care Medical Providers (PCMP) contracts c. Establish an advisory committee that meets at least once per quarter	Success in meeting the objective will be measured by: • 7 RCCO contracts for the ACC are implemented • Advisory committee meeting minutes are posted on the Department's ACC Web site
2. Outcomes *For all Medicaid and CHP+ clients reduce:* a) Emergency Department (ED) visits from 804 visits per 1000 Medicaid clients to 700 visits per 1000 clients.	a. Establish a cross-section, cross-division workgroup that meets at least once per quarter b. Develop and implement a department-wide strategy that requires at least two interventions be implemented by end of the fiscal year.	Success in meeting the objective will be measured by: • Use the established Balanced Scorecard (BSC) criteria to monitor the health outcomes • ED visits reduced to 700/1000 FTE clients per quarter.
b) Unintended pregnancy rates from 58% to 53%	a. Establish a cross-section, cross-division workgroup that meets at least once per quarter b. Develop and implement a department-wide strategy that requires at least two interventions be implemented by end of the fiscal year.	Success in meeting the objective will be measured by: • Use the established Balanced Scorecard (BSC) criteria to monitor the health outcomes • Unintended pregnancy rates reduced by 5%
c) Reduce hospital readmissions within 30 days from 9.6% to 7.6% for all Medicaid clients.	a. Establish a cross-section, cross-division workgroup that meets at least once per quarter b. Develop and implement a department-wide strategy that requires at least two interventions be implemented by end of the fiscal year.	Success in meeting the objective will be measured by: • Use the established Balanced Scorecard (BSC) criteria to monitor the health outcomes • Hospital readmissions within 30 days reduced by 4%

Quality & Health Improvement Unit

Purpose: The purpose of the Quality & Health Improvement Unit is to advance the Department's mission by improving health outcomes and the quality of care for Coloradans served by Medicaid and Child Health Plan Plus (CHP+).

Strategic Goal/s Supported: The unit supports all strategic goals through the engagement and oversight of the External Quality Review Organization, the establishment of performance measures, and guidance of divisions in the examination of health outcomes and quality measurements. There is promotion of improved screening that promotes diagnosis and subsequent treatment.

Staffing Resources:
Total FTE appropriated to organizational unit: 7.0 FTE

Comments: Quality & Health Improvement unit also includes two contributing projects Early Prevention, Screening, Diagnosis and Treatment (EPSDT) as well as the Healthy Living Initiatives.

Objective	Action Plan	Measurement Plan
1. Achieve defined targets for "process" measures on the Healthy Living Data Matrix.	a. Develop indicators that are consistent with state and national metrics for the Healthy Living content areas. b. Ensure stakeholder involvement in the Healthy Living Initiatives.	Results demonstrating improvement will be tracked in the "Healthy Living Matrix."
2. Achieve defined targets for the "outcome" measures on the Healthy Living Data Matrix. *Note: The Healthy Living Data Matrix includes performance measures that support strategic goals re % of Medicaid children with dental caries and % of CHP+ children who receive a dental service.*	a. Create a Department strategy for improving health outcomes (annual). b. Identify baseline measures and track change over time (annual).	Results demonstrating improvement will be tracked in the "Healthy Living Matrix."
3. Increase the number of adolescents ages 11-20 who are screened for depression (from 1,340 to 2,500).	a. Promote depression screening through Healthy Living Initiatives b. Track increased screening through MMIS. c. Increase the proportion of primary care physician office visits that screen youth (ages11-20) for depression.	Complete screening of 2,500 adolescents.
4. Collaborate with the LTC Benefits Division to identify 5 HEDIS performance measures that meet strategic goals of LTC to improve health outcomes.	a. Participate in planning session with LTCB Division to establish priorities. b. Develop a schedule to meet each leader of LTCB to identify areas of impact for each measure. c. Participate in planning sessions for all LTCB programs. d. Collaborate with each manager to establish activities to impact outcome improvements. e. Collaborate with external stakeholders to gather information on primary clinical issues of concern. f. Develop process improvement plan for areas where performance in not improving.	At least 5 recommended measures will be provided to LTC Division Director with rationale for measurement by September 30, 2011.

5. Collaborate with CHP+ program to identify 5 quality measures that meet the goals of improved health outcomes for CHP+ members.	a. Participate in planning session with CHP+ unit to determine priorities. b. Research measures that demonstrate high impact with CHP+ members. c. Work collaboratively with CHP+ staff to align outcomes and realign as needed. d. Develop process improvement plan for areas where performance in not improving.	At least 5 recommended measures will be provided to CHP+ Division Director with rationale for measurement by September 30, 2011.

Long-Term Care Benefits Division

Purpose: The Long-Term Care Benefits Division will improve access to cost-effective, quality long-term care, and community-based services and ensures that programs provide value and result in maximizing the health and functioning of clients.

Strategic Goal/s Supported: The Long-Term Care Benefits Division exists to administer consumer-directed attendant support services, other associated state plan benefits, institutional care and home and community based services (HCBS). The institutional care and HCBS Programs allow for the provision of services to children and adults with developmental and physical disabilities and frail older adults who would otherwise be uninsured or underinsured. The division ensures access to long term care services and programs, assures that programs meet federal and state requirements, that services and programs results in value for clients and the State and strives to support the Department strategic goal of containing health care costs.

