

STATE OF COLORADO FY 2011-12 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Schedule 13 Change Request for FY 2011-12 Budget Request Cycle											
Decision Item FY 2011-12 <input type="checkbox"/>			Base Reduction Item FY 2011-12 <input type="checkbox"/>			Supplemental FY 2010-11 <input type="checkbox"/>			Budget Amendment FY 2011-12 <input checked="" type="checkbox"/>		
Request Title:		ARRA HITECH Provider Incentive Payments									
Department:		Health Care Policy and Financing				Dept. Approval by:		John Bartholomew <i>JB</i>		Date: January 3, 2011 <i>12/13/10</i>	
Priority Number:		BA-8				OSPB Approval:		<i>Ann</i>		Date: <i>12-14-10</i>	
	Fund	1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual FY 2009-10	Appropriation FY 2010-11	Supplemental Request FY 2010-11	Total Revised Request FY 2010-11	Base Request FY 2011-12	Decision/ Base Reduction FY 2011-12	November 1 Request FY 2011-12	Budget Amendment FY 2011-12	Total Revised Request FY 2011-12	Change from Base (Column 5) FY 2012-13
Total of All Line Items	Total	2,739,361	4,519,565	0	4,519,565	4,501,995	0	4,501,995	2,000,000	6,501,995	2,000,000
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,189,435	1,480,361	0	1,480,361	1,480,361	0	1,480,361	0	1,480,361	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	303,858	673,785	0	673,785	665,000	0	665,000	0	665,000	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,246,058	2,365,419	0	2,365,419	2,356,634	0	2,356,634	2,000,000	4,356,634	2,000,000
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	2,739,361	4,519,565	0	4,519,565	4,501,995	0	4,501,995	2,000,000	6,501,995	2,000,000
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,189,435	1,480,361	0	1,480,361	1,480,361	0	1,480,361	0	1,480,361	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	303,858	673,785	0	673,785	665,000	0	665,000	0	665,000	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,246,058	2,365,419	0	2,365,419	2,356,634	0	2,356,634	2,000,000	4,356,634	2,000,000
Non-Line Item Request:		None.									
Letternote Revised Text:		None.									
Cash or Federal Fund Name and COFRS Fund Number:		FF: Title XIX									
Reappropriated Funds Source, by Department and Line Item Name:											
Approval by OIT?		Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/> N/A: <input type="checkbox"/>									
Schedule 13s from Affected Departments:		None.									

CHANGE REQUEST for FY 2011-12 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BA-8
Change Request Title:	ARRA HITECH Provider Incentive Payments

SELECT ONE (click on box):

- Decision Item FY 2011-12
- Base Reduction Item FY 2011-12
- Supplemental Request FY 2010-11
- Budget Request Amendment FY 2011-12

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

- Not a Supplemental or Budget Request Amendment
- An emergency
- A technical error which has a substantial effect on the operation of the program
- New data resulting in substantial changes in funding needs
- Unforeseen contingency such as a significant workload change

Short Summary of Request:

The Department requests an appropriation of \$2,000,000 federal funds beginning in FY 2011-12 for the implementation of section 4201 of the American Recovery and Reinvestment Act (ARRA) of 2009 called the Health Information Technology for Economic and Clinical Health program or HITECH incentive payment program. The request has no General Fund impact for FY 2011-12. The additional federal funds along with \$500,000 total funds in the Department's FY 2011-12 base request would provide \$2,500,000 total funds to implement HITECH.

General Description of Request:

Federal Background for HITECH

The American Recovery and Reinvestment Act (ARRA) of 2009 was enacted on February 17, 2009 and section 4201 established incentive payments to eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and meaningful use of health information technology and qualified electronic health records (EHR). Together these provisions are called the Health Information Technology for Economic and Clinical Health program or HITECH incentive payment program.

To promulgate rules to implement the HITECH incentive payment program and other participation requirements, the Centers for Medicare and Medicaid Services (CMS) issued initial guidance on September 1, 2009 for certain planning activities related to the administration of the HITECH incentive payment program that would potentially qualify for enhanced federal financial participation (FFP). Later on January 13, 2010 CMS issued proposed rules for the HITECH incentive payment program in the Federal Register. Contained within those rules, as required by ARRA, CMS also issued an interim final rule from the Office of the National Coordinator for Health Information Technology (ONC). The interim final rule specifies the adoption of an initial set of standards, implementation, specifications, and certification criteria for EHRs.

