Health Care Policy & Financing

FY 2016-17 PERFORMANCE PLAN

COLORADO
Department of Health Care Policy & Financing

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Introduction

Welcome to the Department of Health Care Policy & Financing's FY 2016-17 performance plan, an annual report detailing efforts to achieve our mission, vision, and goals. This performance plan follows guidelines from the Governor's Office of State Planning and Budgeting, and complies with Colorado's State Measurement for Accountable, Responsive, and Transparent Government (SMART) Act.

We receive federal funding as the single Colorado state agency responsible for administering the Medicaid program (Title XIX) and the Child Health Insurance Program (Title XXI), known as Child Health Plan *Plus* (CHP+). In addition to these programs, we administer the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Primary Care Fund, and the School Health Services Program. We also provide health care policy leadership for the state's executive branch. The Medicaid program receives approximately 61% of its funding from the federal government. The CHP+ program is approximately 86% federally funded.

Our Customers

Our direct customers include Coloradans who are eligible and/or enrolled in Medicaid and Child Health Plan *Plus*, and those who receive services through the other programs described above. Indirect customers (those that impact and are impacted by our work) include medical providers, partners such as non-profit entities and sister state agencies, the Centers for Medicare & Medicaid Services, groups that advocate for member populations, the Governor and the Legislature of the State of Colorado, service contractors, and entities that help eligible individuals apply for benefits. These entities include Colorado counties, local government agencies, and medical assistance sites.

Factors that Influence Our Work

The work we do and the strategy that guides it are shaped by external factors both positive and negative. These include:

- Medicaid member population: shifts in their demographics and health
- Aging technology infrastructure amidst rapidly advancing information technology
- Decisions of the Legislature of the State of Colorado
- Problems related to U.S. health care costs and efficiency that require creative solutions

The most significant external factors currently include issues related to health care costs and technology.

Health Care Costs – Perhaps the most critical environmental factor impacting our business is the escalating cost of health care in the U.S. Along with other payers and influencers of the U.S. health care delivery system, we are working to contain costs and improve the quality and efficiency of care. The strategic policy initiatives described in this performance plan are designed to do just that: Improve health outcomes, select and deliver evidence-based care, and eliminate payment for duplicative or unnecessary services.

Technology – A multi-year initiative to replace the aging Medicaid Management Information System (MMIS) will be completed In FY 2016-17. Impacts of this milestone include more efficient payment of claims, ability to adjust the system to changing policy needs, and access to improved data and analytics tools for measuring health outcomes, assessing value, and minimizing fraud, waste and abuse.

This Year's Performance Plan

The organization and narrative of this performance plan are as simple, concise, and customer-focused as possible, with the understanding that a key customer for this document is the Department itself.

The plan describes our long range goals, strategic policy initiatives, strategies, and performance measures. Data reported for each performance measure includes historical actuals for the prior two fiscal years, as well as one- and three-year targets. Performance is evaluated based on estimates for FY 2015-16, as actuals will not be available for all measures until 2017 as described below.

A glossary of acronyms and relevant terms is provided at the end of this document.

A FEW FACTS ABOUT OUR REPORTING

Performance Measures – We are focused on objectives related to improving health, ensuring members receive quality care, implementing evidence-based policy, and financing services efficiently. In an effort to make our performance plan and goals meaningful, we are using multiple measures to define success achieving our strategic goals. This provides a more complete picture when evaluating progress toward the complex objectives of quality health care, improved member health outcomes, and cost-effective health care.

The Data – The availability of timely and relevant data presents challenges in creating an actionable performance plan. Some of the reporting in this plan relies on de-identified health data from medical claims that can take up to six months to be billed, validated, paid, and entered into an electronic system. All of these steps must be completed before claims information becomes reportable as data for performance measurement. This time period is referred to as *claims run-out* or *lag time*, and it inhibits the ability to use claims data timely. Similarly, some data sets come from third party reports, and are dependent on the third party's processing and reporting times. To overcome these limitations, we maximize use of timely data and operational indicators (not included in the performance plan) to make intermediate course corrections when needed.

Performance Graphics – Most of the graphs and tables we use to display performance data include more than one performance measure. It's important to note that this is not indicative of correlation or cause and effect relationships between measures.

Graphs include more historical data than tables in order to provide more context.

Strategic Management Process

The elements of our strategic framework (described below) were developed during calendar year 2015, and are the creation of the entire agency. Our executive team defined strategic direction and priorities in spring 2015. A draft framework of supporting strategies, programs, and performance measures was then created by management and staff across the Department. Framework elements were revised by subject matter experts and solidified by managers and directors during summer and fall of 2015.

Beginning in January 2016, we constructed an outline of Department programs and work products aligned with the elements of our strategic framework. This process marks our first use of Lean strategic deployment principles and involves annual planning validated at the staff, middle management, and executive levels of the organization. This work has proven invaluable in constructing this year's performance plan.

Strategic Framework and Programs

This year's performance plan is constructed around a new framework using the process described above. Our six core values serve as its foundation, and four strategic policy initiatives support achievement of our long range goals, mission, and vision.

HCPF Strategic Framework Infographic

OUR CORE VALUES

An organization's core values can't be 'set' or created; they must be discovered. Our values, presented below, were identified and refined in much the same way we crafted our strategy – with the executive team initially, and management and staff across the Department contributing to and solidifying them. By declaring these values, we are committed to aligning our actions with them.

Person Centeredness: We respect and value the strengths, preferences, and contributions of employees, members, providers, and stakeholders by adapting and responding to individual needs.

Accountability: We accept responsibility for our actions, learn from our experiences, and inspire others to do the same.

Continuous Improvement: We evaluate our processes and systems, engage in creative problem-solving, and innovate solutions to work more efficiently and effectively.

Employee Engagement: We attract and retain talented people by creating a positive work environment and empowering them to shape our strategies and fulfill our mission.

Integrity: We behave ethically, treat others with dignity and respect, and align our actions with our mission and vision.

Transparency: We openly communicate decision-making processes, clearly articulate roles and responsibilities, and create opportunities to inform and influence policy.

STRATEGIC ELEMENTS AND ASSOCIATED PERFORMANCE MEASURES

ELEMENTS

Long Range Goals: Significant achievements requiring years of commitment to strategic policy initiatives and successful execution of strategies. Must be accompanied by performance measures and strategies.

Performance Measures: These gauge the effectiveness of strategies to achieve strategic policy initiatives and long range goals. Performance measures can be influenced by teams, and they are predictive of success or failure. They must meet "SMART" criteria and be expressed as "achieve X to Y by when" by comparing baseline or historical data to targets.

Strategic Policy Initiatives (SPIs): Significant objectives for the current fiscal year, destination oriented, achievable through strategies, and measurable by SMART performance measures. The ideal number of SPIs is 3-5 per year.

Strategies: High-impact action plans that must be successfully executed to achieve strategic policy initiatives.

FULFILLING THE GOVERNOR'S VISION

To achieve Governor Hickenlooper's vision of Colorado becoming the healthiest state in the nation, we contribute to his statewide health-related goals of *improving health care coverage* and *value in health care service delivery*.

We make progress by committing to the following long range goals and strategic policy initiatives.

LONG RANGE GOALS AND PERFORMANCE MEASURES

Goal	Measures
Improve health for low-income and vulnerable Coloradans	# Physically unhealthy days per month # Mentally unhealthy days per month
Enhance the quality of life and community experience of individuals and families	% New mothers receiving maternal depression screening % Persons receiving HCBS services expressing social inclusion or connectedness to the community % Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services
Reduce the cost of health care in Colorado	$ Medicaid per-capita total cost of care $ Total costs avoided from ACC and Medicaid

STRATEGIC POLICY INITIATIVES AND PERFORMANCE MEASURES – FY 2016-17

SPI	Definition	Measures
1. Delivery Systems Innovation	Medicaid members can easily access and navigate needed and appropriate services	% ACC members with an enhanced primary care medical provider
2. Tools of Transformation	The broader health care system is transformed by using levers in our control such as maximizing the use of value-based payment reform and emerging health technologies	$ Provider payments tied to quality or value through innovative payment methods
3. Partnerships to Improve Population Health	The health of low-income and vulnerable Coloradans improves through a balance of health and social programs made possible by partnerships	# Members in counties with a RCCO-LPHA* relationship
4. Operational Excellence	We are a model for compliant, efficient and effective business practices that are person- and family-centered	% Favorable responses to employee survey "we get work done more efficiently with less waste of money or other resources"

**Regional Care Collaborative Organization-local public health agency*

STRATEGIES AND PERFORMANCE MEASURES – FY 2016-17

The Strategic Policy Initiatives (SPIs) above are achieved through corresponding strategies 1A through 4E below. Performance measures indicate progress in areas relevant to each strategy.

As is apparent below, there is extensive cross-functionality among most of these strategies and performance measures (that is, most of them support more than one SPI).

1. Delivery Systems Innovation

#	Strategy	Measures
1A	Ensure robust management of Medicaid benefits	# Benefits modified to align with new data, research, or evidence-based guidelines through Benefits Collaborative, policy modifications, or rule changes
1B	Expand network of providers serving Medicaid	# Colorado providers serving Medicaid # Colorado primary care providers serving Medicaid
1C	Increase member engagement and health literacy	% Nurse Advice Line calls referred to more appropriate level of care # PEAK App users
1D	Integrate primary care and behavioral health service delivery	% New mothers receiving maternal depression screening # Members in practices that receive behavioral health integration incentives
1E	Make Long-Term Services and Supports easier to access and navigate	# Community Living Advisory Group recommendations fully or partially implemented % Persons receiving HCBS services expressing social inclusion or connectedness to the community % Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services
1F	Strengthen the ability of the ACC to deliver coordinated care	% ACC members with an enhanced primary care medical provider

2. Tools of Transformation

#	Strategy	Measures
2A	Expand the use of value-based purchasing methods	$ Provider payments tied to quality or value through innovative payment methods

2. Tools of Transformation		
#	**Strategy**	**Measures**
2B	Implement cost containment initiatives	$ Total costs avoided from ACC and Medicaid $ Medicaid per-capita total cost of care
2C	Maximize use of health information technology and data analytics, aligning these efforts with the broader health care system	# Medicaid professionals demonstrating meaningful use of electronic health records Providers with a quarterly report card; % of total Medicaid expenditures # Primary care medical providers who log in to the SDAC/BIDM provider portal

3. Partnerships to Improve Population Health		
#	**Strategy**	**Measures**
3A	Support statewide efforts to improve population health	# Members in counties with a RCCO-LPHA relationship # Education activities developed by SIM targeted towards PCMPs and community partners

4. Operational Excellence		
#	**Strategy**	**Measures**
4A	Enhance employee engagement and performance	% Favorable responses to employee survey “we get work done more efficiently with less waste of money or other resources” % Employee retention for 36 months or more
4B	Improve efficiency of business processes	% Electronically submitted clean claims processed within 7 business days % Providers notified of missing or incomplete enrollment information within 5 business days % First call resolution by Member Contact Center $ Dollar equivalent of Lean efficiency gains

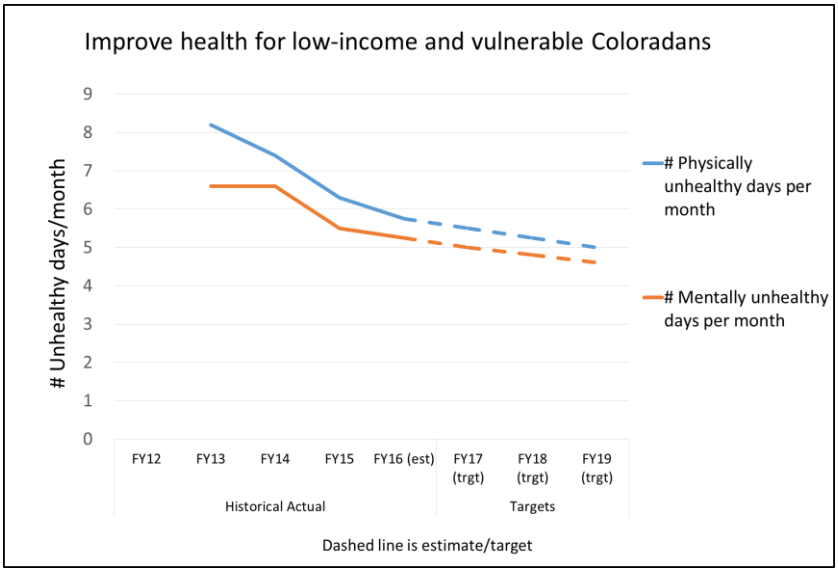
4. Operational Excellence		
#	**Strategy**	**Measures**
4C	Instill a person- and family-centered approach to strengthen employee engagement, client experience, client engagement, and culture change	# Items vetted through person-centered advisory councils % Persons receiving HCBS services with person-centered goals identified in their service plan
4D	Promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures	$ Dollars recovered from over-payments to Medicaid providers $ Dollars recovered from third party liability % Existing OSA audit recommendations resolved
4E	Support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently	# Individuals enrolled in Medicaid/CHP+ % Eligibility determinations processed timely % Real time eligibility applications

Section 1: Long Range Goals

This section presents our long range goals: achievements that will require at least three years of commitment to Strategic Policy Initiatives described in Section 2, and successful execution of Strategies described in Section 3.

LONG RANGE GOAL #1 IMPROVE HEALTH FOR LOW-INCOME AND VULNERABLE COLORADANS

We are committed to delivering a member-focused Medicaid program that improves health outcomes and member experience while delivering services in a cost-effective manner. This goal leverages proven reforms to health care delivery models (such as care coordination and payment incentives) and advances in health information technology to improve member health and well-being.



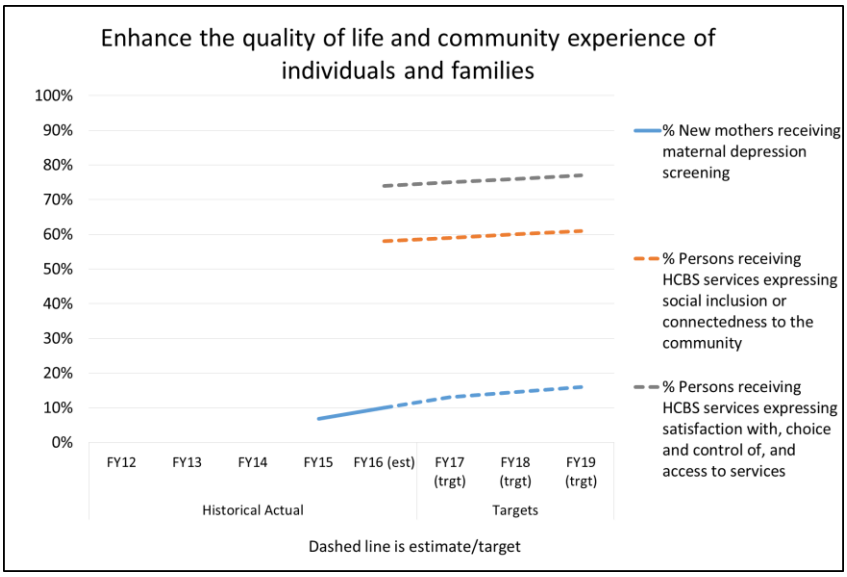
Performance measures indicative of improved health over time include the number of physically and mentally unhealthy days per month reported by our members. Since FY 2013-14, performance is trending downward, indicating steady progress toward achieving this long range goal.

Improve health for low-income and vulnerable Coloradans	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Physically unhealthy days per month	7.4	6.3	5.8	5.5	5.0
# Mentally unhealthy days per month	6.6	5.5	5.3	5.0	4.6

Data provided annually by CDPHE. Data is received approximately 10 months in arrears. Data for 2015 is anticipated in fall 2016.

LONG RANGE GOAL #2 ENHANCE THE QUALITY OF LIFE AND COMMUNITY EXPERIENCE OF INDIVIDUALS AND FAMILIES

This long range goal focuses on improving member experience through health interventions and care that improve conditions of daily life. A strong emphasis of this goal is helping members with complex medical needs get care when and where they need it, with a focus on care in the home and community.



By measuring maternal depression screenings among Medicaid members, and satisfaction rates among individuals receiving home and community based services, we can gauge progress toward enhancing quality of life and community experience. As these performance measures are new this year, there is insufficient data to determine a historical trend; we expect to show progress next fiscal year.

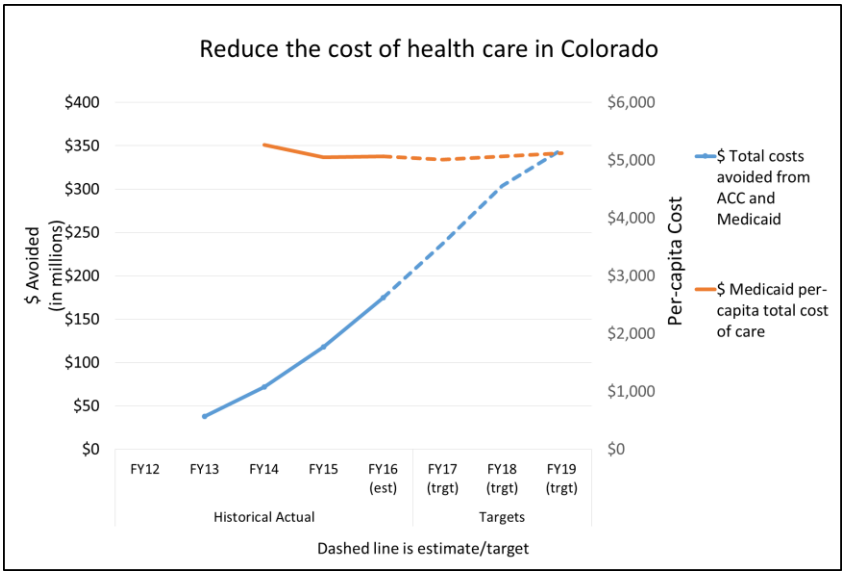
Enhance the quality of life and community experience of individuals and families	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% New mothers receiving maternal depression screening	N/A	7%	10%	13%	16%
% Persons receiving HCBS services expressing social inclusion or connectedness to the community	N/A	N/A	58%	59%	61%
% Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services	N/A	N/A	74%	75%	77%

The Department utilizes the NCI-AD (Aging and Disabled) and NCI-IDD (Individuals with Developmental Disabilities) Consumer Surveys to assess the two "Persons receiving HCBS services..." measures. The Department began tracking results from these surveys in FY 2015-16.

LONG RANGE GOAL #3 REDUCE THE COST OF HEALTH CARE IN COLORADO

This long range goal focuses on efforts to provide care that is high quality and low cost. It is supported by work to slow the growth rate of per-capita costs while improving health outcomes. It is also supported by efforts to make internal business processes more efficient, and to reduce fraud, waste, and abuse in the Medicaid program.

Two measures show progress toward reducing the cost of health care in Colorado: total costs avoided and Medicaid per-capita. Total costs avoided is a cumulative measure of prior year budget initiatives with savings due to cost containment initiatives, plus costs avoided by the Accountable Care Collaborative. Since FY 2012-13, an estimated $175 million in costs has been avoided as a result of improving care coordination and reducing payment for unnecessary, duplicative, and less effective services. By the end of FY 2016-17, that figure is expected to be $237 million. Medicaid per-capita is the annual average cost per member for total cost of care. Per-capita cost has decreased since FY 2013-14, and remains relatively flat.