Staffing Resources:
Total FTE appropriated to organizational unit: 30.0 FTE (10.0 FTE are currently vacant)

Assumptions: Given national health care reform, the current economic environment, and aging Baby Boomers, the elderly and needy begin to represent a greater segment of the population. Therefore, we must take into consideration the increasing need and costs associated with long-term care.

Objective	Action Plan	Measurement Plan
1. Develop a five-year strategy to increase the number of dually eligible LTC clients who have a health home.	LTC Reform unit will: a. Seek direction and coordinate with Rates and Medicaid Program Divisions b. Determine current baseline c. Set incremental goals d. Determine how to reach these goals	Percent of dually eligible clients with a health home
2. Fill 10 vacancies with the Division by February 2012.	LTC Benefits Division will: a. Create PDQs to address gaps in program development and oversight. b. Prioritize positions in line with Division objectives	10 currently vacant positions filled.
3. Transition 90 persons from facility-based care to community based	LTC Reform unit will: a. Coordinate with internal and external workgroups	90 clients transitioned from facility-based care to

Objective	Action Plan	Measurement Plan
care by then end of FY 2011-12.	b. Hire MFP staff c. Establish a robust enrollment and transition process d. Address system changes e. Implement new services f. Execute IA with DOLA g. Train CMAs, TCAs and LTC facilities h. Outreach to stakeholders	community based care.
4. Develop a five-year strategy to improve long-term care population outcomes.	Contracts and Performance Management unit will: a. Coordinate with Quality and Health Improvement and Strategic Projects staff b. Determine current baseline c. Set incremental goals d. Develop and implement relevant balanced scorecard measures	Percent reduction of ER utilization Percent reduction of hospital readmissions
5. Develop a roadmap for waiver consolidation.	Program/Benefit Management Section will: a. Consult with CMS on parameters around consolidation process b. Outreach to stakeholders c. Develop and submit concept paper to CMS by December 11, 2011 d. Ascertain legislative sponsor	Concept approval by CMS for consolidation of waivers by March 12, 2011.
6. Develop a cost containment plan for DD waivers and CDASS.	LTC Benefits Division will: a. Establish and implement Rules b. Develop and submit waiver amendments c. Support level audits d. Submit a SPA	Demonstrate cost effectiveness.
7. Develop tiered Alternative Care Facility (ACF) Rates	LTC Benefits Division will coordinate with Rates to: a. Obtain actuarial analysis of sound tiered rate model b. Develop and submit waiver amendments c. Establish and implement Rule change	Rates established by acuity level. Demonstrate cost effectiveness.

Pharmacy

Purpose: Make effective medications available efficiently and at a low cost.

Strategic Goal/s Supported: Goals align with the strategic plan objectives of containing health care costs, improving health outcomes and increasing access to health care (i.e., medications).

Staffing Resources:
Total FTE appropriated to organizational unit: 7.0 FTE

Assumptions: SMART PA is executed with ACS and implementation successful. Objectives involve Medicaid FFS clients only. Evaluations based on Medicaid FFS medical and pharmacy claims, unless stated otherwise. Pharmacy communication processes include utilizing the monthly provider bulletin and emailing pharmacies and/or pharmacy representatives.

Objective	Action Plan	Measurement Plan
1. Increase percentage of female clients ages14 to 34 yrs old refilling contraceptives.	a. Pharmacy Benefits Section Manager will coordinate provider and client outreach with Health Initiatives position and with Family Planning position. b. Utilize Pharmacy Communication processes. c. Determine baseline percentage of unplanned pregnancies from CHPHE's PRAMS survey (to be released in 2011) and track progress over FY. d. PDCS claims data will be used to calculate the percentage.	Increase percentage from 17% to 19%.
2. Increase generic utilization by volume and by dollars spent.	a. The Pharmacist will designate generics as preferred drugs, when clinically and financially appropriate. b. The Pharmacist will put non-PDL brand name drugs on PA as clinically appropriate. c. Utilize Pharmacy Communication processes.	Increase generic utilization by volume from 93% to 94% and by dollars spent from 62% to 63% by (not including drugs exempt from the generic mandate, brand drugs without generics, and PDL drugs).
3. Increase percentage of clients receiving 79 day or greater supply for maintenance medications.	The Pharmacy Liaison will utilize Pharmacy Communication Processes.	Increase percentage from 14% to15%.
4. Reduce percentage of clients taking 8 or more narcotics per month.	a. The Pharmacist will continue to develop and present narcotic utilization controls to the DUR Board. b. Prior to the start of the program for the FY, the Rx Review Coordinator will add this objective to the target list of drugs to review. c. As quarterly reports are received, the Rx Review Coordinator will identify clients for participation in the Rx Review Program.	Decrease percentage from 0.9% to 0.8%.
5. Reduce percentage of clients taking 3 or more antidepressants.	a. Prior to the start of the program for the FY, the Rx Review Coordinator will add this objective to the target list of drugs to review. b. As quarterly reports are received, the Rx Review Coordinator will identify clients for participation in the Rx Review Program. c. Rx Review Coordinator will utilize Pharmacy Communication Processes.	Decrease percentage from 16% to15%.
6. Decrease percentage of off-label utilization of anti-convulsants.	a. Pharmacist will meet with the Medical Director to identify the baseline. b. Pharmacist will implement prior authorization criteria using SMART PA. c. Pharmacist will add drugs to the PDL. d. Pharmacist will work with the Reports and Data section to identify percentage.	Based on medical and pharmacy claims analysis and in coordination with the Medical Director, identify baseline for off-label utilization and decrease by 1%.
7. Increase number of clients filling tobacco cessation products.	a. Pharmacy Benefits Section Manager will coordinate provider and client outreach with Health Initiatives position.	Increase number of clients taking smoking cessation products from 1,189 to 1,389.