On June 24, 2010, CMS and ONC issued the final rule on the establishment of a temporary certification program for the purposes of testing and certifying health information technology. The temporary certification program will authorize organizations to test and certify complete EHRs and/or EHR modules, thereby making certified EHR technology available prior to the date that EPs, eligible hospitals, and CAHs seek voluntary participation in the HITECH programs. The temporary certification program is expected to sunset on December 31, 2010. On or before this date, CMS will issue rules regarding a permanent certification program.

On July 13, 2010, CMS and ONC issued the final rule for both EHRs and the Medicare and Medicaid EHR incentive programs (HITECH program), which included the definition of meaningful use. Finally, in a State Medicaid Director letter dated August 17, 2010, CMS issued additional guidance on federal funding for Medicaid HITECH activities. In the letter, CMS recommends that in order for states to benefit most from available federal resources and technical assistance, states should timely implement their Medicaid HITECH programs “as soon as possible in 2011”.

Medicaid Provider Scope and Eligibility

According to the final rules and federal statute at 42 C.F.R. §495.304, (2010) the following Medicaid providers are eligible to participate in the HITECH incentive

program: 1) Medicaid EPs; 2) Acute Care Hospitals; and 3) Children's Hospitals. Of the Medicaid EPs, payment is limited to the following provider types: 1) physicians; 2) dentists; 3) certified nurse-midwife; 4) nurse practitioner; and 5) physician assistant practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

There are additional requirements that Medicaid EPs meet one of the following criteria:

- 1) Have a minimum 30% Medicaid patient volume;
- 2) If a pediatrician then they must have a 20% minimum Medicaid patient volume;
- 3) Not be hospital based;
- 4) Practice predominately in a FQHC or RHC and have a minimum 30% patient volume attributable to needy individuals, which include individuals receiving assistance from Medicaid, CHP+, or uncompensated care programs.

Eligible hospitals must also meet additional requirements which include the following:

- 1) Acute care hospitals must have at least 10% Medicaid patient volume for each year the hospital is seeking incentive payments;
- 2) Children's hospitals are exempt from meeting a patient volume threshold.

Eligible hospitals and CAHs may participate in both the Medicare and Medicaid programs under certain conditions (42 C.F.R. §495.10, (2010)). Eligible professionals that may qualify as both a Medicaid and Medicare eligible professional must notify CMS of their intent to participate in either the Medicare or Medicaid EHR incentive program. However, EPs are allowed to switch between programs one-time before calendar year 2014 (42 C.F.R. §495.310 (d), (2010)).

Medicaid Eligible Professional Incentive Payments

In the final rules, CMS estimates the annual average allowable cost to adopt EHR technology at \$54,000 and \$20,610 for maintenance costs. The average allowable costs are further reduced by expected contributions from other sources (other than state or local governments) that the Medicaid EP may receive. The result is called the net average

allowable costs. The annual net average allowable costs to implement and operate EHR technology are estimated at \$25,000 and \$10,000, respectively. In other words, CMS estimates that Medicaid EPs would receive *other* contributions in the amount of \$29,000 and \$10,610 for implementation and maintenance costs, respectively.

If the Medicaid EP elects to participate in the HITECH incentive program on or before calendar year 2016, then their first year payment is not allowed to exceed 85% of net average allowable costs, or \$21,250. The subsequent annual incentive payments may not exceed 85% of the maximum threshold of \$10,000, which equals \$8,500. The maximum incentive payment over the eligible six year period is \$63,750 (42 C.F.R. §495.310 (a), (2010)). However, if the Medicaid EP is a pediatrician then the maximum first year payment and subsequent annual payments are reduced to two-thirds, assuming they meet other qualification criteria. Therefore the maximum incentive payment over the eligible six year period is \$42,500 for pediatricians (42 C.F.R. §495.310 (a) and (b), (2010)). All incentive payments are funded entirely with 100% federal funds (42 C.F.R. §495.320, (2010)).

The table on the following page shows how a Medicaid EP who is not a pediatrician may *maximize* their incentive payments under the HITECH program. It assumes the Medicaid EP meets meaningful use criteria every calendar year for which they are eligible. Moreover it assumes voluntary participation; there are no provisions in HITECH that require consecutive annual participation.

Payment Calendar Year	Non-Pediatrician Medicaid EPs who begin adoption in:					
	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

For example, if a Medicaid EP is engaged in “efforts to adopt, implement, or upgrade certified EHR technology” in calendar year 2011 then they would receive their first incentive payment of \$21,250. If in their second year of participation (CY 2012), they decide not to participate then they do not have to attest meeting meaningful use criteria and consequently forego their second year incentive payment of \$8,500. If, however, they decide to participate in their third through sixth year of eligibility (CY 2013 to CY 2016) then they must attest to meeting meaningful use criteria during the reporting periods in order to receive their annual incentive payments of \$8,500. Under this scenario, the Medicaid EP would receive \$55,250 in incentive payments.