Reduce the cost of health care in Colorado	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
$ Total costs avoided from ACC and Medicaid (in millions)	$72	$118	$175	$237	$346
$ Medicaid per-capita total cost of care	$5,268	$5,053	$5,063	$5,014	$5,119

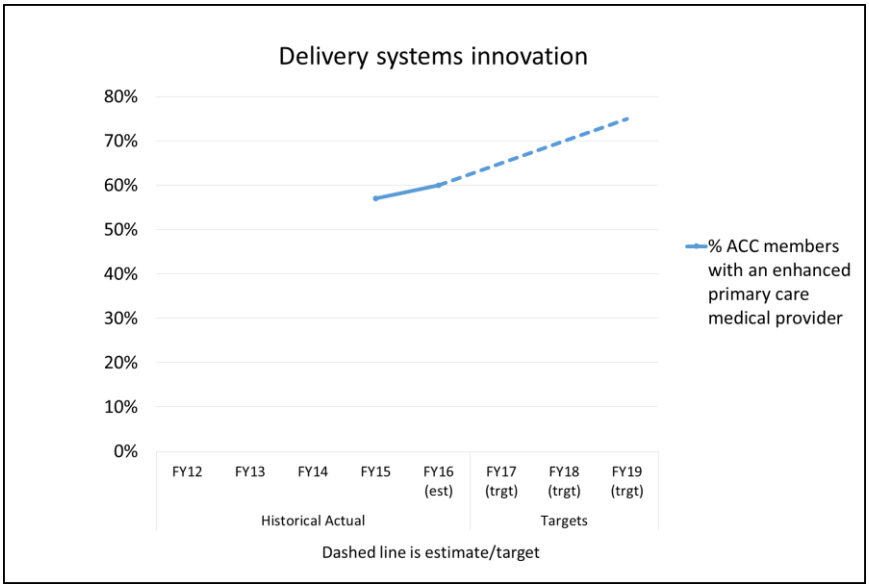
Per-capita costs include medical services, behavioral health, individuals with developmental disabilities, and Child Health Plan *Plus* (CHP+) expenditures.

Section 2: Strategic Policy Initiatives

Our four strategic policy initiatives, or SPIs, represent significant achievements that we expect to deliver through the strategies detailed in Section 3, below. The timeframe for accomplishing them is FY 2016-17. Each is accompanied by a performance measure representative of work accomplished through the SPI. Measures that align with one SPI often provide insight into the progress of others as well.

SPI #1 DELIVERY SYSTEMS INNOVATION

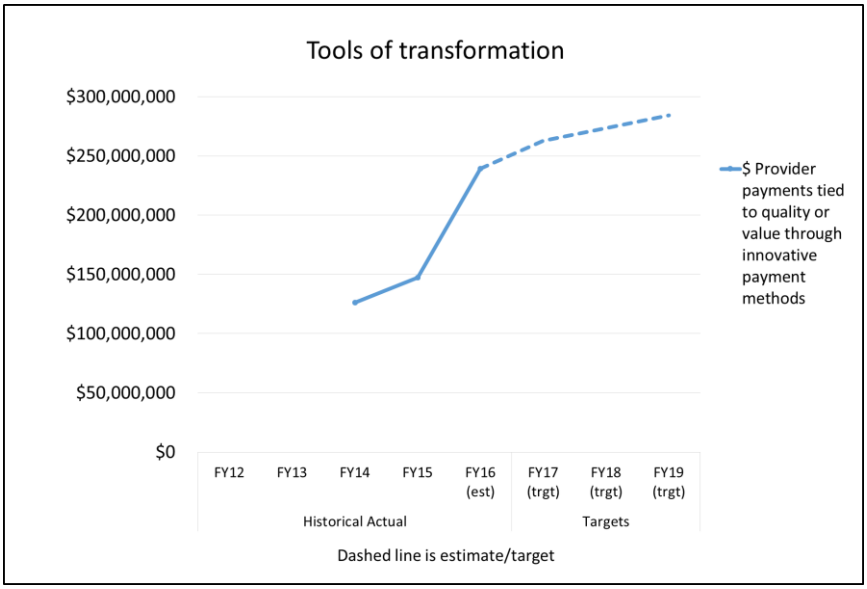
Our development of improved health care delivery systems focuses on enabling members to easily access and navigate necessary and appropriate services. Work supporting this SPI focuses on strengthening delivery systems such as the Accountable Care Collaborative (ACC), Behavioral Health Organizations, and Home and Community Based Services for the Elderly and Disabled. In addition, we are working to increase the integration of physical and behavioral health services. Although a combination of performance measures is necessary to gauge progress of delivery systems innovation, a representative measure is the percent of ACC members with an enhanced primary care medical provider. Efforts to enhance primary care services include incentivizing providers to offer evening and weekend hours, offering on-site behavioral health, and consultations via telephone and secure e-mail. This new performance measure is expected to increase at a rate of 3-5% per year.



Delivery systems innovation	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% ACC members with an enhanced primary care medical provider	N/A	57%	60%	65%	75%

SPI #2 TOOLS OF TRANSFORMATION

Medicaid, like Medicare, is an influential payer and policy maker nationwide. This makes it possible to use levers within our control to impact the broader health care system. For example, by implementing provider payment incentives to improve health outcomes in the Accountable Care Collaborative, we align with other payers in Colorado to use and improve upon these incentives. The same applies to the use of advanced health information technology and data analytics to improve quality and continuity of care. Work supporting this SPI focuses on increasing the impact of Colorado Medicaid investments and innovations to transform the broader health care system.



A good measure of performance for this strategic policy initiative is the dollar amount of provider payments tied to quality or value through innovative payment methods. Since FY 2013-14, the dollar amount of payments made using this methodology has nearly doubled, and is expected to increase by 5-10% per year going forward.

Tools of transformation	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
$ Provider payments tied to quality or value through innovative payment methods	$126,090,496	$147,343,753	$239,370,153	$262,722,933	$284,219,921

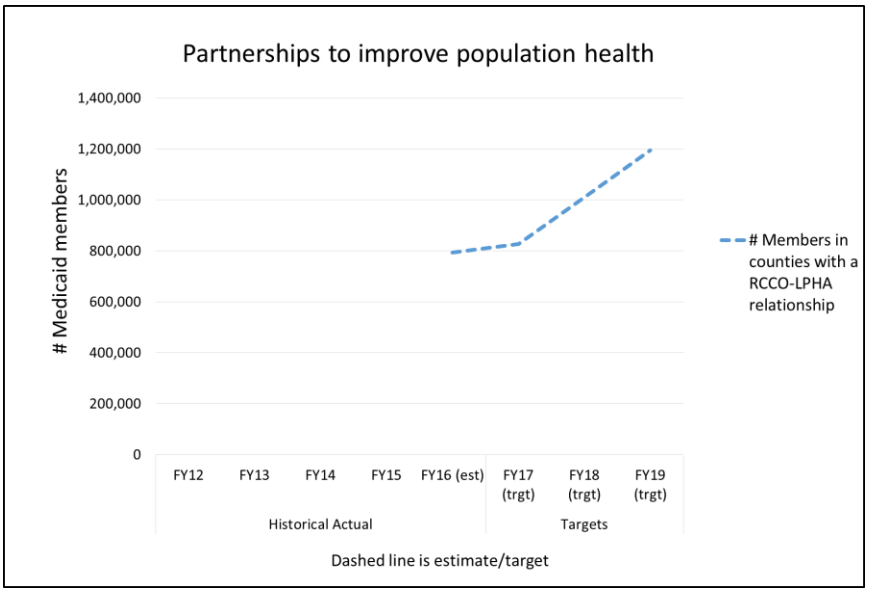
Payments tied to quality or value include: hospital quality incentive payments (HQIP), skilled nursing facility pay for performance (SNF P4P), ACC payments (RCCO+PCMP), health maintenance organization (HMO) incentives (excluding those based on shared savings), after-hours provider bump, and dental provider network adequacy payments (ended FY 2015-16).

SPI #3 PARTNERSHIPS TO IMPROVE POPULATION HEALTH

The Department seeks to improve the health and well-being of Coloradans served by the Medicaid program and of the population as a whole. Appropriate health care must be complemented by addressing additional determinants of health – social, economic, and geographic among them. This SPI focuses on our efforts to advance community-based health supports in partnership with entities including other state agencies, local public health organizations, non-profits, health care providers, and community centers.

We are measuring progress toward this strategic policy initiative by the number of members in counties where the local public health agency (LPHA) is working with a Regional Care Collaborative Organization (RCCO) to provide community-based health supports. LPHAs conduct community needs assessments and have a well-developed understanding of the communities they serve. They also house, or can link to, essential community supports such as the Special Supplemental Nutrition Program for Women, Infants, and Children or the Health Care Program for Children and Youth with Special Health Care Needs.

The RCCOs are encouraged to partner with LPHAs to share information and understanding about community needs as well as available resources. These partnerships are essential to expanding the reach of health care and health interventions such as preventive services supporting physical and behavioral health.



Measuring the number of members in a county with a RCCO-LPHA relationship reflects the enhanced capacity of the county to provide effective community-clinical linkages. This is a new performance measure with an estimated 792,568 members in such counties. We expect this number to increase approximately 4% next year.

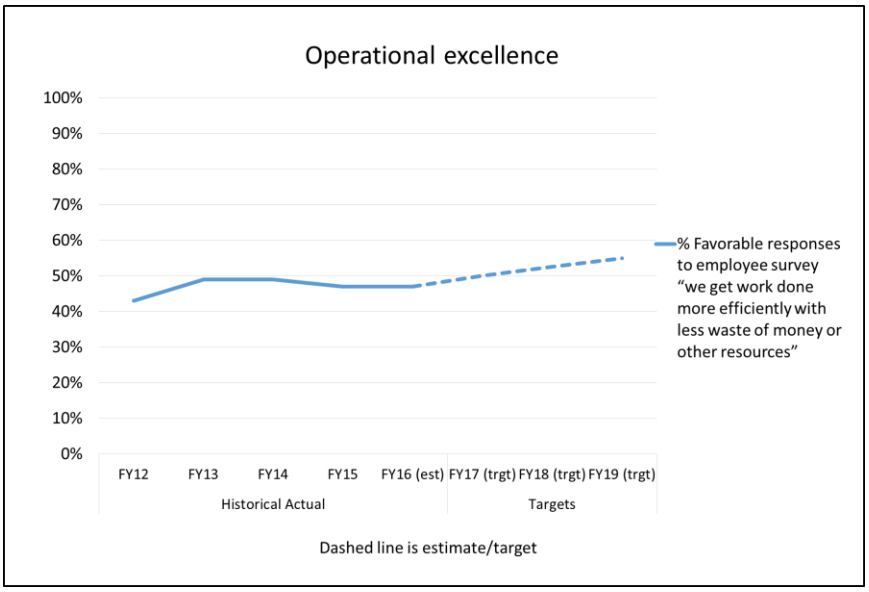
Partnerships to improve population health	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Members in counties with a RCCO-LPHA relationship	N/A	N/A	792,568	827,799	1,195,537

RCCO – Regional Care Collaborative Organization
LPHA – local public health agency

SPI #4 OPERATIONAL EXCELLENCE

We aim to be a model for compliant, efficient, and effective business practices that are person- and family-centered. To achieve this SPI we are redesigning our information technology infrastructure, improving data analytics capacity, advancing a culture of continuous improvement, and nurturing a well-trained, satisfied workforce.

To measure operational excellence, we are focusing on employee perception of efficiency. Current year results are from a biennial survey conducted by the Colorado Department of Personnel and Administration. In order to get annual data, we are exploring alternative survey options. The percentage of employees reporting increased efficiency within the Department dropped 2% in FY 2014-15, and remains at 47% until the next survey. We have employed numerous employee engagement strategies to support this SPI as described in Section 3 below, and we expect to see progress on this measure next year.



Operational excellence	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% Favorable responses to employee survey "we get work done more efficiently with less waste of money or other resources"	49%	47%	47%	50%	55%

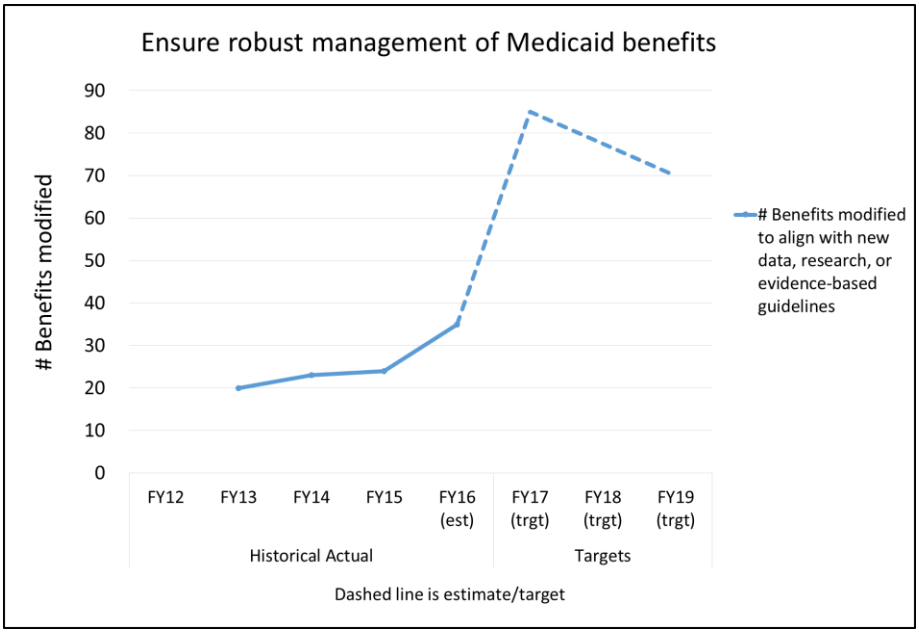
Section 3: Strategies

This section presents our 15 strategies, or high-level action plans for FY 2016-17. Each is accompanied by a selection of programs representing transformative work underway to achieve the strategy.

It's important to remember that many of the programs described in this section contribute support to more than one strategy, although those connections are not shown in this report.

STRATEGY #1A ENSURE ROBUST MANAGEMENT OF MEDICAID BENEFITS

Benefits management refers to a range of functions aimed at balancing member access to high quality and appropriate care with considerations of program cost. Safeguarding access, continuity and quality of care is a critical element of benefits management. The programs described below focus on ensuring that covered services are high quality and limited to those that are necessary and effective, and that provider payment rates are set at actuarially sound, sustainable levels.



A representative measure of progress with this strategy is the number of benefits modified each year to align with new data, research, or evidence-based guidelines. This number has steadily increased with focused efforts to review and modify benefits, and while we will continue to follow new data and evidence, we expect the number to plateau by FY 2018-19.

Ensure robust management of Medicaid benefits	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Benefits modified to align with new data, research, or evidence-based guidelines	23	24	35	85	70

Benefits modified include HCBS waivers and acute care.

The following programs assist in supporting our strategy to ensure robust management of Medicaid benefits.

BENEFIT POLICY ENFORCEMENT

Two mechanisms by which benefit policy is enforced are the Benefit Policy Inventory (BPI), created in 2016, and Benefit Management Reports. The BPI catalogues all fee-for-service benefit policies within the Department, and assists staff in policy enforcement.

The program is comprised of four phases:

- Phase I inventories all benefit policies and where they are located (completed FY 2015-16)
- Phase II catalogues how each policy is enforced (currently underway)
- Phase III analyzes the extent of provider compliance
- Phase IV prioritizes the most costly policies which may be deficient and takes action to remediate them

Benefit Management Reports were created in 2013 to track utilization and expenditure across the entire Medicaid population. The reports are used by staff to identify trends regarding service utilization, demographics, and eligibility types. They assist staff in identifying potential areas for policy improvement and fiscal stewardship.

There are currently 41 services or programs that have Benefit Management Reports. Additional reports will be added as new benefits are created and data becomes available. Following the start date of the new Colorado interChange in November 2016, Benefit Management Reports will include additional access data to further inform staff about penetration rates and areas of concern.

BENEFITS COLLABORATIVE

To support our strategy of ensuring robust management of Medicaid benefits, we routinely review new data, research, and evidence-based guidelines to ensure that covered services are current and appropriate for provision of quality health care.

One mechanism for achieving this is through the public Benefits Collaborative process, which applies person-centered principles to the design and revision of Colorado Medicaid covered services. The Benefits Collaborative seeks to define coverage that

- is based on the best available clinical evidence and best practices,
- outlines the appropriate amount, scope and duration of Medicaid services,
- is cost-effective and sets reasonable limits upon services, and
- promotes the health and functioning of Medicaid members.

Coverage policies established through the Benefits Collaborative are re-examined every three years.

In addition to ensuring responsible allocation of taxpayer dollars and promoting member health, clearly defined coverage provides guidance for service providers and increases member understanding of their benefits.

MEDICAID AND CHP+ MANAGED CARE CONTRACT MANAGEMENT

In FY 2015-16, we changed our approach to managed care contract management from one centered on compliance to one that drives performance. We created a contracts knowledge center to support greater understanding of processes and program activities. We are closely monitoring and analyzing key performance indicators (KPIs), including quality of care, timeliness of care and network adequacy. For example, DHMC's[1] Healthcare Effectiveness Data & Information Set (HEDIS) measure for Well-Child Visits for infants has been below average. After reviewing this issue, we found that the newborn enrollment process impacted continuity of care for newborns. We are working with DHMC to improve this process to ensure newborns are accessing and receiving timely care.

In 2016-17, we will continue to track performance on the KPIs, work with the plans to make sure that members receive the care and support they need, and review contracts with an eye toward clarifying expectations, incentivizing performance and delivering better services to members. In addition, we will continue to build on the contracts management knowledge center to facilitate greater access to progress and performance.

[1] Denver Health Medicaid Choice (DHMC) is a full-risk capitation contract for physical health.

UTILIZATION MANAGEMENT

The ColoradoPAR Program for utilization management (UM) is an effective way to ensure robust management of Medicaid benefits. It is comprised of guidelines that help ensure clients receive the right services and supports at the right time, and for the correct duration. This program improves quality of care and saves taxpayer money by reducing unnecessary and duplicative services.

eQHealth Solutions began as our UM vendor in September 2015. The UM vendor reviews prior authorization requests (PARs) to determine if services are medically necessary according to established criteria and guidelines. The ColoradoPAR Program reviews PARs for the following categories of services and supplies:

- Audiology
- Behavioral therapies
- Diagnostic imaging
- Durable medical equipment
- Habilitative speech therapy
- Inpatient out-of-state admissions
- Medical services, including transplant and bariatric surgery
- Physical & occupational therapy
- Pediatric long-term home health
- Private duty nursing
- Synagis®
- Vision

In FY 2015-16, our focus was on streamlining processes for providers with the new PAR portal, with an emphasis on provider outreach and education. In FY 2016-17, we will work with eQHealth Solutions to continue improving the PAR process through a data-driven, evidence-based approach. eQHealth Solutions has provided their initial UM Plan for the program and identified numerous initiatives to decrease inappropriate utilization of benefits. Alignment with the COMMIT[2] project will provide opportunities to enforce more specialized benefit criteria and enhance system capability to align prior authorization with payment. This will improve provider satisfaction and ease, as well as continuity of client care. We expect to see benefit utilization and cost reductions as collaboration, process efficiencies, program alignment, and policy enforcement increase.

[2] Colorado Medicaid Management Innovation and Transformation. (See *COMMIT* on page 43.)

NURSE ADVICE LINE

Proper utilization of services is also influenced through the Nurse Advice Line (NAL), which provides Medicaid members with free around-the-clock access to medical information and advice. The NAL works with clients to identify the most appropriate level of care based on a client's individual health care needs. It also refers clients to their local Regional Care Collaborative Organization (RCCO) and/or to other appropriate services, such as the Nurse Family Partnership. Daily data feeds of NAL caller information are transmitted to the caller's RCCO to encourage care coordination and greater follow-up with the caller's primary physicians. The Nurse Advice Line also supports our strategy to increase member engagement and health literacy. For measures related to NAL, see the table on page 23.

HCBS PROGRAM EVALUATION

An important focus of our efforts to improve benefits management this year will be on evaluating the Home and Community Based Services (HCBS) program for policy and rule changes needed under the 11 HCBS waivers. The HCBS waiver program is the Medicaid long-term care community alternative to serving eligible persons in an institution. Through HCBS waivers, individuals at risk of being placed in an institution can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Specific examples of evaluation and improvement of these waivers include:

- Consumer Directed Attendant Services and Supports (CDASS): Studying the efficacy of the delivery model to provide qualitative data on whether program participants are (1) receiving sufficient access to meet their identified care needs, (2) experiencing a person-centered approach to service delivery, and (3) achieving better health outcomes.
- Home Modification Benefit: examining the amount of time between a person's request for home modification and the beginning and completion of construction on their home. We have received anecdotal reports of long wait times for home modification to be completed. This evaluation will be used to create new processes to reduce these timelines.