Objective	Action Plan	Measurement Plan
	b. Pharmacy Benefits Section Manager will attend and participate in all scheduled meetings regarding this initiative. c. Utilize Pharmacy Communication processes.	
8. All IUD rebates submitted.	Rate Financial Analyst will work with the Benefits Management Section to define the process that will be used to determine if a rebate should be collected on J codes. The process will include the plan for collecting rebates for previous time periods not submitted.	Reports from DRAMS identifying Para Guard IUD rebates will be used to identify the rebates that must be collected for prior years.

Rates & Analysis Division, Data Analysis Section

Purpose: The purpose of unit is to create and disseminate business intelligence for the Department. The unit's analysis is to support policy-making decisions, to support and inform the Department's executive funding requests, to share with contractors, to enable the performance of vital business functions, and to create and support required federal reports. In addition, the unit analyzes rates and data for contracted Health Maintenance and Organizations (HMOs), Prepaid Health Plans (PHP), hospitals, medical supplies and equipment, transportation and drugs for the Department. Data analysis is performed for the preparation of decision items, fiscal notes, and analysis of ongoing trends in the Medicaid program. The unit collects, develops and evaluates provider cost data for the assistance in the development of reimbursement rates. This unit tracks payments to providers to determine trends and the effect of rate changes.

Strategic Goal/s Supported: This Section provides indirect support in the form of data analysis of Medicaid claims data to assist in program decision making. The production of timely and accurate reports and financial information support the Department's goals of improving health outcomes, containing health care costs and improving the Long Term Care service delivery system. Specifically, the Section's Operational Plan will address and support the development of benchmarks and baselines, increase access to data for program management, as well as providing information for measurement of Department goals.

Staffing Resources:
Total FTE appropriated to organizational unit: 15.0 FTE

Assumptions: We assume maintenance of current funding and staffing levels including the HRSA FTE will be necessary to address the goals stated in this document. We also require cooperation from many other sections within the department including CS&O for the improvement of the MMIS DSS and program staff to address financial management.

Comments: Data Strategy – Encompasses all current and future data needs of the Department for management of Medicaid Benefits, Programs and Contracts. This includes both financial and utilization management. Strategy will include plans to identify the Departments current data use, a gap analysis, Department data relationships with other state entities and re-procurement of the MMIS DSS. Financial Management Workgroup - develop, cultivate, and reinforce a sustainable culture of accountability, based upon

business best practices that will permeate all levels of the Department to support effective financial management of Medicaid programs and benefits in a cohesive, collaborative, and transparent manner consistent with the Department's mission statement, guiding principles, and goals.

Objective	Action Plan	Measurement Plan
1. Complete phases 1, 2 and 3 of the department Data Strategy	a. Workgroup will research MMIS and DSS implementations in other States and have summary grid by December 1, 2011 b. Workgroup will develop data Strategy for long term integration of data sources including both claims and encounters based upon best practices. First draft of recommendations for executive management due June 30, 2012.	Success in meeting the objective will be measured by: • Phase 1: Summary matrix of other states MMIS and DSS procurements. • Phase 2: Draft recommendation for re-procurement either together or separately of MMIS and DSS with supporting literature. • Phase 3: Draft strategy, with diagrams, for the integration (physical or virtual) of all data necessary to department function.
2. Complete phases 1, 2 and 3 of the Financial management process development	a. Assign data analyst for each benefit, program and contract Cross Functional team as defined. b. Analyst on each team will develop and provide regular (within 8 weeks of first team meeting) and ad hoc claims reporting as needed. c. Expand intensive internal financial management program. d. Begin evaluation of Financial Management Pilot Workgroups March 1, 2012.	• Phase 1: List all Cross Functional teams with dates of inception and members of each team. • Phase 2: List and schedule all regular reports developed in the Data Section for each team. • Phase 3: Begin Evaluation of all Cross Functional teams. Include each team's reference sheet, regular reports, cost containment activities and changes to benefit, program or contract based on team's actions.
3. Develop and schedule the 25 missing Balanced Scorecard and Rx measures	a. Develop all missing claims related Rx performance measures (see Rx measure list for BSC and Gold Standards) by June 30, 2012. b. Develop remaining claims related Balanced Scorecard measures (see BSC measure list for Data Analysis Section) by June 30, 2012.	• All Rx performance measures that can be calculated from claims data completed. • All remaining Balanced Score Card measures that can be calculated from claims data completed.
4. Build dashboards and Automated reports	a. Provide Dashboards for both Benefits Management Section and Long Term Care Waivers by December 1, 2011. b. Develop and provide Dashboards for Provider tracking December 1, 2011. c. Automate all applicable Benefits Management reports by December 1, 2011. (Not Substance Abuse or NEMT reports.) d. Develop and provide dashboard of pertinent and requested data for executive director by February 15, 2012. e. (Automate all reports where appropriate.)	• List each Dashboard and automated report and the date finished. (Finished = all data accurate, report is scheduled to run on regular basis automatically, and customer is satisfied with report.)