According to HITECH provisions, Medicaid EPs may not begin to receive incentive payments any later than calendar year 2016 and receive a maximum of five incentive payments after their first year incentive payment (42 C.F.R. §495.310 (a)(2)(i) and (a)(2)(ii), (2010)). Therefore, the total eligibility period is limited to six years (42 C.F.R. §495.310 (a)(3), (2010)).

Medicaid EPs may receive incentive payments from either Medicare or Medicaid but not both. Additionally, if the Medicaid EP practices in more than one state, then he or she may only receive incentive payments from one state. Lastly, there are no provisions to issue Medicaid EPs partial or prorated incentive payments for meeting a partial set of objectives.

Medicaid Eligible Hospitals Incentive Payments

The incentive payments to eligible hospitals are more complex to illustrate because they require information from auditable data sources (e.g., provider's Medicare cost reports; state specific Medicaid cost reports; payment and utilization; and hospital financial statements and accounting records). Based on statutory formula the payments would be calculated as follows: (Overall EHR Amount) * (Medicaid Share) or {Sum over 4 year of [(Base Amount + Discharge Related Amount Applicable for Each Year) *Transition Factor Applicable for Each Year]} *{(Medicaid inpatient-bed-days +Medicaid managed care inpatient bed-days)/[(total inpatient-bed days) * (estimated total charges - charity care charges)/(estimated total charges)]}, (42 C.F.R. §495.310 (f) through (i), (2010) and Federal Register, Volume 75, Number 8, page 1938, January 13, 2010).

Lacking auditable data sources, the Department will only list some of the criteria that eligible hospitals must meet in order to receive incentive payments (not in order of importance):

- 1) Payments are provided over a minimum period of three years and a maximum of six years;
- 2) The total incentive payment received over all years shall not be greater than the aggregate incentive amount as calculated by the state and approved by CMS;
- 3) No single incentive payment may exceed 50% of the calculated and approved amount;
- 4) No incentive payments over a two-year period may exceed 90% of the calculated and approved amount;
- 5) No hospital may receive incentive payments for any year after federal fiscal year 2016; and

- 6) Multi-state hospitals shall be considered one hospital for the purposes of calculating payment amounts.

Under the HITECH program, hospitals may participate in both the Medicare and Medicaid incentive programs depending on successful demonstration of meaningful use and other requirements under both programs. Lastly, hospital payments are determined using the federal fiscal year.

Meaningful Use Definition and Criteria

There are three main components of meaningful use:

- 1) The use of certified EHR in a meaningful manner;
- 2) The use of certified EHR technology for electronic exchange of health information to improve quality of health care; and
- 3) The use of certified EHR technology to submit clinical quality and other measures.

In the proposed rules issued on January 13, 2010, CMS defined 25 requirements for Medicaid EPs and 23 requirements for eligible hospitals to meet in order to qualify as a meaningful user of EHR and receive their HITECH incentive payments. However, in the final rule issued on July 13, 2010, CMS has reconsidered this and proposed a two phased approach to meeting meaningful use criteria.

The new approach is broken down into a core and menu set of requirements. There are 15 core requirements for EPs and 14 core requirements for eligible hospitals. In order for eligible providers to qualify as a meaningful user of EHR technology, they must meet the requirements for each objective in the core set and all but five of the menu requirements. All the requirements currently defined in the final rules of July 13, 2010 are considered Stage 1 meaningful use criteria. CMS intends to update these requirements through Stages 2 and 3 by the end of 2011 and 2013, respectively.

Because the list of core and menu criteria is rather long and sometimes only applicable to certain provider types (EPs or eligible hospitals), the Department will only provide a brief sample of the objectives and measures to achieve meaningful use.

Sample of <i>Core Set</i> of Stage 1 Objectives			
Health Outcomes Policy Priority	Eligible Professionals	Eligible Hospitals and CAHs	Stage 1 Measure
Improving quality, safety, efficiency, and reducing health disparities	Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital have at least one medication order entered using CPOE
	Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
	Generate and transmit permissible prescriptions electronically (eRx)	Not applicable	More than 40% of all permissible prescriptions written by EP are transmitted electronically using certified EHR technology