QUALITY INDICATOR SURVEY – PERFORMANCE MEASURES REDESIGN

Another important effort supporting our strategy for ensuring robust management of Medicaid benefits is the Quality Indicator Survey for performance measures redesign. Our goal is to meet federal requirements[3] for having systems in place to measure, improve performance, and provide assurances of quality for the Home and Community Based Services (HCBS) waivers.

Currently all 11 of Colorado's HCBS waivers meet minimum requirements for CMS assurances. However, many of the current performance measures either do not measure improvement, or do not provide quality data to inform program improvement. We will review and redesign these measures to improve services provided to enrolled participants.

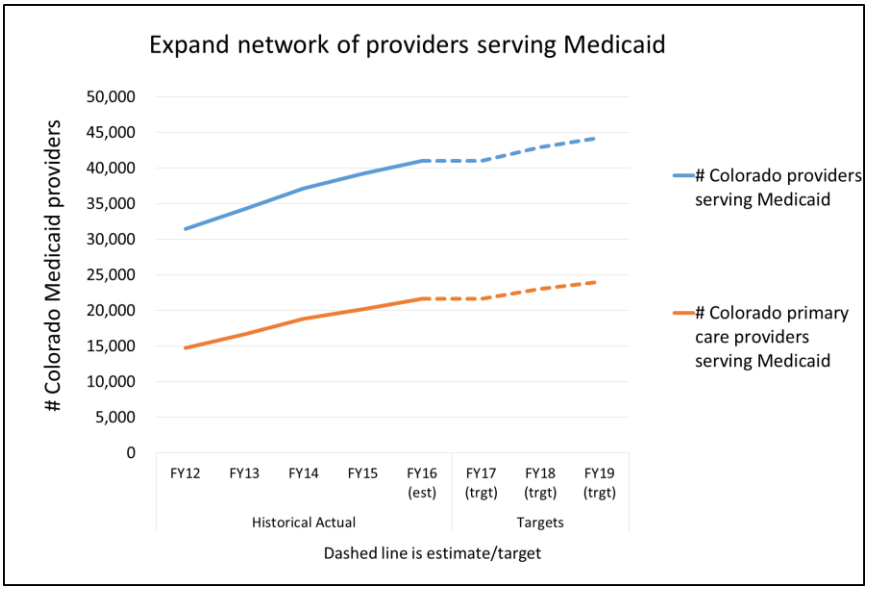
STRATEGY #1B EXPAND THE NETWORK OF PROVIDERS SERVING MEDICAID

Our ultimate aim for this strategy is to improve member access to care. Increasing the number of providers and physicians serving Colorado Medicaid is an important way to achieve this. To gauge progress with this strategy we are measuring the number of health care providers serving the Medicaid population. This

[3] 42 CFR 441.301 and 441.302

number has increased since FY 2013-14 from 37 thousand to an estimated 41 thousand. Among these, approximately half are primary care providers.

During FY 2016-17, we do not anticipate growth in the number of providers due to the federally mandated provider revalidation project requiring providers to re-enroll. The project is establishing more accurate and current enrollment information, and accounting for providers who no longer serve Medicaid clients. While this project may result in a temporary flattening of the number of providers, we expect enrollments to gradually increase again in FY 2017-18 as a result of efforts to expand the network described below.



Expand network of providers serving Medicaid	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Colorado providers serving Medicaid	37,187	39,208	41,008	41,008	44,245
# Colorado primary care providers serving Medicaid	18,822	20,151	21,616	21,616	23,998

This measure restates prior years' reporting to include only providers within the state of Colorado.

The following programs assist in supporting our strategy to expand the network of providers serving Medicaid.

ACCESS TO CARE

A primary focus of the Department is to ensure that members have adequate access to care so that they receive services from appropriate providers, including transportation, as needed. Access to needed services helps to ensure that members receive the right services at the right time. To ensure our members have adequate access to care, we are working to impact three variables:

- Member health needs
- Availability of services to meet member needs
- Member utilization of needed services

Member health needs are being addressed through a number of Department programs. The Medicaid Nurse Advice Line (NAL) serves as one mechanism to improve access to care. Members may call 24 hours a day to receive medical advice to help determine the appropriate level of care (e.g., home care, emergent care, or physician follow-up) based on reported symptoms and conditions. Members may also call to receive advice and education related to chronic medical conditions, such as diabetes. NAL staff refer

members to appropriate Medicaid, Department, state, and community resources (e.g., Nurse Family Partnership) based on their needs, which helps bridge gaps related to health care and social determinants of health. The NAL shares data with Regional Care Collaborative Organizations to help support coordinated care and primary care physician follow-up.

The ColoradoPAR Program and Medicaid member appeals and policy staff work directly with providers and members on a case-by-case basis to direct them to appropriate services based on member needs. For example, if members do not meet criteria for one service, they will be directed to a more appropriate service to best meet their needs.

Medicaid staff, with stakeholder input, develop policies to expand access to care with consideration to provider requirements (e.g., provider types that can render services, prior authorization requirements, limitations), reimbursement, member quality of care, and regional factors. More specifically, the Benefits Collaborative, the Department's formal stakeholder engagement process to define benefits, uses a person-centered, collaborative approach when creating or revising benefits. In addition to supporting access to care, the Benefits Collaborative supports Strategy #1A, *ensure robust management of Medicaid benefits* (see page 14).

Another way access to services is impacted is by how much providers are paid. Federal law requires state medical assistance programs to ensure payments are consistent with efficiency, economy and quality of care, and sufficient to enlist enough providers so that care and services are available.[4] This means, in part, ensuring compensation is adequate across payers, provider types, and health care delivery sites. When provider payment rates are reduced or restructured, we use an access monitoring program to ensure access is not diminished. In cases where access is diminished, corrective action such as a payment increase is taken to reduce barriers to provider enrollment. In addition, we conduct recurring provider rate reviews analyzing utilization, access, and quality, and rate comparison by service. In response to payment rate review findings, strategies are developed to ensure payments are sound, and recommendations are provided to the Joint Budget Committee each November.

Both availability of services and member utilization of needed services are impacted when a member lacks access to transportation in a non-emergency situation. For this reason, non-emergent medical transportation (NEMT) to and from Medicaid services is a mandatory State Plan benefit offered to all Medicaid members. The Department recently took steps to improve access to, and quality of, NEMT services. In November 2014, we contracted with a new NEMT provider, Total Transit, to service nine counties on the Front Range. To support retention of NEMT service providers, we applied a targeted rate increase to a number of transportation services in addition to the 0.5% across-the-board provider rate increase effective July 2015. Most recently, we supported legislation which became effective July 1, 2016 to increase the number of qualified NEMT providers by reducing licensing barriers.

DENTAQUEST PERFORMANCE MANAGEMENT

DentaQuest performance management has enabled us to improve and confirm effectiveness in multiple areas, including expansion of our dental provider network.

[4] Equal access provision in Section 1902(a)(30)(A) of the Social Security Act, amended 2015 in 42 C.F.R. §447.

We added an adult dental benefit in FY 2014-15, and contracted with DentaQuest to administer dental benefits for children and adults. DentaQuest uses an administrative services organization (ASO) delivery model, and sets annual performance goals focused on areas in need of improvement.

The performance goal for FY 2014-15 was to increase the size of the dental network, as prior to adding the adult benefit, our dental network only served children. DentaQuest met the highest/best tier of this goal by increasing the size of its network by 300 dentists and 50 dental hygienists. The goal for FY 2015-16 was to reduce the number of adult dental-related emergency department visits.[5] One of the main reasons for the addition of the adult dental benefit was that members were receiving higher cost emergency room dental services because they did not have access to preventive and restorative care as a covered Medicaid benefit. The goal for FY 2016-17 is to measure health outcomes, with the purpose of ensuring that access to preventive and restorative dental care has had a positive impact on member health (reduced diabetic-related episodes, pre-term deliveries, etc.).

During FY 2016-17 and FY 2017-18, we will evaluate data to set appropriate performance goals for the final two years of the DentaQuest contract, providing flexibility to set goals based on areas in need of improvement as the program matures. Department staff are in active discussions with the American Dental Association to explore measures to confirm the value of offering a dental benefit to Medicaid members, in particular adults (as this is an optional benefit).

PRIMARY CARE MEDICAL PROVIDER OUTREACH & ENROLLMENT FOR THE ACC

Because primary care is critical to preventive health and wellness, our goal for the Primary Care Medical Provider Outreach and Enrollment program is to increase the number of providers available as primary care medical providers (PCMPs). While we have made steady progress since the ACC was implemented in 2011, there is still opportunity for improvement. Important targets for this work are:

- providers that are not PCMPs but are providing care to ACC-enrolled individuals,
- providers serving as the medical home for individuals enrolled in the ACC's Medicare-Medicaid program who accept Medicaid, and
- rural health centers.

Approximately half of the rural health centers are PCMPs, and we target them through outreach at rural health center events.

To support these outreach and enrollment efforts, we have implemented several strategies to increase financial incentives for PCMPs, including the enhanced PCMP initiative. This initiative allows primary care practices that meet at least five out of nine "enhanced" service factors to receive an additional $.50 per member per month. Enhanced service factors include member offerings such as evening or weekend hours, telephone or secure electronic message consultations, and access to onsite behavioral health specialists. Payment incentives are also offered to primary care practices participating in SIM. (See the SIM Practice Transformation program description on page 27.)

[5] Performance goal outcomes are evaluated in the subsequent FY to account for claims run-out.

PROVIDER RELATIONS ENHANCEMENT

Provider relations is critical to our strategy of expanding the network, as well as retaining providers serving Colorado Medicaid. The Department established its Provider Relations Unit in 2014, recognizing a need for dedicated resources for provider recruitment, retention, and relations. This unit is tasked with ensuring the Colorado Medicaid provider network is adequate and comprehensive, with sufficient physical, behavioral, dental, and long-term services. Ongoing responsibilities include outreach, recruitment/retention, enrollment support, and communications.

Beginning in September 2015, this unit began supporting providers in complying with new federally mandated provider screening/revalidation regulations. Completion of the revalidation process is anticipated to occur in October 2016. During FY 2016-17, Provider Relations will focus its efforts on increasing primary and specialty care providers statewide, removing barriers to Medicaid participation, expanding and improving relationships between Medicaid and the provider community, and developing the provider workforce of the future. Also during FY 2016-17, Provider Relations will provide preparation and post-launch support for our new enrollment and claims payment system. This work will include development of provider communications and training to support the launch, and once the system is implemented, development of reporting to support targeted provider outreach and assessment of access to care for Medicaid members across the state.

EXTERNAL RELATIONS

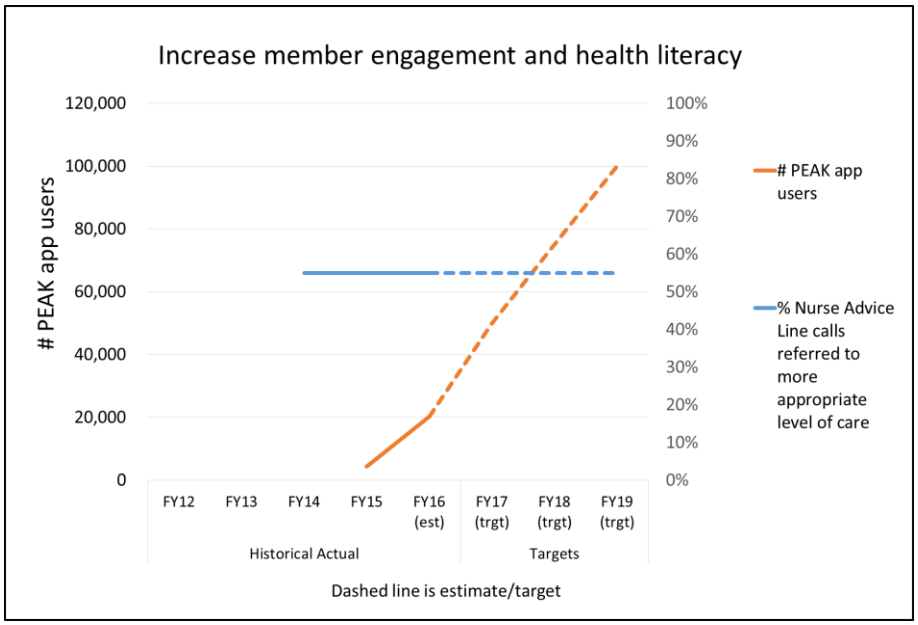
External relations efforts support all of our strategies, but place particular emphasis on our strategy to expand the network of providers serving Medicaid. This is due to the importance of developing messaging to help providers understand changes related to the provider revalidation project and implementation of COMMIT and related IT components this fiscal year. (See *COMMIT* on page 43.)

STRATEGY #1C INCREASE MEMBER ENGAGEMENT AND HEALTH LITERACY

This strategy supports efforts to engage members in their health and health care decision making with the goals of promoting wise use of services and improving health and wellbeing.

Although a combination of performance measures is necessary to gauge progress with member engagement and health literacy, we have selected two representative measures: number of PEAK App users and percent of Nurse Advice Line calls referred to a more appropriate level of care.

The Peak App was launched in December 2014, and the number of users has increased to approximately 20,000 to date. Our goal is to reach 100,000 users by FY 2018-19. The Nurse Advice Line has been steadily referring 55% of its callers to more appropriate levels of care. For example, to a primary care physician instead of an emergency department, or if conditions appear emergent, to visit an emergency department instead of waiting for an appointment.



Increase member engagement and health literacy	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% Nurse Advice Line calls referred to more appropriate level of care	55%	55%	55%	55%	55%
# PEAK app users	N/A	4,337	20,228	50,000	100,000

The Department launched its Peak mobile app in December 2014.
The Nurse Advice Line received over 18,000 calls in FY 2014-15 and will receive an estimated 30,000 calls in FY 2015-16.

The following programs assist in supporting our strategy to increase member engagement and health literacy.

MEMBER PORTAL

Capabilities of the new Colorado interChange system include a web-based member portal that can be accessed from a computer or mobile device. The portal advances our strategy of increasing member engagement and health literacy by allowing members to easily keep their information up to date, find a doctor, and access important health information from their phone or computer. Information and functions available through the portal include:

- Information about eligibility and benefits
- Claims submitted by their providers
- Explanation of medical benefits for each paid claim

- Search for a provider
- Status of coverage appeals
- Authorizations

PEAK APP

The PEAK*Health* mobile application increases member engagement and health literacy by providing members with a simple way to keep their information up to date, find a doctor, and access important health information right from their phone. The free app was introduced in 2014. From PEAK*Health*, members can:

- View information about their benefits
- Update information about their income and upload their paystub
- Update contact and household information
- Set up payments for CHP+ enrollment fees or Medicaid Buy-in program premiums
- Learn about health and wellness
- Find a provider
- View an electronic version of their Medicaid card

HEALTHY COMMUNITIES EVALUATION RECOMMENDATIONS

Healthy Communities is a statewide program administered at the local level by 26 local public health agencies serving all children (birth through age 20) and pregnant women on Medicaid and CHP+. More than 100 Family Health Coordinators across these sites perform community outreach, application assistance, client orientation/navigation services, provider and community resource referrals, client health education, and administrative case management.

In FY 2014-15, we commissioned an evaluation of the Healthy Communities Program and identified recommendations to eliminate duplication of work and to better align Healthy Communities activities with EPSDT well-child visit participation outcomes.[6,7]

As of FY 2013-14, 49% of Colorado's children on Medicaid received a complete well-child visit as compared to a national average of 63% and a CMS mandate of 80%.[8] The most recent data reported for FY 2014-15 shows a further decline of three percentage points to 46%.[9]

The evaluation recommended focusing program resources on those age groups (6-9, 10-14, 15-18) with the highest number of eligible children and with the greatest need for improvement. It further recommended that to make the most impact on state performance, improving performance in the top 12 (of 64) counties by program population would affect 85% of eligible children.

The Healthy Communities Program began implementing evaluation recommendations in FY 2015-16 by incorporating Medicaid claims data into its Client Relationship Management system to enable Family

[6] Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the pediatric component of Medicaid
[7] EPSDT Outcomes Mapping Report. Upleaf, 2015. Annex C
[8] FY14 CMS EPSDT 416 Report: Colorado
[9] FY15 CMS EPSDT 416 Report: Colorado

Health Coordinators to better prioritize and follow up on children who have not had a well-check during the previous year. This also allows us to better ensure compliance in this area.

MEMBER ENGAGEMENT

Our goal for the Member Engagement program is to infuse policy, programs, and operations with an understanding of how members engage with, participate in, use and respond to the Medicaid and CHP+ health care system. One outcome of member engagement is better health outcomes for members at lower cost. For example, we know that successfully finding a provider can be the difference between an office visit and an emergency room visit.

A centerpiece of member engagement efforts during the previous year is PEAK*Health*, a mobile app launched in December 2014. The app was designed to meet growing demand from members for better access to their health coverage information. Research for its development uncovered the main needs motivating members to contact the Member Contact Center. Five self-service options to meet those needs were built into the app: 1) provider search 2) medical card 3) coverage status, 4) basic benefits, and 5) updating information.

During FY 2016-17, we will be focusing member engagement work on appropriate use of care. We will continue to improve member engagement through trusted, clear and easy-to-access information and tools. For example, streamlining and consolidating member handbooks and offering them in more widely accepted formats.

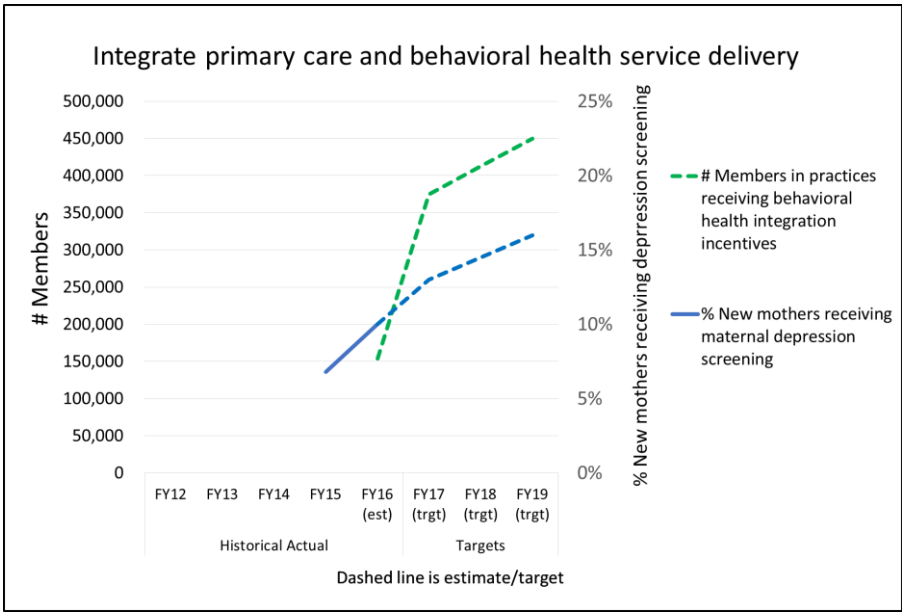
CLIENT COMMUNICATIONS

External relations efforts dedicated to client communications are another way we are advancing our strategy to increase member engagement and health literacy. This work, taking place during FY 2016-17, focuses on improving correspondence with Medicaid clients and involves use of plain language and accessibility. It is complemented by creation of a set of client communication best practices that can be leveraged by other state agencies through the Colorado Benefits Management System (CBMS).

STRATEGY #1D INTEGRATE PRIMARY CARE AND BEHAVIORAL HEALTH SERVICE DELIVERY

Behavioral and substance use disorder health care delivery systems are often entirely separate and excluded from the physical health system, resulting in substandard care and increased costs.[10] In addressing the problem of behavioral and physical health care segregation, we have integrated substance use disorder and behavioral health care, and are piloting an integrated physical and behavioral health delivery model through the Colorado State Innovation Model Practice Transformation project, described below.