5. Reconcile historical encounters for Rocky Mountain Health Plan (RMHP)	a. Reconciliation plan done by July 1, 2011. Submit to CMS for approval. b. Provide RMHP with all data needed to complete reconciliation by November 30, 2011. c. Review RMHP reconciliation for Calendar Year 2010 for accuracy; provide written report on accuracy for executive approval by December 31, 2011.	• Reconciliation plan submitted to CMS by due date determined by CMS. • Data extract provided to RMHP by due date. • Reconciliation review finished and submitted for executive approval by due date.

Rates & Analysis Division, Fee-for-Service Rates Section

Purpose: The Fee-For-Service Rates Section develops rate-setting methodology and implements the reimbursement rates for Federally Qualified Health Centers (FQHCs), hospitals, Rural Health Clinics (RHCs), long-term care, and home and community based waiver services. Rate development must comply with all applicable state statutes, federal regulations and actuarial standards of practice. The Fee-For-Service Rates Section utilizes many data sources in order to develop provider rates, such as claims and eligibility data, provider encounter data, cost reports, and Medicare rate information. The section evaluates, validates and reconciles claims and eligibility data for the purpose of rate development.

Strategic Goal/s Supported: This section supports the policy objectives of the Department by designing reimbursement methodologies and setting rates that achieve maximum value for the state, as measured by desired outcomes, provider participation, and efficiency of service use. The goals outlined below support the strategic goals of improving health outcomes, improving the long-term care delivery system, and containing health-care costs by realigning provider incentives.

Staffing Resources:
Total FTE appropriated to organizational unit: 8.0 FTE

Assumptions: The section relies on a close collaboration with several other sections in the Department to achieve its goals. Chief among these is the relationship between the policy leads for each program which coordinate rule changes and provider communications of new policy initiatives which include reimbursement-related policy as well as other programmatic changes. The section also works closely with the Claims Systems & Operations section to implement reimbursement changes that require updates to the claims payment system.

Objective	Action Plan	Measurement Plan
1. Reduce total FFS Pharmacy expenditure by 5% compared to the FY 2010-11 base year.	a. Implement WAC pricing program by September 30, 2011 b. Work with stakeholders to develop a mutual understanding regarding cost savings using the MAC list. c. Integrate semi-aggressive MAC pricing methodology into pharmacy rates.	Successful implementation will be measured by: Total utilization-adjusted pharmacy expenditure does not exceed 95% of the baseline amount for FY 2010-11.
2. Implement Money-Follows-the-Person	a. Research national rates for MFP core services. b. Develop a reimbursement strategy for clients on each of the 11 waivers	Successful implementation will be measured by: Rates are established for all core services prior

Objective	Action Plan	Measurement Plan
(MFP) benefit package.	c. Convene stakeholder meetings with potential providers of MFP services d. Update MFP protocol with revised rates and units before implementation deadline	to go-live date for MFP.
3. Long-Term Care Rate Reform: Reduce case-load adjusted units-per-client utilization across all LTC waivers by 5% compared to FY 2010-11 volume.	a. Develop a baseline methodology to measure unit-per-client utilization. b. Work with policy to implement a shift from full nursing units to brief nursing units for specific services in home health. c. Develop wage caps and allocation setting controls for CDASS - specifically: work with LTBD to modify the way CDASS allocations are set d. Work with vendor to determine implementation strategy for tiered ACF rates e. Develop rate reform strategy to implement a new care planning tool and waiver rate methodology for outcome-based payment	Successful implementation will be measured by: Caseload-adjusted total units per-client utilization for LTC programs is reduced by 5% from FY 2010-11 levels. Waiver reform plan is approved by the Rates & Analysis and Long Term Care Benefits division directors by October 1, 2011.
4. Reduce overall FQHC/RHC expenditure by 5% compared to FY 2010-11 levels.	a. Using information from CHPRA pilot, develop a value-based purchasing / incentive payment program for FQHCs/RHCs that puts all or a portion of BIPA/APM difference at risk for quality/outcomes payments b. Modify pharmacy rules for FQHCs/RHCs to require in-house pharmacies by January 1, 2012 c. Develop a mechanism to measure hospital readmissions attributed to FQHCs for the purpose of a quality /gain-sharing payment. d. Strategy for APM/Gainsharing Methodology has been developed and agreed to by providers by June 30, 2012	Successful implementation will be measured by: Medicaid spending on FQHC/RHC (either direct or as attributed to other providers) decreases by 5% compared to FY 2010-11 levels.
5. Reduce 30-day All-Cause readmissions by 4% compared to FY 2010-11 levels.	a. Work with Data Section to develop a methodology for measuring readmission rates. b. Measure outcomes of year 1 of HQIP program to determine impact on 30-day readmissions c. Coordinate readmission reduction efforts across several other programs to measure effectiveness and duplicity of effort. d. A standardized, department-wide readmission measurement / attribution strategy is developed by January 1, 2012.	Successful implementation will be measured by: Unduplicated readmission rates are reduced by 4% compared to FY 2010-11.
6. Bring all primary care codes to a defined* percent of Medicare, based on sub-category. **Defined % for each category will be determined collaboratively within the department and be approved by leadership.*	a. Develop a policy review plan for NCCI edits with CS&O. b. Evaluate % of Medicare for each sub-category and develop a stakeholder outreach plan. c. Write a task order or RFP to evaluate the use of bundles for primary care payments d. Policy review plan begins by August 1, 2011 e. Vendor evaluation of bundled payment options begins by December 31, 2011	Successful implementation will be measured by: A rebalance plan for 80% of the NCCI-affected cotes is in place by January 1, 2012. A rebalance plan for >95% of NCCI-affected codes is in place by June 30, 2012.