Sample of <i>Menu Set</i> of Stage 1 Objectives			
Health Outcomes Policy Priority	Eligible Professionals	Eligible Hospitals and CAHs	Stage 1 Measure
Improving quality, safety, efficiency, and reducing health disparities	Implement drug-formulary checks	Implement drug-formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
	Not Applicable	Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years or older admitted to the eligible hospital have an indication of an advance directive status recorded
	Send reminders to patients per patient preference for preventive/follow up care	Not Applicable	More than 20% of all unique patients 65 years or older and 5 years old or younger were sent an appropriate reminder during the EHR reporting period

State Background for HITECH

In the Department's February 15, 2008 Budget Request Amendment, S-1A, BA-A1A, "Building Blocks to Health Care Reform", the Department requested \$500,000 total funds for the Colorado Regional Health Information Organization (CORHIO), comprised of \$250,000 General Fund and \$250,000 matching federal funds. This funding was approved and appropriated to the General Professional Services and Special Projects line item in the Department's FY 2008-09 Long Bill, HB 08-1375.

Although the Department received the appropriation, it was later determined that the \$250,000 General Fund could not be matched with federal funding. As a result, the Joint Budget Committee (JBC) removed the M Headnote provision from the \$250,000 General Fund for FY 2009-10 through the Long Bill Add On, SB 09-259, page 519. After the restriction was removed and with the passage of ARRA on February 17, 2009, the Department received initial guidance on September 1, 2009 from CMS on certain planning activities related to the administration of the HITECH program that would potentially be eligible for enhanced federal financial participation.

With this guidance, the Department developed its list of planning activities and requested approval from CMS through the submission of a Planning Advanced Planning Document (P-APD) as required by federal statute at 42 C.F.R. §495.336 (2010). The Department submitted its P-APD on January 25, 2010 and received approval on February 10, 2010 from CMS for 90% FFP for initial planning, assessment, and analysis activities to implement the HITECH incentive payment program in Colorado. The initial planning activities include the development of Colorado's State Medicaid Health Information Technology Plan (SMHP), which will provide a plan for: 1) administration of the HITECH incentive payment program; 2) Medicaid provider adoption and meaningful use of electronic health records; and 3) how the plan will work in conjunction with the larger statewide health information technology goal. The SMHP will be developed by CORHIO and delivered in December 2010. Having received federal approval for a limited number of planning activities, the Department expended \$265,043 total funds in FY 2009-10.

For FY 2010-11, the JBC again removed the M Headnote provision on the \$250,000 General Fund through the Department's Long Bill, HB 10-1376. Due to the publication of the final rules regarding HITECH on July 13, 2010 and subsequent guidance to State Medicaid Agencies on the implementation of the HITECH incentive payment program on August 17, 2010, the Department believes the \$250,000 General Fund could be matched with enhanced FFP in FY 2010-11. Based on the final rules issued by CMS, states may receive 90% FFP for expenditures related to the implementation of the HITECH incentive payment program for certain Medicaid providers that are adopting, implementing, or upgrading and meaningfully using certified EHR technology (42 C.F.R. §495.322, (2010)); and 100% FFP for provider incentive payments (42 C.F.R. §495.320, (2010)). Utilizing the \$250,000 General Fund for this purpose would result in total funds of \$2,500,000 to implement HITECH.

In FY 2010-11 the Office of State Planning and Budgeting approved spending authority of \$2,000,000 in additional federal funds from using enhanced federal financial participation for HITECH implementation and administrative activities. Subsequently, the Department's spending authority was changed by the Office of State Controller, and the Department is seeking approval from CMS for enhanced FFP for implementation and administrative expenditures related to the HITECH incentive payment program. The approval would come after the Department submits its SMHP and Implementation Advanced Planning Document (I-APD), as required under 42 C.F.R. §495.332 and §495.338, (2010). The Department anticipates approval from CMS before January 2011.

Implementation and Administrative Activities for HITECH Program

The implementation activities will require extensive software and system development changes to both the Provider Web Portal and Medicaid Management Information System. Additionally the Department would continue working with the designated state-entity for health information technology, CORHIO, to expand electronic health information across Colorado. The estimated cost for CORHIO to continue this work would be \$380,000 total funds and would include, but not limited to: updating the I-APD, SMHP, and Vision and

Strategy Plan, provider outreach and stakeholder meetings, and developing communication material.

In addition to the one-time system development changes, the Department anticipates ongoing operational and administrative costs, especially to the Provider Web Portal as it will undergo development changes with each of the three stages of meaningful use criteria. After providers attest to meeting meaningful use criteria and payments are issued, the Department assumes it would require independent contractors to perform periodic account auditing of incentive payments and onsite audits of provider's EHR systems or modules. In addition to the contractors, the Department estimates additional ongoing activities, but not limited to: data sharing agreements, staff development, and creating a data warehouse. The estimated total cost for all these activities is \$1,220,000 total funds. Based on federal statute at 42 C.F.R. §495.316, (2010), the state is responsible for monitoring and reporting activities required to receive incentive payments. The Department believes these audit functions would help to combat fraud, waste and abuse as required by federal statute at 42 C.F.R. §495.368, (2010).