[10] Nardone, et al. :Integrating Physical and Behavioral Health Care: Promising Medicaid Models." Feb 12, 2014. Kaiser Commission on Medicaid and the Uninsured.



To gauge progress with this strategy we are measuring the percent of new mothers receiving maternal depression screening, and the number of members in practices that receive financial incentives to integrate physical and behavioral health services. Both of these measures are on track and expected to trend upward due to the efforts described below.

Integrate primary care and behavioral health service delivery	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% New mothers receiving maternal depression screening	N/A	7%	10%	13%	16%
# Members in practices receiving behavioral health integration incentives	N/A	N/A	154,147	375,000	450,000

Claims are submitted based on the child's enrollment in Medicaid/CHP+. Behavioral health services for maternal depression are billed with services for the child. Because no claims are submitted until after the birth of the child and require a three month runout to ensure accurate reporting, the Department reports this metric one year in arrears.

The following programs assist in supporting our strategy to integrate primary care and behavioral health service delivery.

MATERNAL DEPRESSION SCREENING

We are working with primary care providers to provide preventive services such as information on nutrition, vaccinations, depression screenings and more. Preventive strategies help providers identify problems before they turn into serious complications. To increase the number of new mothers screened for depression, we are partnering with the Colorado Department of Public Health and Environment on ways to share data on this population and collaborate about detection and referral strategies. Untreated postpartum depression negatively impacts the health and well-being of mothers and their families. Early intervention and treatment is attainable through coordinated care and integrated physical and behavioral health services.

SIM PRACTICE TRANSFORMATION

Accountable Care Collaborative (ACC) participation in the Colorado State Innovation Model (SIM) Primary Care Practice Transformation project is a central component of the Department's behavioral and physical health integration strategy.

Colorado SIM is a statewide public health project funded by a grant from the Center for Medicare & Medicaid Innovation (CMMI). Its goal is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated community systems. An integral focus of this goal is to pay for value, not volume (using value-based payment structures), for 80 percent of Colorado residents by 2019.

Through Colorado SIM, the Regional Care Collaborative Organizations are making payments to selected primary care medical practices to help them integrate physical and behavioral health care and move along Colorado SIM's 10 Building Blocks of High-Performing Primary Care. The Department is providing financial and administrative oversight for Colorado SIM, and has placed key staff in each of the eight Colorado SIM workgroups to ensure continuity of Colorado SIM support and facilitate alignment and synergy with the ACC. The Department also serves as a payer supporting Medicaid practices participating in Colorado SIM.

From February 2016-February 2018, we will be supporting Colorado SIM's goal of recruiting 400 primary care practices and helping them transition to care delivery models that integrate physical and behavioral health care. To do so, SIM is collaborating with ACC providers to implement models of integrated care with the objective of providing consumers access to behavioral and physical health care services in coordinated systems of care.

Through the involvement of ACC primary care practices, the Department is receiving benefits of SIM practice transformation. Benefits include SIM-funded education for Medicaid providers that supports practice integration and transformation, and connection between communities and practices. These and other aspects of our participation in Colorado SIM are helping us prepare providers to integrate physical and behavioral health in FY 2018-19 when the new ACC contract begins (ACC Phase II). See the ACC program description on page 32 for more about ACC Phase II.

BEHAVIORAL HEALTH

Behavioral Health Organizations (BHOs) and the ACC are advancing our strategy of integrating primary and behavioral health service delivery through the Community Behavioral Health Services program. This program provides comprehensive mental health and substance use disorder (SUD) services to Medicaid-enrolled Coloradans. The program is operated by four BHOs in five geographical regions statewide.

Following integration of SUD benefits into the BHOs, initiation for SUD increased by 47% and treatment for SUD increased by 38%. During FY 2016-17, we will extend treatment delivered through the BHOs by

- optimizing treatment for substance-use dependent members who use the emergency department,
- increasing the number of foster care children receiving assessments and services by 5%, and
- working with state and county partners to increase services and care coordination for members transitioning back to the community from the criminal justice system.

In addition, the Department is collaborating with providers to develop models of integrated care, enabling consumers to access behavioral and physical health care services in one location. When physical health

providers become fully integrated into the flow of behavioral health care services, consumers can attend groups or individual appointments with their psychiatrist or therapist, then meet with the nurse practitioner to follow up on other medical conditions, receive wellness checks and health education services. Communication between the medical and behavioral health providers is seamless and bi-directional.

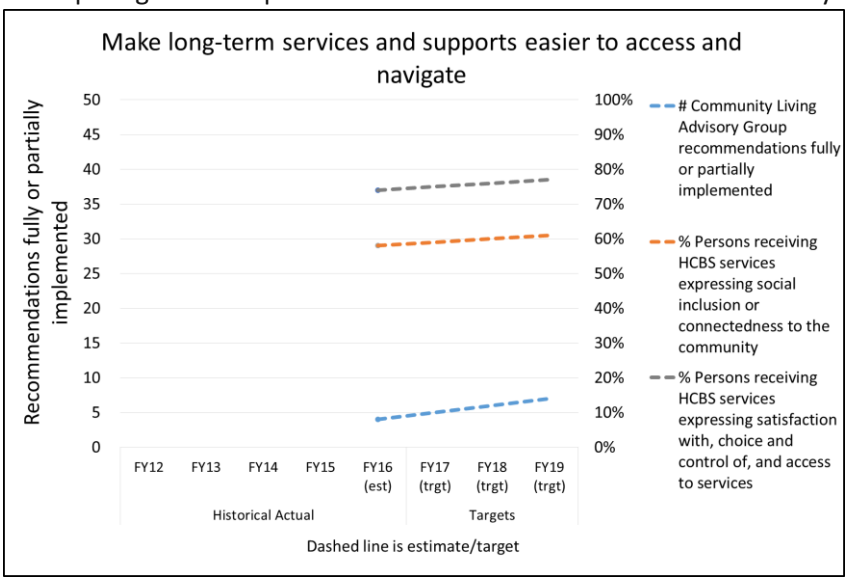
Further plans to integrate behavioral and physical health care will be realized when we launch ACC Phase II in FY 2018-19. The concept includes contracting with one regional entity to focus on whole-person care and provide multidisciplinary health teams that, based on a client's needs, can include specialty behavioral health providers, long-term services and supports, case management agencies, and other specialists.

STRATEGY #1E MAKE LONG-TERM SERVICES AND SUPPORTS EASIER TO ACCESS AND NAVIGATE

Colorado has begun a large-scale effort to transform its delivery system for long-term services and supports (LTSS). Efforts focus on increasing ease of access, simplifying processes, expanding services, and reducing administrative burden. Programs supporting this strategy focus on simplifying Colorado Medicaid State Plan waivers for older Coloradans and persons with disabilities, and developing infrastructure to transition members from long-term care facilities to community-based settings.

We have chosen three new performance measures this year to gauge success of this strategy: the number of Community Living Advisory Group (CLAG) recommendations implemented, and two satisfaction measures from individuals receiving Home and Community Based Services.

We expect gradual improvement in satisfaction scores as the LTSS system shifts to being more person-centered. With respect to the number of CLAG recommendations implemented, we will submit a report to the legislature this fall providing a comprehensive update.



Make long-term services and supports easier to access and navigate	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Community Living Advisory Group recommendations fully or partially implemented	N/A	N/A	4	5	7
% Persons receiving HCBS services expressing social inclusion or connectedness to the community	N/A	N/A	58%	59%	61%
% Persons receiving HCBS services expressing satisfaction with, choice and control of, and access to services	N/A	N/A	74%	75%	77%

The Department began implementing Community Living Advisory Group recommendations in FY 2015-16.
The Department utilizes the NCI-AD (Aging and Disabled) and NCI-IDD (Individuals with Developmental Disabilities) Consumer Surveys to assess the two "Persons receiving HCBS services..." measures. The Department began tracking results from these surveys in FY 2015-16.

The following programs assist in supporting our strategy to make Long-Term Services and Supports easier to access and navigate.

NO WRONG DOOR

No Wrong Door (NWD) is a state grant program administered by the federal Administration on Community Living. Grants are designed to help states develop No Wrong Door systems that streamline Long-Term Services and Supports processes, making it easier for older adults and people with disabilities to learn about – and access – the services they need.

After receiving a NWD planning grant in 2014, we developed a NWD framework based on recommendations in Colorado's Community Living Plan and the Community Living Advisory Group.

To implement these recommendations, we have chosen to adopt the six components of a fully functioning NWD system created by the Administration on Community Living:

- Information, referral, and awareness
- Person-centered counseling
- Streamlined eligibility for public programs
- Person-centered transition support
- Individual populations, partnerships, and stakeholder involvement
- Quality assurance and continuous improvement

During 2015, we developed a model for deploying NWD systems at a regional level, and will test the model by financing three to five regional NWD systems as pilot sites during 2017 and 2018 through a NWD implementation grant. During 2016, we will identify pilot sites for these efforts, and plan to continue refining the model based on best practices and statutory and regulatory requirements over the course of the pilot. We will also determine financing for statewide implementation.

HOME AND COMMUNITY BASED SERVICES WAIVER REDESIGN

Our Strategy for waiver redesign is to simplify access to services, and improve satisfaction, health, and quality of life for Coloradans requiring long-term services and supports.

A waiver enables us to set aside Medicaid State Plan requirements in order to provide a specified member population with needed services. Our redesigning of services provided under the 11 Home and Community Based Services (HCBS) waivers was initiated in response to the Community Living Advisory Group 2014 recommendations to the Governor of Colorado for improving the state's system of Long-Term Services and Supports.

HCBS waiver redesign work will incorporate principles established by the Community Living Advisory Group, including:

- Freedom of choice over living arrangements, social, community, and recreational opportunities
- Individual authority over services and supports
- Ability and support to organize resources in meaningful ways to individuals receiving services
- Assurance of health and safety
- Opportunity for community contribution
- Responsible use of public dollars

CONFLICT-FREE CASE MANAGEMENT – NEW CHOICE INFRASTRUCTURE

Members receiving Home and Community Based Services rely on case managers to recommend community service and support options. Ensuring case managers do not have a conflict of interest with the services they recommend is important to both access and quality of care. Otherwise, service plans can include expensive, complex, or unnecessary services that benefit the provider who is making the recommendation. A bill to develop a plan to eliminate conflicts of interest in case management (HB 15-1318) became law last year.

In response to HB 15-1318, we developed a plan to implement conflict-free case management, and submitted it to the General Assembly on July 1, 2016. In addition to separating case management from service providers to remove conflicts of interest, this plan will put individuals and families in control of choosing both their direct service provider agency and their case management agency. Likewise, case management agencies will be able to choose which waiver populations they serve. We expect the transition to conflict-free case management to take three to five years.

FUNCTIONAL ASSESSMENT TOOL FOR LTSS

We are leveraging funding from the federal Testing Experience and Functional Tools (TEFT) grant to advance implementation of a new functional assessment tool for Long-Term Services and Supports (LTSS). The tool will improve efficiency of these critical business processes:

- functional eligibility determination (will increase reliability of eligibility decisions),
- support planning (will provide a more comprehensive data set to better inform support planning), and
- resource allocation (will provide algorithms to assign individuals eligible for Medicaid LTSS to different funding levels based on their needs.

We developed the new assessment tool and piloted intake screenings during 2015, and expect to pilot the support planning assessment portion of the tool in summer 2017. Statewide rollout and automation of the new assessment tool in the interChange system environment is planned with timing yet to be determined.

INTENSITY SCALE ASSESSMENT PROCESS EVALUATION

We are using the Supports Intensity Scale (SIS) assessment to determine the level of supports needed for all adults with an intellectual or developmental disability. We contracted with the Human Services Research Institute to review current policies and procedures regarding the use of SIS in Colorado; reviewed other assessment tools used for support planning, reviewed and determined SIS best practices, and compared the use of the SIS in other states versus Colorado. The report was delivered to the Department in June, 2016.

In addition, pursuant to SB 16-192, we will use the current stakeholder process to select and develop a new needs assessment tool for all individuals needing long-term services and supports. The tool will be implemented over the next three to five years.

SUPPORTED LIVING SERVICES ALLOCATION REDESIGN

Our goal for the State-Supported Living Services Allocation Redesign project is to establish maximal utilization of available funds by increasing administrative efficiency of the Home and Community Based Services Supported Living Services Waiver (SLS program).

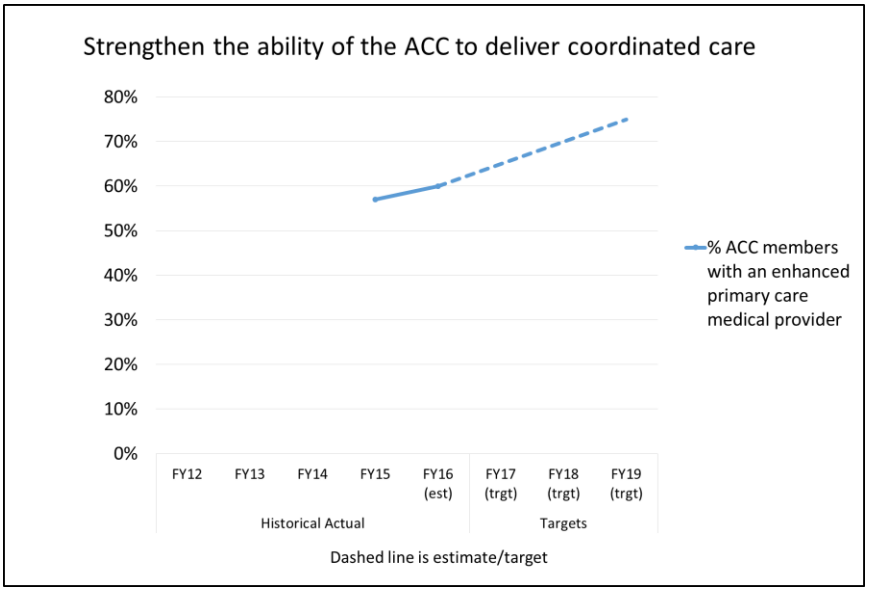
The SLS program provides assistance and support to meet daily living and safety needs of adults who are responsible for their own living arrangements. This means they are living independently with limited supports, or if they need extensive support, are receiving it from other sources such as family.

The SLS program is funded by the Colorado General Assembly and is comprised entirely of General Fund dollars. In FY 2014-15, 88% of State-SLS Direct Service funds were expended. We seek to redesign allocation of program funds to achieve 95% utilization of funding while introducing safeguards to ensure consistency of use in future distributions.

STRATEGY #1F STRENGTHEN THE ABILITY OF THE ACC TO DELIVER COORDINATED CARE

Care coordination has been shown to reduce costs and improve quality by ensuring that members receive the right services at the right place at the right time. This is a central reform mechanism of the ACC. Programs supporting this strategy focus on coordinating member care through an enhanced primary care medical provider;[11] identifying members with complex medical needs and managing their care across providers; and adopting technology that facilitates shared access to member information among providers.

[11] See description of enhanced PCMPs under Primary *Care Medical Provider Outreach & Enrollment for the ACC* on page 21.



We are measuring success of the ACC's ability to deliver coordinated care by reporting the percent of ACC members with an enhanced primary care medical provider. Efforts to enhance primary care services include incentivizing providers to offer evening and weekend hours and consultations via telephone and secure e-mail. This new performance measure is expected to increase at a rate of 3-5% per year.

Strengthen the ability of the ACC to deliver coordinated care	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% ACC members with an enhanced primary care medical provider	N/A	57%	60%	65%	75%

The following programs assist in supporting our strategy to strengthen the ability of the ACC to deliver coordinated care.

PRIMARY AND PREVENTIVE CARE

The Accountable Care Collaborative (ACC) recognizes the importance of primary and preventive care to ensure the health and well-being of individuals. Upon enrollment into the ACC, individuals are attributed to a Regional Care Collaborative Organization (RCCO). The RCCOs coordinate care of individuals through outreach, referrals and follow up, making sure the individual is connected to a primary care provider.

The primary care provider is central to an individual's health as they assess health needs and provide preventive care such as information on nutrition, vaccinations, depression screenings and more. Preventive strategies help providers identify problems before they turn into serious complications.

The ACC uses a value-based payment system that rewards RCCOs if they reach set targets on three key performance indicators (KPIs) – well-child visits, emergency department visits, and post-partum care. These KPIs incentivize health care providers to focus on primary and preventive care. Future KPI's will focus on chronic conditions, behavioral health, value, and experience to drive improved health and well-being among the Medicaid population.

ACCOUNTABLE CARE COLLABORATIVE

The Accountable Care Collaborative (ACC) is the cornerstone of our efforts to improve member health while containing costs, and is the primary vehicle for Medicaid reform innovations that incentivize care coordination and the wise use of health services. The ACC focuses on the needs of its members and leverages local resources to best meet those needs, while fostering integration and collaboration across the spectrum of member health care.

Since the ACC's inception in 2011, member enrollment in the ACC has increased from fewer than 10,000 to more than one million. During that time, we have focused on expanding the ACC statewide, enrolling primary care medical providers (PCMPs),[12] and solidifying a strong stakeholder engagement process. As of July 2016, this work has largely met its goals, and our focus is shifting. ACC infrastructure will be strengthened through increased attention to RCCO activities, specifically, regular discussions of initiatives underway, reviews of contract deliverables and processes, and frequent on-site visits. We will develop and implement new initiatives supporting member health outcomes, provider performance, and greater data and performance transparency. Internally, ACC processes and program activities will be optimized through process improvement efforts.

The ACC is being formally evaluated; we have contracted with the Colorado School of Public Health to conduct the evaluation,[13] which will include quantitative and qualitative analyses of the impact of the ACC on health care utilization, costs and quality. Findings will inform program changes to be implemented during the final two years of the current ACC contracts and during the new contracts commencing on July 1, 2018.

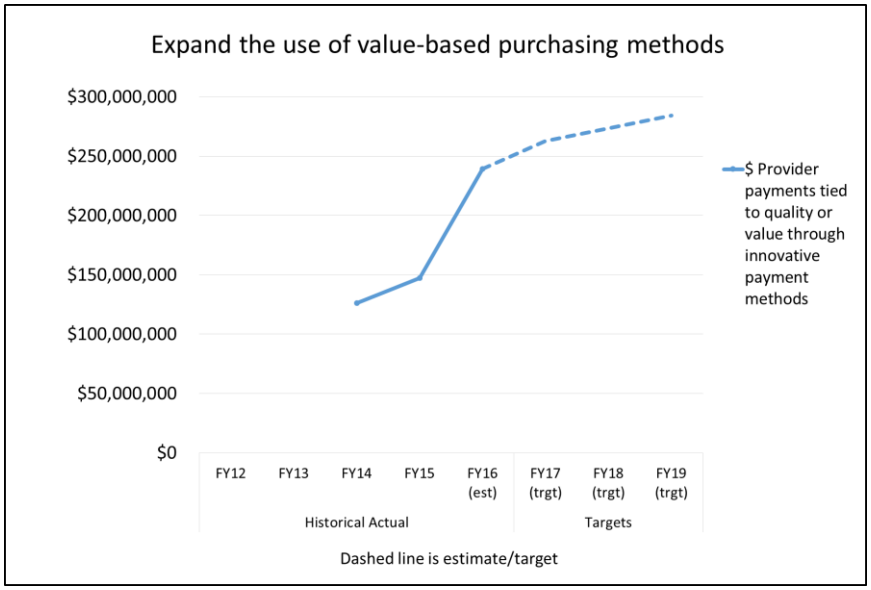
Looking to the future, ACC Phase II will be implemented in FY 2018-19. There will be many changes to the ACC program at that time, including integration of physical and behavioral health care by contracting with one regional entity (the Regional Accountable Entity or RAE). The RAE will focus on whole person care and there will be multidisciplinary health teams that, based on a client's needs, can include specialty behavioral health providers, long-term services and supports, case management agencies and certain specialists. The single entity and also the formal introduction of health teams will further advance coordinated care.