Rates & Analysis Division, Managed Care Rates Section

Purpose: The Managed Care Rates Section develops rate-setting methodology and implements the rates for the Department's managed care entities, including: Health Maintenance Organizations (HMO), Program for All-Inclusive Care for the Elderly (PACE), and Behavioral Health Organizations (BHO). Rate development must comply with all applicable state statutes, federal regulations and actuarial standards of practice. The Managed Care Rates Section utilizes many data sources in order to develop provider rates, such as claims and eligibility data, provider encounter data, cost reports, and Medicare rate information. The section evaluates, validates and reconciles claims and eligibility data for the purpose of rate development. In addition, the Managed Care Rates Section utilizes its technical expertise to evaluate data elements and methods for payment reform efforts such as the Accountable Care Collaborative.

Strategic Goal/s Supported: This section supports the policy objectives of the Department by designing reimbursement methodologies and setting rates that achieve maximum value for the state, as measured by desired outcomes, provider participation, and efficiency of service use. The goals outlined below support the strategic goals of improving health outcomes, improving the long-term care delivery system, and containing health-care costs by realigning provider incentives.

Staffing Resources:
Total FTE appropriated to organizational unit: 8.0 FTE

Assumptions: The section relies on a close collaboration with several other sections in the Department to achieve its goals. Chief among these is the relationship between the policy leads for each program which coordinate rule changes and provider communications of new policy initiatives which include reimbursement-related policy as well as other programmatic changes. The section also works closely with the Claims Systems & Operations section to implement reimbursement changes that require updates to the claims payment system.

Objective	Action Plan	Measurement Plan
1. Reduce annual BHO rate growth from 3.8% to 3.4% without adverse effects on quality	a. Communicate proposed methodology to stakeholders (BHOs) by June 2011 b. Measure CY 2010 encounter data case rate as compared to CY 2009 baseline c. Define Prevention and Early Intervention services to be measured via BHO rate reform workgroup: September 2011 d. Incorporate measure into capitation rate setting for rates effective January 1, 2012	Successful implementation will be measured by: • Average CY2012 BHO rate growth over CY 2011 baseline • CY 2012 utilization of Prevention/Early Intervention services compared to CY 2011 baseline
2. Reduce psychotropic pharmacy expenditure by 5% based on the trend from CY2011	a. Identify SPMI population and targeted formulary by June 30, 2011 b. Work with stakeholders to develop a mutual	Successful implementation will be measured by: • FY 2013 SPMI Rx PMPM compared to FY 2012 SPMI Rx PMPM

Objective	Action Plan	Measurement Plan
	understanding regarding cost savings c. Provide Rx claims data to stakeholders d. Gather input on quality measures from stakeholders by November 2011	
3. Increase the number of Medicaid clients with a focal point of care from approx 38% to 42% of total Medicaid clients	a. Enroll 60,000 clients into the ACC effective September 1, 2011; transfer process to the SDAC for November 1, 2011 enrollment b. Enroll an additional 63,000 clients into the ACC effective December 1, 2011 c. Participate in ACA 2703 decision item development d. Participate in cross-section workgroup to integrate behavioral and physical healthcare	Successful implementation will be measured by: • 42% of total Medicaid clients have a focal point of care by June 30, 2012
4. For all ACC program participants, reduce: a) Emergency Department (ED) visits from 804/1000 FTE clients per quarter to 700/1000 FTE clients per quarter. b) Hospital readmissions from 22%to 18%	a. Implement SDAC data repository b. Regular MMIS data feed by August 1, 2011 c. Participate in SDAC Advisory Committee meetings d. Rocky incentive payment calculation for FY 2011 contract period e. Test MMIS encounter data by December 31, 2011 f. Preliminary calculations by February 28, 2012	Successful implementation will be measured by: • ED visits reduced to 700/1000 FTE clients per quarter. • Hospital readmissions reduced by 4% • A standardized, ACC readmission measurement / attribution strategy is developed by January 1, 2012.
5. Make CHP+ manual enrollment reporting and payments through December 2011 from backlog of FY2010-2011	a. Work with Maximus to build process around manual enrollment reporting b. Hire and train new FTE to manage process and reporting requirements. Transfer responsibility to FTE within 60 days of hire	Successful implementation will be measured by: • Finish All Manual enrollment payments made through December 2010 by September 30, 2011 • Eliminate backlog of manual enrollment payments as of October 31, 2011
6. Support Department-wide Data Strategy implementation to improve business intelligence and data response times	a. Work with claims systems section to develop CORATEP user stories by June 30, 2011 b. Work with ACS to process transmittal for data adjustment purposes by July 15, 2011 c. Investigate MMIS BHO encounter validity for incorporation into the SDAC d. Integrate Medicare claims analysis into SDAC contract	Successful implementation will be measured by: • Rate setting data adjustments completed in 2 calendar weeks for CY 2012 rate setting by September 1, 2011. • BHO encounter data utilized by SDAC vendor for predictive analytics by December 31, 2011 • Acquire first-half FY 2012 Medicare claims by December 31, 2011