The Department will also require an attestation vendor to perform functions such as setting up a provider enrollment website and call center and collecting, verifying, and auditing meaningful use data from providers' EHRs and provider attestations. Due to the State competitive bidding process, the Department is not providing detailed estimates for these functions.

If any of the costs associated with implementing or administering the HITECH incentive payment program should change, then the Department will submit a budget request through the normal budget cycle to adjust its appropriation.

Consequences if Not Funded:

According to a report released in April 2009 by the SB 07-196 Health Information Technology Advisory Committee, Colorado has several health information exchange (HIE) efforts currently underway, the largest of which include CORHIO and Quality Health Network (QHN) in Mesa County.¹ During 2010, CORHIO is committed to

¹ Colorado SB 07-196 Health Information Technology Advisory Committee, Report and Recommendations April 24, 2009.

launching two HIE communities and later integrate its network with QHN.² As of December 2009, QHN has recruited approximately 85% of Mesa County physicians and is seeking to expand its network to include 20 western Colorado counties.³

The Department assumes that the providers participating in health information exchanges would be some of the first providers to participate in the HITECH incentive payment program beginning calendar year (CY) 2011. If these providers fulfill the first-year HITECH requirements to adopt, implement or upgrade certified EHR technology during CY 2011 they will be eligible to receive their first-year payment beginning CY 2012.

Based on federal statute at 42 C.F.R. §495.316, (2010) the state Medicaid agency is responsible for monitoring and reporting the activities required to receive an incentive payment. If this request is not approved, the Department would not have adequate financial resources to modify its systems and issue payments to eligible providers beginning CY 2012. According to CMS guidance issued on August 17, 2010, states must make incentive payments within 45 days of completing all eligibility verification checks.

Calculations for Request:

Summary of Request FY 2011-12	Total Funds	General Fund	Federal Funds
Total Request	\$2,000,000	\$0	\$2,000,000
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	\$2,000,000	\$0	\$2,000,000

Summary of Request FY 2012-13	Total Funds	General Fund	Federal Funds
Total Request	\$2,000,000	\$0	\$2,000,000
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	\$2,000,000	\$0	\$2,000,000

² "CORHIO Frequently Asked Questions", July 7, 2010, www.CORHIO.org

³ "Quality Health Network Overview", Colorado Academy of Family Physicians, www.coloradoafp.org/pdf/article1.pdf

Row	Description	Total Funds	General Fund	Federal Funds	FFP Rate
A	FY 2011-12 Base Request	\$500,000	\$250,000	\$250,000	50%
B	Adjusted Appropriation with Enhanced FFP	\$2,500,000	\$250,000	\$2,250,000	90%
C	Total Need (Row B – Row A)	\$2,000,000	\$0	\$2,000,000	

Cash Funds Projections: Not Applicable.

Assumptions for Calculations: The Department assumes the implementation and administrative activities required to implement the HITECH incentive payment program would qualify for 90% FFP as defined by 42 C.F.R. §495.322, (2010).

Impact on Other Government Agencies: Not applicable.

Cost Benefit Analysis: Not applicable due to request being technical adjustment.

Implementation Schedule:

Task	Month/Year
Submitted Implementation Advanced Planning Document to CMS	December 2010
Begin System Development Changes to Provider Web Portal and Medicaid Management Information System	Early Calendar Year 2011
Complete System Development Changes	December 2011
Issue Incentive Payments to Eligible Providers	Early Calendar Year 2012

Statutory and Federal Authority:

42 C.F.R. §495.316, (2010) State monitoring and reporting regarding activities required to receive an incentive payment. (a) *Subject to § 495.332 the State is responsible for tracking and verifying the activities necessary for a Medicaid EP or eligible hospital to receive an incentive payment for each payment year as described in § 495.314.*

42 C.F.R. §495.322, (2010) FFP for reasonable administrative expenses. *Subject to prior approval conditions at § 495.324 of this subpart, FFP is available at 90 percent in State expenditures for administrative activities in support of implementing incentive payments to Medicaid eligible providers.*

Performance Measures:

This request will assist the Department in meeting its performance measure to contain health care costs. The health information exchanges being developed in Colorado would allow for comprehensive management of electronic health information and data exchange between medical providers and health care consumers. These efforts would help to improve health care quality; lower medical errors; and increase administrative efficiencies.

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