STRATEGY #2A EXPAND THE USE OF VALUE-BASED PURCHASING METHODS

This strategy focuses on purchasing value: effective services resulting in better health outcomes for the lowest practicable cost. Data analytics tools are used to correlate high quality with low cost to inform selection of services and providers. Incentive programs reward providers for improving member health and limiting unnecessary use of services.

[12] See description of enhanced PCMPs under *Primary Care Medical Provider Outreach & Enrollment for the ACC* on page 21.

[13] The Colorado Health Foundation and Rose Community Foundation are providing financial support for the evaluation.



To measure performance of this strategy, we are reporting the dollar amount of provider payments tied to quality or value through innovative payment methods. Since FY 2013-14, these payments have nearly doubled and are expected to increase by 5-10% per year going forward.

Expand the use of value-based purchasing methods	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
$ Provider payments tied to quality or value through innovative payment methods	$126,090,496	$147,343,753	$239,370,153	$262,722,933	$284,219,921

Payments tied to quality or value include: hospital quality incentive payments (HQIP), skilled nursing facility pay for performance (SNF P4P), ACC payments (RCCO+PCMP), health maintenance organization (HMO) incentives (excluding those based on shared savings), after-hours provider bump, and dental provider network adequacy payments (ended FY 2015-16).

The following programs assist in supporting our strategy to expand the use of value-based purchasing methods.

PAY FOR PERFORMANCE ACROSS THE ACCOUNTABLE CARE COLLABORATIVE

Our value-based purchasing strategy is supported by pay for performance as a demand-side strategy to measure, report, and reward excellence in health care delivery.[14] The Department has numerous value-based purchasing agreements in place, which hold a portion of compensation due to providers and contractors 'at risk,' requiring measured performance prior to payment.

The Department's most significant value-based purchasing program is the Accountable Care Collaborative (ACC). The ACC pays for value through a number of methods. First, one dollar per member per month (PMPM) is withheld from both the payments made to the Regional Care Collaborative Organizations (RCCOs) and the primary care medical providers (PCMPs). This money is then paid out based on performance on emergency room visits, postpartum visits, and well child visits. Also, RCCOs can earn incentives for performance on visits post-hospitalization. In addition, RCCOs are at risk for a percentage of the base PMPM for clients not attributed to a PCMP for more than six months. The Department recognizes and reimburses an additional $0.50 PMPM for PCMPs who offer services beyond the traditional fee-for-service primary care model of care.

[14] http://www.nbch.org/Value-based-Purchasing-A-Definition

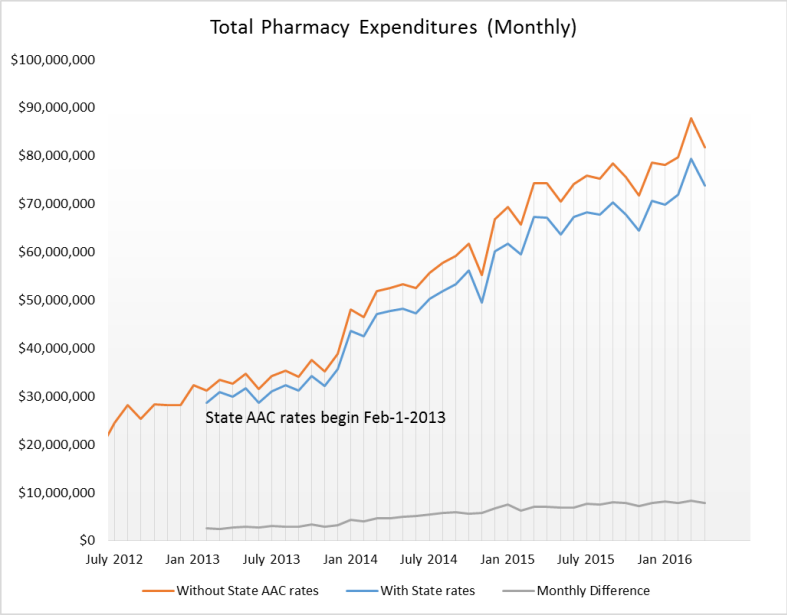
Within the ACC there are two payment reform programs using alternative value-based purchasing methods: Rocky Mountain Health Plans-Payment Reform Initiative for Medicaid Expansion (RMHP Prime), and the Access KP program, a partnership between the Department, Colorado Access, and Kaiser Permanente (KP). RMHP Prime is a value-based contract in a two ways. First, RMHP is at risk for all medical services needed by its members. Second, it is at risk for its medical loss ratio (MLR) which is lowered based on performance on four different quality metrics. Access KP is also a value-based contract because all of the covered services are at risk, and a little more than 5% of the PMPM is withheld for performance on well child visits ages 3-9, post-partum visits, emergency room visits, and inpatient admissions.

Additionally, the ACC is purchasing value through the State Innovation Model (SIM) program. Through SIM the RCCOs are making payments to selected PCMPs to help them integrate physical and behavioral health care and move along the 10 Building Blocks as defined by SIM.

Value-based purchasing can be measured in the number of members enrolled in the program, or by the total dollar amount in which the provider or contractor is at risk. The Department's three-year plan (aligned with implementation of ACC Phase II) is to have all Medicaid members enrolled in the ACC or an ACC payment reform program.

PHARMACY PAYMENT REFORM

In addition to value-based purchasing efforts in the ACC, we are leading similar efforts for pharmacy payment reform. The reimbursement methodology for pharmaceuticals ties payment to the actual value or cost of the drugs rather than paying a pre-determined market price. Colorado was one of the first states to implement a pricing methodology like this. In 2013, we switched to using average acquisition cost, which involves obtaining invoices from Colorado pharmacies and using their acquisition costs to set reimbursement. This ensures that reimbursement rates are updated regularly so pharmacies are reimbursed fairly on a continual basis, and so we receive maximum value for pharmaceutical expenditure. Savings are estimated at approximately $77 million in FY 2014-15 and $78 million in FY 2015-16.



Average acquisition cost is gaining favor in the Medicaid arena, as the Centers for Medicare & Medicaid Services recently finalized a rule requiring all states to use a similar reimbursement methodology.

MANAGED CARE PAYMENT REFORM

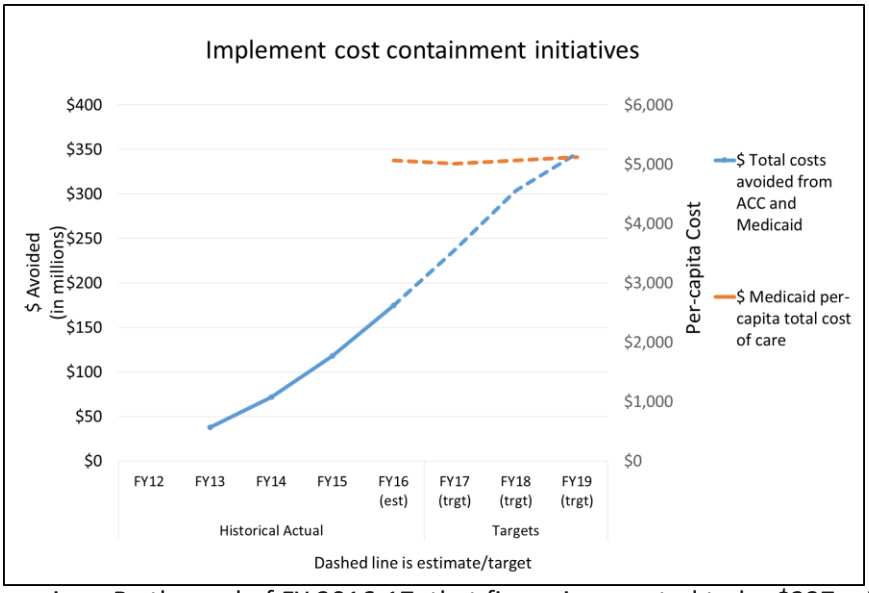
Adding to our value-based purchasing efforts, we recently completed medical loss ratio reconciliations with Rocky Mountain Health Plans for the HB 12-1281 pilot program. Through an innovative application

of what is typically a financial control mechanism for managed care contracts, we were able to directly connect performance on quality metrics to payments under a capitated program in a truly meaningful way.

Over the next 24 months we will be working to broaden the scope of Medicaid value-based purchasing beyond the areas mentioned above. Behavioral health contract rates will be tied to performance on quality metrics, and a program for value-based purchasing of primary care services will be put in place. In addition, a primary care capitation pilot with payment tied to performance on quality metrics will be implemented, Program of All Inclusive Care for the Elderly payment rates will be tied to quality, and the reimbursement methodology for federally qualified health centers will be updated to reward quality and efficiency.

STRATEGY #2B IMPLEMENT COST CONTAINMENT INITIATIVES

This strategy focuses on reducing the growth rate of Medicaid expenditures by implementing programs that lower per-capita costs while improving health outcomes and the experience of people served by Medicaid.



Two measures show progress toward this strategy: total costs avoided and Medicaid per-capita. Total costs avoided is a cumulative measure of prior year budget initiatives with savings, plus costs avoided from the Accountable Care Collaborative. Since FY 2012-13, an estimated $175 million in costs have been avoided as a result of implementing cost containment initiatives aiming to reduce unnecessary, duplicative, and less effective services. By the end of FY 2016-17, that figure is expected to be $237 million. Medicaid per-capita is the annual average cost per member for care. Per-capita cost has decreased since FY 2013-14, and remains relatively flat.

Implement cost containment initiatives	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
$ Total costs avoided from ACC and Medicaid (in millions)	$72	$118	$175	$237	$346
$ Medicaid per capita total cost of care	$5,268	$5,053	$5,063	$5,014	$5,119

Per-capita costs include medical services, behavioral health, individuals with developmental disabilities, and Child Health Plan *Plus* (CHP+) expenditures.

The following programs assist in supporting our strategy to implement cost containment initiatives.

COLORADO INDIGENT CARE PROGRAM TRANSFORMATION

We are developing a proposal for the 2017 legislative session to modernize the Colorado Indigent Care Program (CICP) as part of our cost containment strategy. Historically, CICP has provided a partial solution to the health care needs of the state's medically indigent citizens. It allows low-income Coloradans with incomes up to 250% of federal poverty level (FPL) who are not eligible for Medicaid or Child Health Plan *Plus* (CHP+) to obtain discounted health care services at participating hospitals and community health centers. CICP provides some reimbursement for uncompensated costs incurred by CICP providers serving low-income Coloradans. CICP is a cost-effective program because uncompensated costs in the health care system disproportionately impact overall health care costs and drive increases in insurance premiums for all payers.

The Affordable Care Act (ACA) expansion of Medicaid coverage for adults in Colorado to 133% FPL reduced the number of uninsured Coloradans. Consequently, the number of persons served by CICP decreased 72% in FY 2014-15 compared to FY 2012-13. However, while many former CICP clients are now eligible for health coverage, individuals under 250% of the FPL who are not eligible for Medicaid or CHP+ and cannot meet their out-of-pocket expenses remain. We are collaborating with stakeholders to understand the needs of lower-income Coloradans in the post-ACA environment. In FY 2016-17, we are developing a proposal for legislation to modernize the CICP in line with the needs of local communities today. Our goals are to improve administrative efficiency and preserve access to health care services for low-income Coloradans while encouraging enrollment in Medicaid or health insurance through the Connect for Health Colorado marketplace. We expect program changes will be implemented in FY 2017-18.

CHRONIC PAIN MANAGEMENT

The Chronic Pain Management program is another part of our strategy to implement cost containment initiatives while improving health outcomes. Implemented through the Accountable Care Collaborative (ACC) in March 2015, this program is modeled after the Project ECHO programs developed by the University of New Mexico. These programs use interactive video technology to connect primary care medical providers (PCMPs) and specialists to discuss client cases and share best practices for treating difficult cases. Providers can log on from the device of their choice and are immediately connected to a team of pain specialists, even if their practice is located great distances from the nearest specialist. The Program promotes the use of evidence-based pain management practices, and supports PCMPs in treating clients with chronic pain within their primary care practice.

The first year of the program concluded in March 2016 with 42 clinic sites and 84 providers participating. The second began in May 2016, and offers providers the current Chronic Pain Telehealth Program and the new Buprenorphine Telehealth Program, which is aimed to assist providers with prescribing licenses in treating clients with opioid addiction. Recruitment is still underway, and the Department expects similar participation numbers as in the first year.

We will evaluate the first year of the program through a series of provider surveys and analysis of claims data. The outcomes measures include

- PCMP participation,
- provider satisfaction and knowledge,

- cost and utilization of emergency department and hospitalization rates for pain/prescription opioid-related issues,
- clinical measures (use of provider assessment tools to track patient function and pain scores),
- a best practice measure that includes the number of opioid prescribers per client and number of pharmacies dispensing opioids per client, and
- a measure of the reduction in deaths resulting from opioid overdose.

This program is funded for two years. Original funding came from a federal match of General Fund and expires after the second year is completed. While there are no plans to expand the Chronic Pain Management program, the Department is attempting to partner with the University of Colorado to implement more ECHO programs for Medicaid providers. The results from the chronic pain programs and the ability to partner with the university could determine our ability to fund more telehealth disease management programs in the future.

CLIENT OVER UTILIZATION PROGRAM

The Client Overutilization Program (COUP) is a statewide program that identifies and addresses unnecessary or inappropriate utilization of pharmacy and emergency services. In collaboration with the Regional Care Collaborative Organizations, we have implemented client outreach strategies to reduce inappropriate utilization of these benefits over the past four years.

The scope of the program was modernized after the launch of the Accountable Care Collaborative to employ additional interventions for clients and providers. Within the next fiscal year, the program will expand to include more comprehensive care coordination, client and provider education and outreach, and lock-in strategies (such as assigning clients to a single pharmacy and/or provider to oversee care) to improve appropriate utilization and health outcomes for Colorado Medicaid clients. Efforts to modernize the program will be made in collaboration with stakeholders and will include mechanisms to track the impact of interventions.

COMPREHENSIVE PRIMARY CARE INITIATIVE

The Comprehensive Primary Care initiative (CPCi) is a multi-payer Center for Medicare & Medicaid Innovations project that attempts to engage multiple payers to fund practice transformation in primary care. CPCi began in 2013 and will end in December 2016. Colorado is one of seven regions participating in this initiative.

We participate in CPCi as a component of the Accountable Care Collaborative (ACC) program. All Medicaid practices participating in CPCi are ACC primary care medical providers, and their performance is tracked on the same key performance indicators as other ACC providers. CPCi practices have access to Medicaid member data both through the Statewide Data and Analytics Contractor (SDAC) and the multi-payer funded data aggregator tool for Colorado's CPCi program.

In Year 3 of CPCi, Colorado showed a gross savings of 1.3%. An external evaluation of Year 2 of the program showed that practices were making significant investments in practice transformation, with large improvements in their use of risk-stratified care management. In April 2016, the Centers for Medicare & Medicaid Services announced it would continue the CPCi project as Comprehensive Primary Care Plus (CPC+), a five-year initiative running from January 2017 through December 2021 with the intent of building on the successes of the original CPCi. We are currently exploring participation.

E-CONSULT PRIMARY CARE

Another program supporting our strategy to implement cost containment initiatives is the electronic consultation (eConsult) program, which began with a test group in May 2016. The software being tested to support this program is part of the Colorado Regional Health Information Organization's Patient Care 360 platform, and it is expected to run for approximately six months. The eConsult program is designed to provide primary care medical providers access to new telemedicine technologies to connect with specialty care providers for consultations and member referrals. Through structured communications, primary care providers can submit clinical questions and relevant personal health information to a specialist for guidance on how to treat a member, or determine if the specialist is willing to see the member for a formal appointment. Nationally, eConsult programs have reported cost savings by reducing specialty care face-to-face visits, decreasing duplication of medical tests, and reducing need for non-emergency medical transportation.

MATERNAL AND CHILD HEALTH

We are advancing efforts in maternal and child health (MCH) services as part of our strategy for containing costs and improving health outcomes.

During FY 2014-15, we updated key performance indicators (KPIs) for the Accountable Care Collaborative (ACC) to include postpartum care, which has been shown to reduce mortality and improve health in new mothers.[15] The KPIs form the basis for incentive payments designed to encourage ACC providers to use services and practices that improve health outcomes. Increases in postpartum care utilization since addition of the new KPI have been encouraging.

During FY 2016-17, we plan to increase maternal and child health services for high-risk pregnant women and their children – particularly the Nurse Home Visitor Program (NHVP). The program, which provides home visits by a registered nurse from pregnancy through the child's second birthday, is projected to reduce national Medicaid spending per child by 8.5%, saving $1.4 billion.[16] It also greatly improves outcomes in several health indicators: Clients enrolled in the NHVP have lower preterm birth rates than the Colorado average,[17] significantly higher child immunization rates at 24 months than the national average (92% compared to 74.6%[18]), 21% reduction in smoking and 32% reduction in alcohol use during pregnancy.

Since 2012, NHVP enrollment has increased 80% as a result of implementing a referral system and improving RCCO and NHVP coordination. We will continue to support NHVP expansion through the Colorado Opportunity Project, and are including NHVP and other evidence-based services in ACC reprocurement plans.

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[15] Cheng et al. "Postpartum Maternal Health Care in the United States: A Critical Review." The Journal of Perinatal Education 15.3 (2006): 34–42.

[16] Miller, Ted R. "Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996–2013, USA." Prevention Science 16.6 (2015): 765-777.

[17] March of Dimes Peristats, State Data 2014. Available at http://www.marchofdimes.org/materials/Colorado_Databook2014.pdf. Accessed 11/24/15.

[18] Kids Count Data Center, "2-Year-Olds Who Were Immunized." September 2015. Available at: http://datacenter.kidscount.org/data/Tables/8001-2-year-olds-who-were-immunized?loc=1&loct=1#detailed/1/any/false/869,36,868,867,133/any/15387. Accessed 11/18/15.

Two partnership efforts with the Colorado Department of Public Health and Environment (CDPHE) will further advance our MCH efforts. The two agencies are planning a FY 2016-17 referral program to increase dual enrollment in Medicaid and the WIC program (Special Supplemental Nutrition Program for Women, Infants, and Children). WIC provides nutrition education, breastfeeding support, health referrals and other services to Colorado families who qualify, and currently reduces the average Medicaid cost per client by 29%. We are also partnering with CDPHE in a new data sharing agreement focused on improving maternal depression screenings and referrals. Untreated postpartum depression is a strong predictor of unemployment, and early intervention and treatment can reduce the need for reliance on public assistance.[19]

Finally, we are exploring Medicaid funding for the Healthy Steps program, which focuses on early intervention for families with children age 0-3 years and improves immunization rates and pediatric development.[20]

COLORADO CHOICE TRANSITIONS

Another important component of our strategy to implement cost containment initiatives is the grant-funded Colorado Choice Transitions (CCT) program. This program transitions Colorado Medicaid members out of nursing homes and long-term care facilities into home and community-based settings. Members receive enhanced services designed to support transitions and promote independence. In order to be enrolled in CCT the member must:

- meet long-term care Colorado Medicaid eligibility requirements,
- currently reside in a nursing facility, and have been there for at least 90 consecutive days, and
- be willing to move into qualified housing.

The CCT Program was launched in April 2013, and as of February 2016, has completed 64 transitions and an associated total cost avoidance of $8,992,827.[21] For budgeting purposes, these figures are based on average monthly enrollment to reflect the fact that clients enroll in the program over time rather than all at once. In total, we have transitioned 150 clients from nursing facilities and intermediate care facilities as of April 2016, and anticipate transitioning approximately 490 people by the end of the program on December 31, 2018.

The program has encountered barriers to achieving the number of transitions initially targeted. These include insufficient availability of affordable and accessible housing in Colorado, as well as insufficient capacity of case management agencies and transition coordination agencies.