Office of Client & Community Relations

Purpose: The Office of Client and Community Relations (OCCR) increases access to health care by engaging community partners and in performing outreach, streamlining the enrollment and application process, provider outreach and resolving provider and client issues. OCCR oversees policy regarding a client's eligibility for Medical Assistance Programs, maintains the operational side of the Colorado Benefits Management System (CBMS) for Medical Assistance Programs and provides monitoring and quality initiatives for eligibility sites. OCCR maintains customer service outlets for clients, providers and advocates and provides guidance to Department staff in legal related matters. OCCR offers Department staff and providers training to improve quality of work and increase the number of providers and clients enrolled in Medical Assistance Programs. OCCR serves a central role in building taxpayer confidence that dollars appropriated to the Department are being spent wisely through its programs ensuring timely disclosure of information through CORA requests and by protecting the privacy and security of health information through its HIPAA compliance activities. OCCR ensures compliance with state and federal law thereby providing accountability, trust and respect for the Department's ability to operate its programs

Strategic Goal/s Supported: OCCR contributes to two of the Department's strategic goals: increase the number of insured Coloradans, and increase access to health care. OCCR supports the Department's strategic goals by providing support to other divisions within the Department, providing research, problem-solving issues or initiatives, implementing policy and operational changes, maintaining accurate reports, providing trainings, providing CORA requests, combating fraud/waste, and producing quality work.

Staffing Resources:
Total FTE appropriated to organizational unit: 61.0 FTE

Assumptions: Eligibility Policy Section assumes that no major policy implementation will occur prior to achieving the goal requiring major rework and rewriting of existing manuals in process.

Eligibility Operations Section assumes that the CBMS vendor and OIT processes shall remain the same so that the new clearance process will improve currently practiced standards.

Eligibility Monitoring & Quality Unit assumes current operational funding shall be maintained for anticipated travel to monitor eligibility sites.

Program and Policy Training Unit with the exception of ACS's provider trainings, evaluation data is currently tracked only for Department trainings entered in GoSignMeUp. In order for the Program and Policy Training Unit to complete the following objectives, Department trainers/presenters must post their trainings/presentations within GSMU and ensure that the Department-approved evaluation option is enabled. All Objectives formulated on the assumption that staffing levels will be maintained.

The County Liaison/Outreach Team assumes that FTE resources will be evaluated and maintained to continue current projects and that funding through HRSA and operating budget will continue to support county site visits to support county and community trainings and education. In order to complete MOU with counties, the attorney general's office and counties need to be in collaboration and all political ramifications need to be addressed, recognized and evaluated prior to implementation.

The Customer Contact Center assumes that current allotted FTEs and staffing levels will remain consistent (no staffing changes).

HRSA Section assumes that a majority of projects under the HRSA grant are absorbed in Objectives of other Divisions or Sections within the Department.

The Legal Division is contingent on personnel issues with respect to FTE that must be hired. Also, process improvements for Benefits Coordination include changes to MMIS, which are outside of the Section's control. The Benefits Coordination Section must also send its third-party liability contract out to bid and expand the scope of work.

Objective	Action Plan	Measurement Plan
1. Eligibility Division-Policy Section: All policy user manuals completed and posted to the Department website by November 30, 2011.	a. Adult and Adult General manuals to be completed and posted on the Department website by July 31, 2011. b. PE manual to be completed and posted on the Department website by July 31, 2011. c. LTC and FM manuals to be completed and posted to the Department website by November 30, 2011. d. Communications distributed to partners directly prior to publishing each document. e. Revise the correspondence database to track policy-related partner correspondence in order to begin measuring partner awareness and effectiveness of policy manuals.	Success in meeting the objective will be measured by: • Complete and accurate policy manuals posted to the Department website by the deadline.
2. Eligibility Division-Operations Section: • Reduce the average time to complete the clearance process by 1 week (from 3-4 weeks to 2-3 weeks).	a. Develop a "New Requirements" clearance walk-thru process for operations related projects b. Assigned operations project lead will set up a clearance walk-thru for the High Level Business Requirements Document (HLBR) with all required internal parties prior to HLBR submission to CBMS/OIT. Feedback will be documented, discussed and incorporated if necessary by the project lead at this meeting. All required sign-offs will happen at this meeting. c. Assigned operations project lead will set up a clearance walk thru(s) for the Business Requirements Document (BRD) prior to the BRD walk-thru with the CBMS Vendor and CBMS/OIT. Feedback will be documented, discussed and	Success in meeting the objective will be measured by: • The average time to complete the clearance process is documented as taking 2-3 weeks.

Objective	Action Plan	Measurement Plan
	incorporated if necessary by the project lead at this meeting. d. Assigned operations project lead will set up a final clearance walk-thru(s) for the BRD with all required internal parties. All required sign-offs for the BRD will happen at this walk-thru. This walk-thru will take place after the project lead has had a walk-thru with the CBMS vendor and CBMS/OIT and after all changes from this walk-thru have been incorporated into the BRD. This will be the final document that is submitted to CBMS/OIT and the CBMS vendor to request a Technical Design Document. e. Stakeholder satisfaction and/or collaboration by receiving final approved sign-off.	
3. Eligibility Division-Monitoring & Quality Unit: Monitor at least 25% of the eligibility sites.	a. Develop a monitoring plan for eligibility site reviews by August 31, 2011. b. Create a review tool to evaluate eligibility site determinations for initial applications and RRRs by August 31, 2011. c. Perform onsite and desk reviews. d. Based on site review error findings, conduct trainings.	Success in meeting the objective will be measured by: • Monitoring plan drafted by August 31, 2011. • Review tool drafted by August 31, 2011. • Reviews completed on at least 25% of the eligibility sites. • Trainings provided to eligibility sites. • Baseline data collected from review tool and trainings.
4. Eligibility Division-Eligibility Sites Contract Unit: 90% of all applications received at the EEMAP Vendor (MAXIMUS) to be processed within 10 business days of receipt. This is a monthly objective.	a. Draft a contract amendment with this new Service Level Agreement (SLA). b. Change monthly report requirements for MAXIMUS based on the new SLA. c. Create appropriate Incentive Payments/Liquidated Damages based on the new SLA/Contract Amendment.	Success in meeting the objective will be measured by: • The date the Contract amendment is drafted and signed. • Receiving and reviewing monthly reporting data on the new SLA. • Measurement on Liquidated Damages versus Incentive Payments.
5. County Liaison/ Outreach Team: Develop a standardized performance measure and communication policy for all eligibility sites.	a. Survey all eligibility sites regarding current communication, measures and collaboration with HCPF. b. Develop an SOP for communicating with all eligibility sites. c. Develop a policy for performance measures in collaboration w/ eligibility sites.	Success in meeting the objective will be measured by: • Draft Performance plan will be submitted to EC by November 1, 2011. • Draft Communication SOP by November 1, 2011.
6. County Liaison / Outreach Team: Develop a county collaboration plan per Executive Order D 2011-005.	a. Develop an SOP for communicating with counties by September 1, 2011. b. Develop a survey for all counties with specific questions for opportunities for collaboration by October 1, 2011.	Success in meeting the objective will be measured by: • Measurement plan established by October 1, 2011.
7. County Liaison / Outreach Team: Work with Program and Policy Training Unit to	a. Identify trainers and develop a matrix containing subject matter and responsible trainers. b. Grade the trainers and rank feedback and assign a value to	Success in meeting the objective will be measured by: • Evaluation Plan established by November 1, 2011.

Objective	Action Plan	Measurement Plan
develop an Evaluation Plan for all trainers within the County Oversight & Outreach Unit.	the quality of training. c. Establish quarterly training reports. d. Report on results and identify areas of improvement.	
8. County Liaison / Outreach Team: Work toward implementing a strategic outreach plan specific to the HCAA expansion populations by January 1, 2012.	a. Develop an outreach plan by August 31, 2011. b. Community Outreach Specialist to meet weekly with Benefits and Eligibility teams to discuss implementation status, stakeholder feedback and specific eligibility criteria. c. Establish quarterly trainings for all Application Assistance Sites on the expansion programs once program development is complete.	Success in meeting the objective will be measured by: • Community Outreach Specialist submits a draft HCAA outreach plan to the Benefits and Eligibility Teams by December 1, 2011.
9. County Liaison / Outreach Team: Determine annual benchmarks to measure enrollment of newly eligible populations under HB 09-1293 expansions by June 30, 2012.	a. Collaborate with the Budget Division, Data Section, and Medicaid/CHP+ Programs to set benchmarks for FY 2012-13 and beyond. b. Distribute draft benchmarks to appropriate managers and division directors by April 30, 2012. c. Complete revised benchmarks by May 31, 2012. d. Get Executive Committee approval of 1293 expansion population enrollment benchmarks by June 30, 2012.	Success in meeting the objective will be measured by: • 1293 expansion population benchmarks are approved by Executive Committee by June 30, 2012 for incorporation into the FY 2012-13 strategic plan.
10. Program and Policy Training Unit: Establish baseline data to measure training effectiveness in FY 2011-12. (Work toward improving training effectiveness by 10% in FY 2012-13)	a. PPTU collaborates with Department trainers/managers to develop at least 1 new method to obtain Level 2-4 evaluation data in addition to standard training/evaluation forms. b. Staff to utilize additional method to evaluate training effectiveness for at least 70% of Department trainings tracked through GoSignMeUp.	Success in meeting the objective will be measured by: • New evaluation tool drafted by August 31, 2011. • Obtain data from training attendees using new tool for at least 70% of Department trainings posted in GSMU from Sept 1, 2011 – June 30, 2012.
11. Program and Policy Training Unit: Work toward achieving 10% increase in "positive response ratings" on all training revisions	a. PPTU will deliver training evaluation results to all trainers within 1 month of training completion. b. PPTU will offer a minimum of 2 Presenter Training courses addressing best practices of evaluation and revision. c. Prior to trainer delivering a repeat training, member of PPTU will meet with trainer to review past evaluations/feedback and suggest potential revisions.	Success in meeting the objective will be measured by: • For all Department trainings offered multiple times, obtain evaluation/feedback data from GSMU for each iteration for comparison • Measure percentage of "positive responses" for each iteration of training
12. Program and Policy Training Unit: Collaborate with ITConMon to implement a plan to improve provider trainings	a. Member(s) of PPTU will meet with ITConMon to establish need for improvement plan. b. Member(s) of PPTU will participate in intra- ITConMon and other Department staff to develop training departmental workgroup to improve program communication with ACS. c. PPTU will collaborate with improvement plan. d. PPTU will coordinate with Department staff and ACS to implement changes to trainings in accordance with plan.	Success in meeting the objective will be measured by: • Develop plan to improve provider trainings. • Develop evaluation method to define and assess improvement. • Collect baseline data using established evaluation method. • Implement a minimum of 2 action items from plan