[19] Sontag-Padilla et al. "Maternal Depression: Implications for Systems Serving Mother and Child." Rand Research Report Series (2013).
http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR404/RAND_RR404.pdf

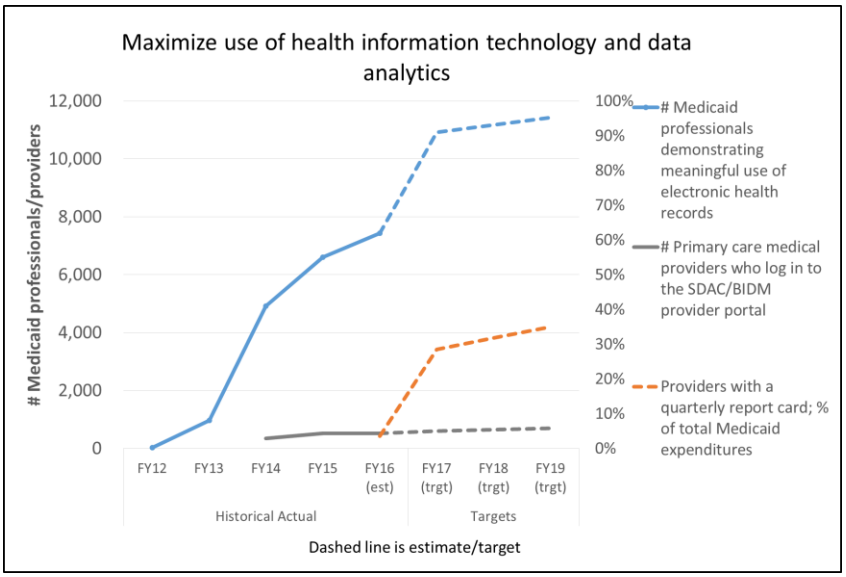
[20] Minkovitz et al. "Healthy Steps for Young Children: Sustained Results at 5.5 Years." Pediatrics 120 (2007):e658-e668.

[21] These figures are updated biannually through the Department's R-1 "Medical Services Premiums" budget request.

To address the housing issues, we were successful in securing General Fund dollars to subsidize rents for up to 75 individuals per year, and partnered with the Colorado Division of Housing to secure additional federal funds from the Department of Housing and Urban Development. These successes have yet to increase the inventory of units available, and the Division of Housing is working on strategies to address this shortage of housing units.

To address the provider capacity issue, we were successful in obtaining an increase in the payment rate to transition coordination agencies during FY 2015-16. We are continuing to explore other ways to increase the capacity of case management agencies and transition coordination agencies.

STRATEGY #2C MAXIMIZE USE OF HEALTH INFORMATION TECHNOLOGY AND DATA ANALYTICS, ALIGNING THESE EFFORTS WITH THE BROADER HEALTH CARE SYSTEM



This strategy emphasizes the importance of advancing information and data technologies as a means to improve health outcomes for members, reduce fraud, waste and abuse in the Medicaid program, and reduce the cost of health care. Our work aligns with a statewide information technology strategy focused on radically transforming the state's health care system.

Three measures show progress toward this strategy: number of Medicaid professionals demonstrating meaningful use of electronic health records, providers with a quarterly report card as a percentage of total Medicaid expenditures, and number of Primary Care Medical Providers who login to the SDAC/BIDM Provider Portal.

Maximize use of health information technology and data analytics	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Medicaid professionals demonstrating meaningful use of electronic health records	4,915	6,597	7,424	10,924	11,420
Providers with a quarterly report card; % of total Medicaid expenditures	N/A	N/A	4%	29%	35%
# Primary care medical providers who log in to the SDAC/BIDM provider portal	340	527	521	600	690

Data for providers logging in to the BIDM portal will become available in late 2016.

The following programs assist in supporting our strategy to maximize use of health information technology and data analytics, aligning these efforts with the broader health care system.

FINANCIAL REPORT TRANSFORMATION

We are transforming the way we produce financial reports as part of our strategy to maximize the use of health information technology and data analytics. By leveraging different ways to view and analyze

expenditure and utilization data through provider variation measurement, we deliver more targeted, meaningful, and user-friendly financial information to the public, providers, and Department staff. This supports transparency in decision making, and provides a more complete view of financial performance.

During FY 2015-16, we released a dashboard of county-level summaries of expenditure and utilization on the Department web site. In FY 2016-17, we will release an interactive presentation of monthly premiums, expenditures, and caseload reports, allowing users to select their own areas of interest to view appropriations and expenditures for specific programs.

In addition, the Colorado Medicaid Management Innovation and Transformation project will help us develop a suite of financial reports for primary care medical providers to use in managing their practices. Once these report cards are available for certain provider types, we intend to publish them to highlight variation between providers.

PROVIDER REPORT CARDS

We are using claims data and analytic tools to create provider report cards with the goal of identifying high and low-value providers. In the case of healthcare providers, variation in costs, processes, and outcomes are key determinants for quality of care and Medicaid program costs. We are using provider report cards to select the highest quality, most cost-effective care for members.

In FY 2015-16, we developed report cards for three types of providers to assess high and low value within each type: federally qualified health centers (FQHCs), Regional Care Collaborative Organizations/primary care medical providers (RCCOs/PCMPs), and hospitals. We established requirements for each, gathering feedback from internal and external stakeholders.

- For development of the FQHC report card, the Colorado Community Health Network and many individual health centers were consulted in order to gather feedback, hear concerns, and refine how FQHCs are measured.
- For the RCCO/PCMP report card, we defined new key performance indicators and other dashboard measures for the ACC, and worked with contractors to improve data quality and availability.
- For the hospital report card, we are using advanced analytics to measure variation in procedures, surgeries, and aftercare.

Once sources of variation are identified across providers, we will work with each provider group to determine acceptable levels of variation, and decide where best practices can be shared to increase efficiency.

HEALTH INFORMATION TECHNOLOGY

We have planned and developed our health information technology projects to align with the State of Colorado's strategy for adoption and widespread use of Health Information Technology (HIT) by enrolled medical providers.[22] The ultimate aim of this state strategy is to improve member outcomes and reduce health care costs statewide.

[22] Articulated in 2011 by the state's Information Technology Advisory Committee

Beginning in 2013, we worked with a contractor to design, develop, test and implement a new state of the art Medicaid Management Information System, the Colorado interChange.[23] The new system, which will launch in November 2016, will advance our analytic and business intelligence capabilities through a business intelligence and data management (BIDM) vendor, and include a pharmacy benefit management system (PBMS) providing claims processing, drug utilization review, and other pharmacy benefit management functionality.

COMMIT

Colorado Medicaid Management Innovation and Transformation (COMMIT) refers to our four-year project to design, develop, test and implement systems to replace the 20-year-old Medicaid Management Information System (MMIS) and other information technology components. COMMIT includes three distinct systems: the Colorado interChange, the Pharmacy Benefits Management System (PBMS), and the Business Intelligence and Data Management (BIDM) system. The Colorado interChange will improve our ability to process and pay medical claims, BIDM will enhance our analytic and business intelligence capabilities, and PBMS will enable point of sale pharmacy claims processing, drug utilization review, and other functions.

Health information technology and data analytics emerging from COMMIT will advance our ability to improve member health outcomes and reduce health care costs. As an initiative aligned with the State Health Information Exchange strategic plan, and integrated with broader statewide enterprise architecture development, COMMIT will contribute to expansion of health information technologies throughout the state.

CROSS-AGENCY HEALTH STRATEGY ALIGNMENT

The Colorado Cross-Agency Collaborative (CCAC) is a collaborative between the Colorado Departments of Human Services, Public Health and Environment, and Health Care Policy and Financing. Its goal is to maximize sharing of health information technology and data analytics between these three agencies. By creating an aligned data strategy, the CCAC will enable these three health agencies to collectively report on metrics relevant to assessing performance in areas of overlapping health impact. Through this initiative, state health agencies can identify gaps in measurement and jointly determine where resources need to be focused in order to address health disparities in Colorado.

The Collaborative was tasked to complete four reports using aligned data on Behavioral Health, Child Health, Older Adult Health, and Adult Health. The Older Adult Health report was published in February 2016. The Adult Health report is expected to be completed by September 2016.

With the completion of all reports, the Collaborative workgroup will begin trending all of the collected metrics on a yearly basis. Performance targets will be set on those indicators that the state health agencies are currently working on to improve outcomes.

[23] The Medicaid Management Information System (MMIS) is the hardware, software, and business process workflows that processes our medical claims and payments. Additional functions include provider enrollment and management, certain client management functions, and analytics and reporting.

ELIGIBILITY REPROCUREMENT

Our goal for the Eligibility Reprocurement Project is to achieve the maximum value of the Department's eligibility and benefits-related systems.

Eligibility reprocurement refers to operating, maintaining and enhancing functionality of the Colorado Benefits Management System (CBMS), the Program Eligibility and Application Kit (PEAK), and related systems and making CBMS more interoperable, configurable, and modular based on industry direction.

The project, which is focused on making these systems more effective and reliable, is a cooperative effort between the Department, the Office of Information Technology and the Colorado Department of Human Services, in collaboration with the 64 Colorado counties.

STRATEGY #3A SUPPORT STATEWIDE EFFORTS TO IMPROVE POPULATION HEALTH

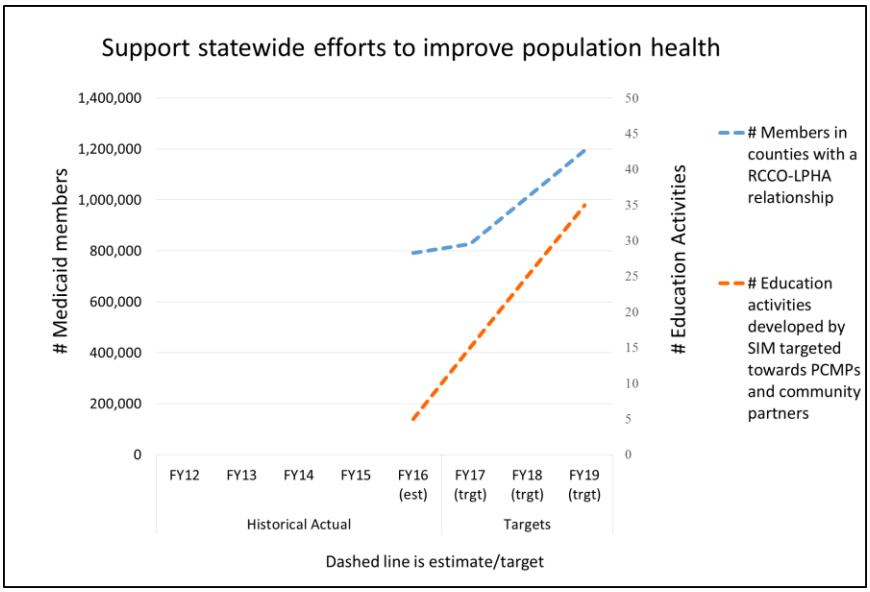
Impacting health goes beyond health care, and extends to socioeconomic circumstances and environmental influences, which disproportionately determine poor health in vulnerable populations across the U.S.[24] Cross-agency partnerships enable us to engage these critical factors and promote the health and wellbeing of all Coloradans.

Programs supporting this strategy include collaboration with Colorado Opportunity Project state partners to deliver high-quality, cost-effective, evidence-based programs to Coloradans with the goal of helping them move up the economic ladder and towards self-sufficiency.

Two measures show progress related to this strategy: members in counties with a Regional Care Collaborative Organization (RCCO) relationship with a local public health agency (LPHA), and education activities to help primary care medical providers and community partners work together to integrate physical and behavioral health care. Both are new performance measures for newly launched programs with no historical data.

[24] Woolf SH, Purnell JQ. The Good Life: Working Together to Promote Opportunity and Improve Population Health and Well-being. JAMA. Published online April 10, 2016. doi:10.1001/jama.2016.4263.

There are an estimated 792,568 members in counties where RCCOs are working with LPHAs to provide community-based health supports; we expect this number to increase approximately 4% next year. The number of integration-targeted education activities is expected to ramp up from 5 to 15 this year, and to 35 by FY 2018-19. Examples of education activities include developing SBIRT[25] training to help ensure provider competency in substance use and depression screening and intervention.



Support statewide efforts to improve population health	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Members in counties with a RCCO-LPHA relationship	N/A	N/A	792,568	827,799	1,195,537
# Education activities developed by SIM targeted towards PCMPs and community partners	N/A	N/A	5	15	35

RCCO – Regional Care Collaborative Organization
LPHA – local public health agency

The following programs assist in supporting our strategy to support statewide efforts to improve population health.

COLORADO OPPORTUNITY PROJECT

The Colorado Opportunity Project represents the efforts of three Colorado state agencies aligning to deliver evidenced-based programs supporting low-income Coloradans with opportunities for moving up the economic ladder towards self-sufficiency, and away from reliance on safety net programs.

[25] The Screening, Brief Intervention, and Referral to Treatment program is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment to persons with substance use disorders and those at risk of developing these disorders.

In 2013, 13% of Coloradans lived below the federally designated federal poverty level.[26] The impacts of poverty are significant. Those in poverty are more likely to have complex health conditions, and treating these conditions is expensive. Providing child care and food assistance is expensive. Housing Coloradans in the criminal justice system is expensive. The Project uses high-quality, cost-effective, evidence-based programs already available in Colorado and improves them with better coordination and well-defined goals and measures, saving taxpayer resources and moving citizens out of poverty and towards independence.

The Project is a collaboration of the Colorado Departments of Health Care Policy and Financing, Public Health and Environment, and Human Services. Its alignment of government programs eliminates fragmentation among these agencies, reducing duplication of services and making more efficient use of taxpayer dollars. Key initiatives of the three agencies, including 10 Winnable Battles, Two-Generation, and the Accountable Care Collaborative, as well as the Cross-Agency Collaborative on Quality Measurement, are tied together to deliver the Colorado Opportunity Project framework. Representatives from the agencies serve on the Colorado Opportunity Project Steering Committee charged with developing the Project framework.

In FY 2016-17, we are placing opportunity liaisons in six communities across the state that have partnerships with Accountable Care Collaborative RCCOs. These liaisons will work to increase access to and participation in interventions that impact indicators of self-sufficiency.

CDC 6|18 INITIATIVE

Our participation in the CDC 6|18 Initiative represents a targeted alignment of Medicaid and Public Health programs in Colorado to address high-burden health conditions statewide. CDC 6|18 is a project of the federal Centers for Disease Control (CDC) that creates collaborative partnerships between the CDC and health care purchasers, payers, and providers throughout the U.S. to improve health and control health care costs. For the initiative, the CDC has identified six health conditions as potential subjects for collaboration: diabetes, high blood pressure, health-care associated infections, asthma, unintended pregnancy, and tobacco use – and 18 proven specific interventions forming the starting point for discussions between collaborators. The Department and the Colorado Department of Public Health and Environment will focus on two of the six health conditions: unintended pregnancy and tobacco use.

The project is limited to one calendar year, beginning January 1, 2016 and ending December 31, 2016. The goal of the collaboration is to nurture results-oriented collaboration between the two agencies. To support the effort, the CDC will provide peer facilitation through monthly telephone conferences and targeted technical assistance from national experts focused on interventions to improve health. Work will be organized around two goals: increasing utilization of long-acting reversible contraceptives among women age 27 and under, and increasing utilization of the tobacco cessation Medicaid benefit through outreach to providers and consumers enrolled in Public Health and Colorado Medicaid programs.

COUNTY INCENTIVES PROGRAM

The County Incentives Program advances our strategy to support statewide efforts to improve population health by incentivizing activities that promote access to timely and accurate benefits and a balance of health and social programs made possible through collaboration in the community.

[26] 2013 American Community Survey (a report by the U.S. Census Bureau)

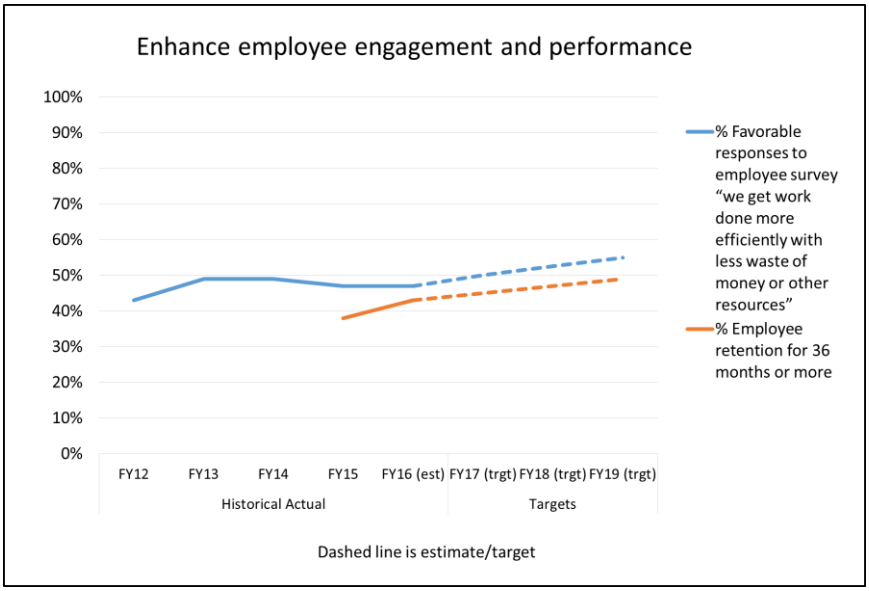
The Program encourages county departments of human/social services to ensure eligibility determinations are processed prior to federal requirements, granting beneficiaries access to medical, dental, and behavioral health benefits. The Program also ensures counties support adequate training for county staff and quality assurance reviews that limit eligibility to only those who are truly eligible. These efforts work to minimize fraud, waste, and abuse and allow us to have adequate financial resources to support other programs focused on population health.

In addition, the County Incentives Program encourages collaboration between counties and entities such as single entry points for member enrollment, community centered boards, Regional Care Collaborative Organizations, local law enforcement, and others. The aim of incentivizing collaboration is to bring together disparate agencies with a role to play in population health to assist local efforts in improving population health.

STRATEGY #4A ENHANCE EMPLOYEE ENGAGEMENT AND PERFORMANCE

Our strategy for enhancing employee engagement focuses on retention, recruitment, efficiency, and productivity. Work teams require a combination of relevant technical skills as well as the ability to collaborate productively, resolve conflicts, and integrate alternative thinking and working styles to solve complex problems.

Two measures show progress related to this strategy: employee perception of efficiency and retention for 36 months or more. The percentage of employees reporting increased efficiency within the Department dropped 2% in FY 2014-15, and remains at 47% until the next survey is conducted in FY 2016-17. Employee retention for 36 months or more is a new measure. We have employed the strategies described below to improve performance of both of these measures, and we expect to see progress by the end of the fiscal year.



Enhance employee engagement and performance	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% Favorable responses to employee survey "we get work done more efficiently with less waste of money or other resources"	49%	47%	47%	50%	55%
% Employee retention for 36 months or more	N/A	38%	43%	45%	49%

Employee retention – measures the retention rate of employees hired three years prior.

The following programs assist in supporting our strategy to enhance employee engagement and performance.

HUMAN RESOURCES

Transforming the way we manage human resources is a key part of our strategy to enhance employee engagement and performance. The Human Resources (HR) Section provides a full range of personnel services pertaining to benefits, recruitment, selection, job classification, training, rules interpretation, and employee/manager counseling. It also oversees corrective and disciplinary actions, maintains personnel records, and oversees our delegation agreement with the Department of Personnel and Administration.

We aim to transform this work by improving HR efficiency and effectiveness while ensuring compliance with state and federal law. The HR section is working to better define its role within the organization by proactively engaging managers and staff through a person-centered consulting role. It has created an operations dashboard that includes metrics on turnover, time to hire, position allocations, trust and confidence in leadership, and internal response times. The dashboard enables HR to measure improvements within these core service areas while working on goals identified in a strategic planning process to streamline HR business processes.

WORKFORCE DEVELOPMENT

The Workforce Development section provides three primary services to the Department: training, consultation and coaching. Although each has particular objectives, the overarching goals of the section are to enhance employees' ability to be efficient and effective in carrying out their job responsibilities and improve employee experience. Our training programs provide a full spectrum of learning opportunities that increase technical knowledge and the ability to successfully navigate and negotiate with multiple internal and external stakeholders and perspectives. Coaching includes working with employees to determine goals and strategies to promote successful employment and full engagement. Consultation includes working with managers and teams to solve problems, build strong team relationships, and strategize for ultimate team performance.