Objective	Action Plan	Measurement Plan
		• Collect data to measure improvement.
13. Customer Contact Center: Provide 1st call resolution to 80% of calls answered	a. Monitor call-management review. b. Provide re-current training to CS staff. c. Communicate Department updates to CS staff. d. Review call transfer rate.	Success in meeting the objective will be measured by: • Verify progress by taking a monthly sample of Client Database notes and comparing returned call rate with the same client issue/subject.
14. Customer Contact Center: Establish baseline data to measure the average total client contacts responded to/answered per month. .	a. Monitor call volume peak periods and adjust schedules as needed. b. Maintain/increase staffing levels in response to increasing Medicaid case load. c. Utilize additional communication options for client correspondence (ex. emails, letters).	Success in meeting the objective will be measured by: • Review monthly progress in Avaya call center system for the total number of public email and written correspondence (letters) answered or responded to against the total of all inbound client communications.
15. Customer Contact Center: Implement 2nd level staff program/policy training for certified CS staff	a. Coordinate with the Program and Policy Training Unit. b. Provide rotational program and policy training to CS staff. c. Utilize DPA offered trainings.	Success in meeting the objective will be measured by: • Track new training module creation. • Review training modules to establish a 2nd level training schedule for CS staff.
16. HRSA Section: Increase provider participation in Medicaid from 27,336 providers to 28,702 providers.	a. Develop a strategic plan for provider recruitment for the expansion populations by September 1, 2011. b. Identify locations (cities/ counties/ etc.) where there are minimal provider servicing Medicaid clients by August 1, 2011. c. Identify types of provider services that are missing or inadequate by August 1, 2011. d. Identify current provider applications that are declined for administrative reasons monthly beginning July 1, 2011.	Success in meeting the objective will be measured by: • 5% increase in provider participation.
17. Determine appropriate benchmarks to measure increases in provider participation to serve future expansion populations by June 30, 2012.	a. Collaborate with the Budget Division, Data Section, and Medicaid/CHP+ Programs to set benchmarks for FY 2012-13 and beyond. b. Distribute draft benchmarks to appropriate managers and division directors by April 30, 2012. c. Complete revised benchmarks by May 31, 2012. d. Get Executive Committee approval of expanded provider participation benchmarks by June 30, 2012.	Success in meeting the objective will be measured by: • Expanded provider participation benchmarks are approved by Executive Committee by June 30, 2012 for incorporation into the FY 2012-13 strategic plan.
18. Legal Division: CORA: Meet timeliness requirements for all open records requests pursuant to C.R.S. § 24-72-203.	a. Perform CORA training sessions to HCPF employees.	The Legal Division's CORA log shows that all requests were timely provided (CORA generally requires records to be provided within 3 business days).
19. Legal Division: HIPAA: Ensure HIPAA privacy and security compliance by the Department.	a. Require all employees to attend HIPAA training. b. Train the executive committee on breaches and new developments in HIPAA.	• 100% of HCPF's employees and temporary employees have attended the required training. • Perform training to the executive committee.

Objective	Action Plan	Measurement Plan
20. Benefit Coordination Section: Recoveries. Recover monies for the Medicaid Program from tort & casualty, trusts, and post-pay sources to achieve $33 million in recoveries.	a. Present State Deficit Reduction Act compliance issues to insurance carriers to facilitate post-pay recoveries. b. Review compliance by insurance carriers and managed care entities around the submission of eligibility data.	Achieve $33 million* in recoveries. *Estimated amount recoverable is based upon prior 6 years recovery data.
21. Benefit Coordination Section: Process Improvement Initiatives. Expand programs performed by the Department's recovery vendor.	a. Contract with vendor to provide HIBI services. b. Develop systems interfaces between MMIS and current TP recovery vendors' systems for data matching and pharmacy payer information. c. Facilitate prioritization of CSR 2350 to change TPL resource to MMIS to improve cost avoidance.	Complete initial actions for these initiatives by mid – FY 11-12.
22. Benefits Coordination Section: PARIS Implementation: (a) Identify Medicaid/CHP+ recipients in Colorado's program who have moved out-of-state; (b) identify Medicaid recipients who are eligible for VA benefits.	a. Remove individuals from the Colorado Medicaid and CHP+ programs if they have moved out of state (identified in PARIS as residing/receiving benefits in another jurisdiction). b. Perform outreach with counties to ensure that the PARIS data is being used. c. Provide PARIS matches to the counties for follow-up on VA benefits.	• Number of individuals seeking benefits from the VA. • Number of individuals removed from the Colorado Medicaid or CHP+ program.
23. Appeals Section: Ensure accuracy and soundness of reasoning in final agency decisions.	a. Exercise a high level of diligence in interpreting the Department's rules when drafting final agency opinions.	Fewer than fifty reversals occur at the district court level of the Department's final agency decisions.