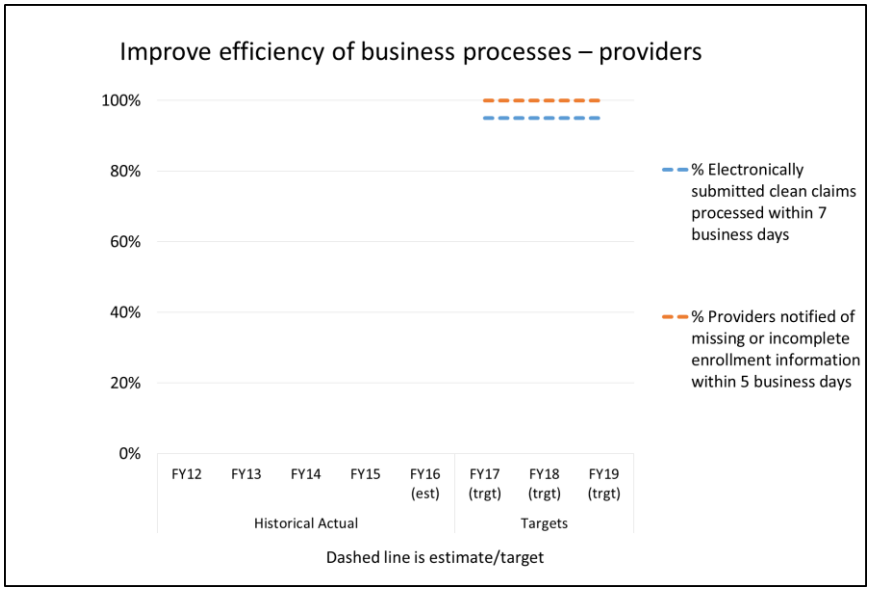
We have utilized our evaluation process to gain insight into how our program enhances both ability to do the work and the employee experience. The evaluations reveal that over 90% of aggregate responses indicate that our programs add significant value. FY 2016-17 goals include increasing Medicaid literacy and employee engagement through the development of the Medicaid Learning Community, building upon and enhancing the success of the Onboarding and Ambassador programs, and continuing to build the capacity of staff and managers to work successfully together through continued and new training products.

STRATEGY #4B IMPROVE EFFICIENCY OF BUSINESS PROCESSES

Programmatic areas supporting this strategy focus on efficient and effective administration of the Medicaid program. Mechanisms include improving IT infrastructure, increasing efficiency of our employees and business processes, and promoting a culture of openness to change and continuous improvement.

We are using four measures to evaluate performance of this strategy (graphs/tables are presented throughout this section):

- timely processing of provider claims
- timely notification to providers about the status of their enrollment applications
- Lean efficiency gains
- first call resolution rates in the member contact center



Timely processing of provider claims and timely notification about missing information in provider enrollment applications are new performance measures with no historical data. Data for these will be available after the launch of the new Colorado interChange in November, 2016.

Improve efficiency of business processes – providers	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% Electronically submitted clean claims processed within 7 business days	N/A	N/A	N/A	95%	95%
% Providers notified of missing or incomplete enrollment information within 5 business days	N/A	N/A	N/A	100%	100%

The following programs assist in supporting our strategy to improve efficiency of business processes.

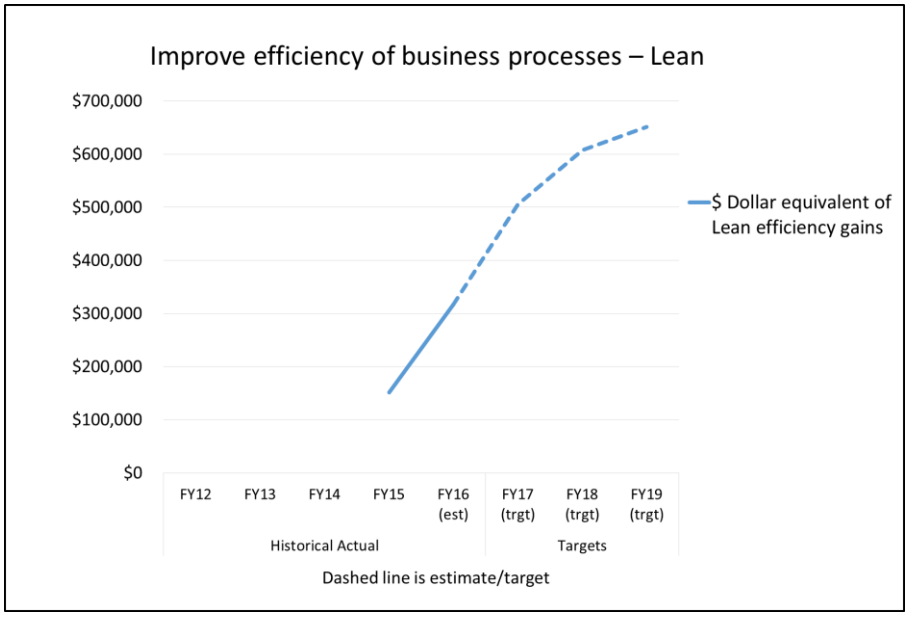
LEAN COMMUNITY

To support our business process efficiency strategy, we seek to instill a continuous improvement mindset and customer focus throughout the Department through our Lean Community program. We are advancing this goal by incorporating team skills, Lean principles and tools into work processes. The Lean Community delivers facilitated sessions, large-scale projects, Quick Hits,[27] and staff instruction through our Culture of Improvement Academy.

Large scale Lean projects have focused on streamlining administrative processes such as travel approvals, reimbursements, time to hire, security/IT systems access, and converting paper to electronic forms. The Travel Approvals project from FY 2013-14 is being used to estimate the dollar equivalent of staff time saved to measure efficiency gains through FY 2018-19.

[27] Small scale Lean projects requiring 4 hours or less to complete.

Lean efficiency gains are based on data collected as a result of streamlining the travel approval process. Dollar equivalent of staff time repurposed to higher priority work has saved approximately $318 thousand since completion of the project. Future savings are estimated based on continued return on investment from this and other Lean projects.



During FY 2016-17, objectives include deepening the Lean Community's reach within the Department by increasing the number of Quick Hits delivered and expanding the number of employees participating in Lean projects. Equally important will be our focus on advancing the program's maturity in alignment with the State's Lean organizational model.

Improve efficiency of business processes – Lean	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
$ Dollar equivalent of Lean efficiency gains	N/A	$151,786	$318,115	$505,885	$651,351

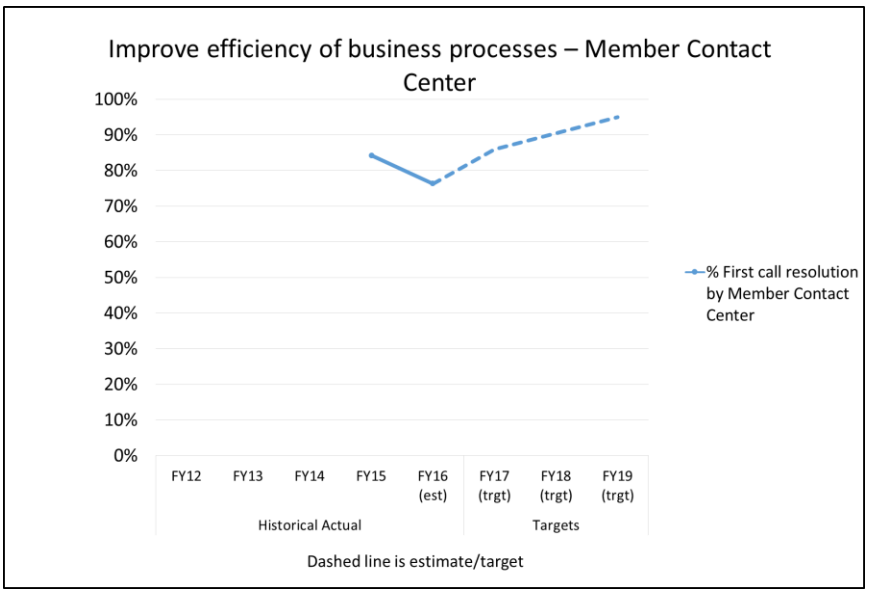
Lean efficiency gains is a cumulative estimate of staff time saved converted to an average dollar equivalent.

MEMBER CONTACT CENTER TRANSFORMATION

The Member Contact Center (MCC), is improving quality and efficiency of customer service for members by integrating technology in its processes, and using data to increase efficiency and measure performance.

The MCC is our main public-facing point of contact for members with inquiries about benefits and billing. To meet the challenges of high call volume, the MCC has incorporated new technological solutions and increased the number of agents in the center. Customer relationship management (CRM) software has facilitated tracking of member interactions and, coupled with a new and improved interactive voice response (IVR) system, the MCC can maximize the use of data to drive greater efficiencies.

In FY 2016-17, the MCC will build on these enhanced data reporting capabilities to expand how it measures performance. In addition to improving our call answer rate metric, the MCC is collecting data on first call resolution (FCR), which tracks the effectiveness and efficiency with which representatives resolve customer issues. An important advantage of measuring FCR is its usefulness in assessing new process initiatives such as procedural changes, training, and coaching. Measuring FCR before and after introduction of a process improvement enables the MCC to track success and make adjustments if necessary.

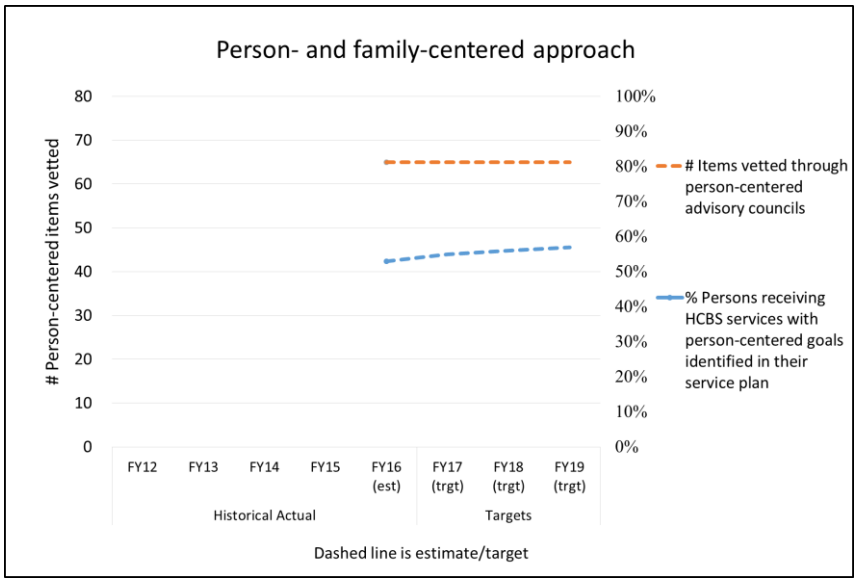


First call resolution rates decreased from 84% to 76% in FY 2015-16 due to rising enrollments of newly eligible members under the Affordable Care Act. We have hired additional staff in the call center, and with enrollments stabilizing, we anticipate improvement to 86% by the end of FY 2016-17.

Improve efficiency of business processes – Member Contact Center	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
% First call resolution by Member Contact Center	N/A	84%	76%	86%	95%

STRATEGY #4C INSTILL A PERSON- AND FAMILY-CENTERED APPROACH TO STRENGTHEN EMPLOYEE ENGAGEMENT, CLIENT EXPERIENCE, CLIENT ENGAGEMENT, AND CULTURE CHANGE

Programs supporting this strategy focus on increasing awareness about member needs and perspectives in order to inform policy decisions, engage members in their health and health care, and infuse partnership into interactions with members and health care providers. A person and family-centered approach ensures that our practices support the values, preferences, skills, and abilities of the individuals we serve.



Two measures show progress related to this strategy: items vetted through person-centered advisory councils and existence of person-centered goals in service plans for individuals receiving Home and Community Based Services. The efforts described below are designed to maintain both of these measures at or above existing levels.

Person- and family-centered approach	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Items vetted through person-centered advisory councils	N/A	N/A	65	65	65
% Persons receiving HCBS services with person-centered goals identified in their service plan	N/A	N/A	53%	55%	57%

The Department is currently beginning the process of incorporating/identifying person-centered processes for HCBS service plans.

The following programs assist in supporting our strategy to instill a person- and family-centered approach to strengthen employee engagement, client experience, client engagement, and culture change.

COMMUNITY LIVING ADVISORY GROUP RECOMMENDATIONS

The Community Living Advisory Group (CLAG) was created in 2012 by Governor's Executive Order to recommend changes focused on providing efficient and person-centered community-based care to Colorado's delivery system for long-term services and supports (LTSS).

The resulting CLAG Recommendations Report, published in 2014, has contributed significantly to our work orienting staff and the LTSS system toward person-centeredness. During FY 2015-16, the Department secured a federal No Wrong Door implementation grant to pilot a replicable model for connecting older adults and people with disabilities to long-term services and supports, regardless of pay source. We are currently finalizing our Request for Applications that will be submitted to potential pilot sites around the state. (See *No Wrong Door* on page 29.)

In FY 2015-16, we worked with a task group and solicited community input to develop a plan for conflict-free case management. Once implemented, the plan will increase person-centered care coordination in Colorado. We also provided training in person-centered thinking and service planning to more than 1,000 LTSS caregivers and providers across the state during March-June 2016, including case managers and state staff. This training is expected to continue through 2018. In January 2016, we launched a person-centered LTSS quality improvement initiative informed by member experience to define service quality through the lens of member values and life goals.

HCBS SETTINGS RULE

In 2014, the Centers for Medicare & Medicaid Services (CMS) adopted a final rule for Home and Community Based Services (HCBS) Settings. The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services, and defines person-centered planning requirements. HCBS settings must promote independence and community integration, and any restriction in individual rights must be agreed to by the recipient of services in the person-centered plan. In addition, the rule ensures individuals receiving services and supports through HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.

Since implementation of the Settings rule, we have created and updated the Statewide Transition Plan and Systemic Assessment Crosswalk, which were distributed to stakeholders, posted on our website, and submitted to CMS in June 2016. We have been working with stakeholders to ensure Colorado is fully compliant by March 2019.

CLIENT AND FAMILY ENGAGEMENT – PHASE II

We began planning for a person-centered approach to Department operations in 2012, with the goal of ensuring that all employees, providers, clients and their families experience person-centered policies, practices, and partnerships that respect and value individual preferences, strengths, and contributions. Work conducted since that time has included development of in-person and virtual advisory councils to work on person- and family-centered projects. In addition, we engaged an internal group of champions to lead, manage, and facilitate culture change by identifying specific processes and policies that can become more person-centered.

We are continuing to work toward greater, more meaningful engagement with clients and their family members by:

- continuing to operationalize the definition of client engagement,
- strengthening existing relationships with clients and families as advisors to the Department, and creating new ones
- supporting clients' and families' participation in care and decision making,
- improving access to understandable information, education, and support for clients and families, and
- extending person-centered practices to our work with contractors and vendors.

A key achievement of Phase I in 2014 was creation of a Person- and Family-Centeredness Advisory Council. Council members worked collaboratively with us to identify and implement person-centered practices and proactively offer feedback, information and recommendations on planning, policies, and procedures.

In March 2016, we were awarded funding from the Colorado Health Foundation to extend person-centered practices to selected contractors as a pilot project, with the ultimate goal that person- and family-centered principles permeate all Department business practices, policies and partnerships. The same month, the Division for Intellectual and Developmental Disabilities launched a statewide person-centered thinking training initiative for stakeholders of the Intellectual and Developmental Disabilities system. As of April 30, 2016 a total of 1,329 attendees had participated.

During FY 2016-17, our strategic plan for person- and family-centeredness will continue to be implemented. This plan focuses on increasing employee engagement, connecting employees to the client, and improving client engagement and experience. We will also focus on externalizing our engagement work with counties and other partners to improve the experience of clients as they apply and are determined eligible for Medicaid.

HCBS ASSESSMENT TOOL FOR SUPPORT LEVELS

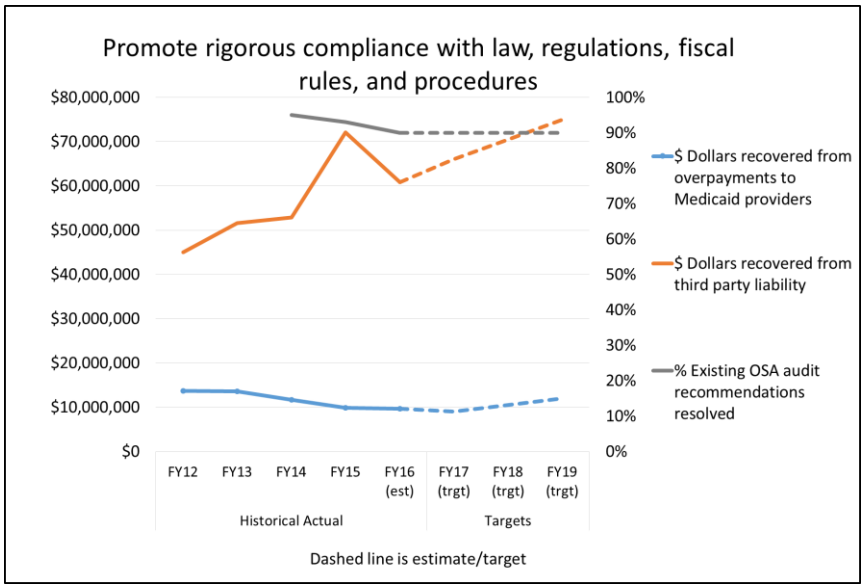
Another important component of our strategy to instill a person- and family-centered approach will be using the Home and Community Based Services (HCBS) assessment tool to increase the focus on the client throughout the assessment and planning process. Recommendations from Colorado's Community Living Plan and Community Living Advisory Group call for broadening the types of home and community-based supports that individuals receive. This expansion of the service array will enhance client preference and choice in determining supports and services. To ensure clients can access a flexible package of benefits, the HCBS assessment tool will be used for support planning, creating person-centered budgets and making sure clients are empowered in the planning process. It is important to note that the work related to

person-centered budgets is dependent upon completion of the Support Planning Assessment pilot, a key milestone in the Functional Assessment for Long-Term Services and Supports project (see page 30 to read a description of the project).

STRATEGY #4D PROMOTE RIGOROUS COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS, FISCAL RULES, AND INTERNAL OPERATING PROCEDURES

Our work administering the federal Medicaid program in Colorado takes place in a heavily regulated environment. Ensuring rigorous compliance internally with our own processes, and externally by holding our business partners accountable, enables us to minimize waste of resources resulting from fraud, waste and abuse.

Three measures show progress related to this strategy: dollars recovered from overpayments to providers, dollars recovered from third party liability, and number of audit recommendations resolved from the Office of the State Auditor (OSA). Dollars recovered from overpayments to medical providers increased in FY 2015-16, and a slight reduction is anticipated this year while we complete preliminary implementation work to launch the Recovery Audit Contract described below. Third party liability recoveries are projected to increase up to 10% per year over the next two to three years, eventually tapering downward as we reduce the amount of post-payment recoveries needed by ensuring more claims are initially submitted to the correct payer. Percent of OSA audit recommendations resolved is expected to stay relatively flat at 90%. The reduction from prior years is due to the number of outstanding audit recommendations decreasing over the last year and a decrease in the number of new findings being released by OSA each year.



Promote rigorous compliance with law, regulations, fiscal rules, and procedures	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
$ Dollars recovered from overpayments to Medicaid providers	$11,741,194	$9,911,777	$9,671,011	$9,000,000	$12,000,000
$ Dollars recovered from third party liability	$52,896,045	$72,091,076	$60,814,521	$66,000,000	$75,000,000
% Existing OSA audit recommendations resolved	95%	93%	90%	90%	90%

FY 2016-17 provider overpayment recoveries consist of $8M for the Department's Program Integrity Section and $1M for the Department's Audit Information Management Section only. The recovery amount for the Recovery Audit Contract (RAC) is $0.

FY 2018-19 provider overpayment recoveries consist of $8M for the Program Integrity Section, $1M for the Audit Information Management Section and $3M for the RAC.

There are many programs that support our strategy to promote rigorous compliance with federal and state laws and regulations, fiscal rules, and internal operating procedures. Three are listed below.

RECOVERY AUDIT CONTRACT

The Recovery Audit Contract (RAC) is a federally required program in an early stage of implementation at the Department. The RAC's primary responsibility is to identify and recover overpayments from medical assistance providers. The RAC will analyze provider claims and review those most likely to contain improper payments for both fee-for-service and managed care populations. Improper payments can come in the form of payment for items or services that do not meet our coverage or medical necessity criteria, payment for items that are incorrectly coded and payment for services where the documentation submitted did not support the ordered service. The RAC oversight promotes provider compliance with state and federal regulations and coding guidelines. The RAC contractor is also required to develop provider training so that the providers become aware of rules they may not have known about or understood.

Some of the obstacles may be the contractor learning Department program rules, claims data and the new MMIS and BIDM systems, and obtaining Centers for Medicare & Medicaid Services approval of the State Plan Amendment authorizing new work under the RAC. Taking these challenges into account, we expect to have the RAC up and running in approximately two years. We do not expect any immediate recoveries during the initial startup period.

EXTERNAL AUDITS

Audits conducted on the Department by external agencies such as the Office of the State Auditor (OSA), help to identify areas of non-compliance within Department programs, processes or systems. Once issues are identified through an audit, appropriate areas within the Department develop comprehensive corrective actions along with timelines for completion. Timelines for the strategies developed to correct problems are monitored both internal and externally to ensure compliance is achieved as soon as possible.

Each year the Department uses OSA's Annual Status of Outstanding Audit Recommendations report to monitor the number of audit recommendations that have not been resolved. The Department then encourages the affected areas to implement their outstanding recommendations before we are required to testify in front of the Legislative Audit Committee. Over the last two fiscal years the Department has reduced the number of outstanding audit findings by 95%. Because the number of outstanding audit recommendations has decreased in the last year and the number of new findings being released by OSA has also decreased, this prompts a reduction in the possible percentage of recommendations needing to be resolved to 90%.

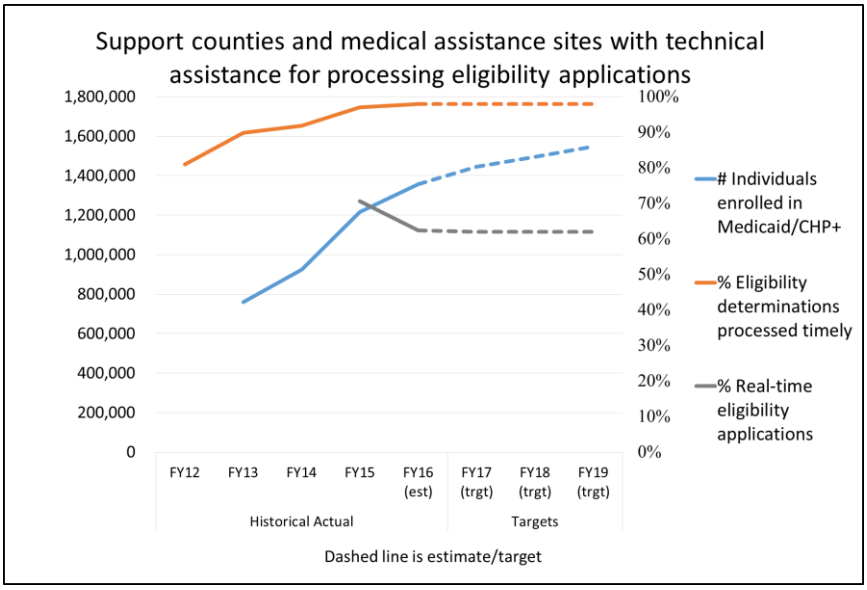
BENEFITS COORDINATION

The Benefits Coordination Section is responsible for recovering monies from third parties and ensuring that Medicaid dollars are spent appropriately and in compliance with state and federal regulations. The Section's approaches include: 1) avoid costs where appropriate by identifying third party payers and directing claims to such payers, 2) recover medical payments from liable third parties, 3) fund premium assistance for commercial health coverage when doing so is cost-effective, 4) recover trust dollars where appropriate, 5) facilitate access to other available federally funded health coverage, and 6) identify areas of waste and eliminate funding of Medicaid to non-eligible individuals.

Approximately 70% of the Section's recoveries come from recovering payments from health care payers after the claims system has already paid the provider. With the development of a new claims system, we will improve processes to acquire and retain information pertinent to other health coverage held by a Medicaid member. The new claims system will modernize these processes to enhance our cost avoidance. Specifically, it is more efficient to facilitate submission of claims to the primary payer prior to adjudication of the claim than recovering the payment after paying the claim. The goal is to reduce the amount of post-payment recoveries over time by ensuring that claims are initially submitted to the correct payer, rather than to the Department.

STRATEGY #4E SUPPORT COUNTIES AND MEDICAL ASSISTANCE SITES WITH TECHNICAL ASSISTANCE FOR PROCESSING ELIGIBILITY APPLICATIONS ACCURATELY AND EFFICIENTLY

Work supporting this strategy is critical to bringing Medicaid-eligible individuals into the health care system so their health and quality of life can be improved. Three measures show progress related to this strategy: number of individuals enrolled in Medicaid/CHP+, percent of timely eligibility determinations, and percent of real-time eligibility applications.



We anticipate Medicaid and CHP+ caseload to increase approximately 6% per year through FY 2018-19. This is a result of processing applications from eligible individuals who apply through counties, medical assistance sites, PEAK, and the Connect for Health Colorado exchange web site. We expect the efforts described below to help us maintain our timely processing rate of 98% indefinitely, and for real-time eligibility applications to plateau at approximately 62%.

Support counties and medical assistance sites with technical assistance for processing eligibility applications	Historical Actual		FY 2015-16 YE Estimate	1 and 3 Yr Target	
	FY 2013-14	FY 2014-15		FY 2016-17	FY 2018-19
# Individuals enrolled in Medicaid/CHP+	923,464	1,215,592	1,357,417	1,444,761	1,546,973
% Eligibility determinations processed timely	92%	97%	98%	98%	98%
% Real-time eligibility applications	N/A	71%	62%	62%	62%

Real-time eligibility data is for medical assistance only applications

The following programs assist in supporting our strategy to support counties and medical assistance sites with technical assistance for processing eligibility applications accurately and efficiently.

STAFF DEVELOPMENT CENTER

The Staff Development Center (SDC) contributes to our strategy to support counties and medical assistance sites by serving as their training connection to the Department.

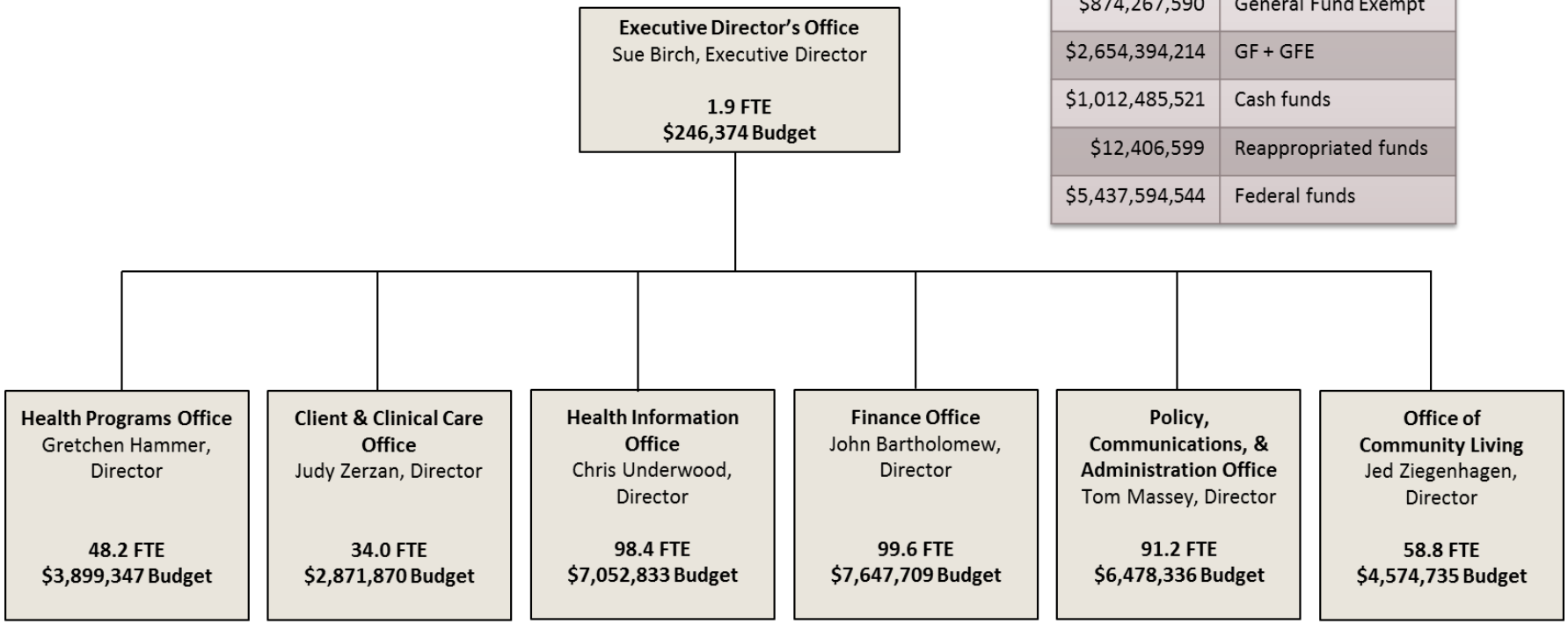
The SDC works to identify essential training needs and to establish, facilitate, and maintain competency-based training curricula, while continually evaluating results. Its training represents a collaboration of the Colorado Departments of Human Services and Health Care Policy and Financing and the Governor's Office of Information Technology. Its training supports county-based departments of social/human services and medical assistance sites throughout Colorado as they assist Coloradans in accessing medical and other public assistance.

During FY 2015-16, the SDC developed the *Expanding Foundations* training series for new workers focused on Medicaid eligibility and a refresher series for existing workers. The SDC provided policy and system training for Colorado Benefits Management System builds, conferences, and regional training focused on quality assurance results.

In FY 2016-17 the SDC will be introducing a new process-based training model and delivery system focused on the day-to-day activities of a generalist. The trainings will be based on three guiding principles: customer-centric, process-based, and outcomes-focused work. The customer-centric approach is designed to meet diverse learner needs and utilizes a variety of mediums including instructor-led, and self-paced on-demand modules. Process-based training focuses on specific eligibility tasks completed by specialists, with the goal of allowing them to focus on client needs rather than memorizing rules or regulations. Benefits of the new model include decreased error rates, increased efficiency through remote delivery, and improved learner retention of training material and concepts.

Organizational Chart & Total Budget

Total Department FTE & budget breakdown (based on FY 2016-17 appropriations)	
432.0	Total FTE
$9,116,880,878	Total funds*
$1,780,126,624	General Fund
$874,267,590	General Fund Exempt
$2,654,394,214	GF + GFE
$1,012,485,521	Cash funds
$12,406,599	Reappropriated funds
$5,437,594,544	Federal funds



*$9.1 billion in total funds is not distributed across the organizational chart, as the majority of the Department's budget is for expenditures across multiple offices and programs, e.g., medical services premiums.

Department Description

Executive Director's Office

Susan E. Birch was appointed Executive Director of the Department effective January 18, 2011. The Executive Director is responsible for setting the strategic direction of the Department, defining the vision and mission and ensuring we are operating in an efficient and effective manner. The Executive Director creates alignment between Department initiatives and the priorities of the Administration to ensure Colorado meets its goal to become the healthiest state in the nation. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

Health Programs Office

The Health Programs Office develops, implements, administers, monitors and improves Medicaid acute care and the Child Health Plan *Plus* (CHP+) programs. The Office is made up of three divisions: Delivery System and Payment Innovation, Provider Relations and Dental Program, and Health Programs Benefits and Operations.

DELIVERY SYSTEM AND PAYMENT INNOVATION DIVISION

The Delivery System and Payment Innovation Division is responsible for administering Colorado Medicaid and CHP+ acute care physical and behavioral health programs, including the Accountable Care Collaborative. Its responsibilities also include program monitoring, performance, innovation/delivery system reform, and payment reform.

PROVIDER RELATIONS AND DENTAL PROGRAM DIVISION

The Provider Relations and Dental Division is responsible for provider outreach, enrollment support, retention and ongoing relations. The division manages the dental program for children and adults including stakeholder relations, policy development and implementation, contract management and performance, and program administration.

HEALTH PROGRAMS BENEFITS AND OPERATIONS DIVISION

The Health Programs Benefits and Operations Division is responsible for Medicaid acute care benefits management and operations activities. The Benefit Management Section defines, updates, implements, and manages Colorado Medicaid fee-for-service benefits, including defining coverage, and implementing, monitoring, and evaluating benefits. The Operations Section develops, oversees, and executes numerous processes that support the acute care fee-for-service benefits and managed care programs. These processes include medical coding, utilization management, contract management and performance, program development and management, client appeals, the Benefits Collaborative process, stakeholder engagement, project management, federal and state compliance activities, as well as collaborative benefit development and implementation.

Client and Clinical Care Office

The Client and Clinical Care Office provides clinical expertise and advice regarding Department services, programs, policy, client and provider relations, and performance. The Office is comprised of the Chief Nursing Officer, the Pharmacy Section, the Data Analysis Section, and the Quality and Health Improvement Unit. It focuses on preventing the onset of disease and helping our clients manage chronic diseases in such a way that their health improves.

PHARMACY SECTION

The Pharmacy Section oversees access to medication for Medicaid clients, and administers the Rx Review Program (a session for counseling on drug therapy for Medicaid clients). The Section ensures clinically appropriate and cost-effective use of medications through the Colorado Preferred Drug List Program, drug-utilization analysis, and input from the Drug Utilization Review contractor. Additional responsibilities include collecting federal and supplemental drug rebates from pharmaceutical manufacturers, ensuring pharmacy benefit compliance with federal and state statutes and regulations, providing pharmacy benefits information and assistance to clients, pharmacies, and prescribers, and managing the Durable Medical Equipment benefit.

DATA ANALYSIS SECTION

The Data Analysis Section establishes standards for analysis of data utilized in Department decision making. It is responsible for meeting internal data analysis needs, as well as extracting data for research, policy formation, report writing, forecasting, and rate setting for Department programs. It is also responsible for providing data and analytical services to stakeholders, partners, or others outside the Department who request it.

QUALITY AND HEALTH IMPROVEMENT UNIT

The Quality and Health Improvement Unit conducts and coordinates performance improvement activities supporting care and services delivered by Colorado Medicaid and Child Health Plan *Plus* (CHP+). Specific functions of the unit include:

- managing external quality review,
- monitoring managed care plan contract compliance,
- overseeing client satisfaction surveys for Medicaid and Child Health Plan *Plus* (CHP+),
- developing long-term care quality tools and interagency quality collaborations,
- developing and implementing quality strategies, and
- consulting with program managers regarding performance measurement and improvement.

Health Information Office

The Health Information Office (HIO) develops, implements, and maintains our Health Information Technology (HIT) and related Information Technology (IT) infrastructure, while coordinating with the Governor's Office of Information Technology and other stakeholders on HIT and IT projects that impact the Department. In addition to aligning our infrastructure, the Office creates a foundation for emerging HIT solutions necessary for implementing our transformational vision for the future of Medicaid.

HIO project management teams provide coordination and management assistance for projects and serve as a bridge between our Department, providers and vendors to streamline project approval processes and timeframes. The HIO contract management team provides coordination and management assistance for contracts and serves as a bridge between our Department and contractors. The contract management team helps to establish a clear scope of authority, and clear lines of communication and reporting when interacting with contractors. These teams play a vital role, as our Department contracts out IT and HIT solutions rather than building and maintaining infrastructure in-house.

The Office serves as the primary point of contact regarding data integration and interoperability for multiple external stakeholders, including the Office of Information Technology (OIT), the Center for Improving Value in Health Care (CIVHC) who administers the All-Payers Claims Database (APCD), Colorado Regional Health Information Organization (CORHIO), and Quality Health Network (QHN).

The Health Information Office is comprised of the HIO Systems Division, HIO Operations Division, Eligibility Division, Health Data Strategy Section, and Purchasing and Contracting Services Section.

HEALTH INFORMATION OFFICE SYSTEMS DIVISION

The Health Information Office Systems Division is made up of the Colorado InterChange Systems Section, the Case and Care Management Section, Testing Support Section, and Eligibility Systems Section. The Division is responsible for enhancing and maintaining our health care claims payment system and client eligibility system, by developing requirements documentation, reviewing system design approaches, proposing systems solutions to program staff, and implementing systems solutions to support Department policies. The Division manages maintenance of and updates to Department systems by working closely with its contractor and gathering requirements in consultation with policy staff. The Division also proposes and implements solutions for program staff, and uses feedback from project stakeholders to verify and ensure accuracy of the claims payment and client eligibility systems.

HEALTH INFORMATION OFFICE OPERATIONS DIVISION

The Health Information Office Operations Division is comprised of the Fiscal Agent Operations Section and the Eligibility Monitoring and Quality Section. The Fiscal Agent Operations Section supports health care claims processing, provider reimbursement, provider enrollment, and State and federal audits of the Medicaid Management Information System (MMIS) related to health care claims processing and provider enrollment. The Eligibility Monitoring and Quality Section oversees the work and performance of eligibility sites statewide where Coloradans can sign up for Medicaid and receive eligibility services (point of entry sites). Section staff interpret state and federal regulations concerning Medicaid eligibility, ensure compliance with state and federal regulations and laws, and enroll members in Medicaid.

ELIGIBILITY DIVISION

The Eligibility Division is comprised of the Eligibility Contracts and Site Relations Section, the Eligibility Policy Section, and the Eligibility Project Management Unit. The Division is responsible for policy and operations related to Medicaid and CHP+ eligibility. The Division is responsible for ensuring policy and contracts implementation required by changes in eligibility due to changes in law. The Division interprets new and existing Medicaid/CHP+ law to define eligibility requirements for Coloradans, and oversees the site agreements, contracts, rules, processes, and systems involved in granting membership, as well as determining and redetermining eligibility. The Eligibility Project Management Unit provides coordination and management assistance for projects throughout our Department that impact the MMIS, CBMS, and PEAK. The Unit works with Department staff, state agencies, federal partners, and vendors to guide project costs, time, scope, quality, and approval processes.

HEALTH DATA STRATEGY SECTION

The Health Data Strategy Section is responsible for managing our Statewide Data Analytics Contractor (SDAC)/ Business Intelligence and Data Management Services (BIDM) and implementing a Medicaid data infrastructure that supports strategic uses of health data. In addition, the Section provides data-related expertise to Colorado health reform efforts such as the Accountable Care Collaborative.

PURCHASING AND CONTRACTING SERVICES SECTION

The Purchasing and Contracting Services Section provides all aspects of procurement and contracting for our Department under state and federal laws, rules, policies, procedures and guidelines. The team reviews Department contracts and purchase orders for compliance with state rules, regulations, and contracting standards and processes.

Finance Office

The Finance Office consists of the Chief Financial Officer, the Budget Division, Controller Division, Payment Reform Section, Special Financing Division, Audits and Compliance Division, Financial Analytics Unit, and Strategy Section.

The Chief Financial Officer (CFO) is accountable for the financial and risk management operations of the Department, and oversees control systems that report financial results and maintain Department compliance. The CFO is responsible for our financial data and reporting, and for use of data analytics to define value and measure quality with regard to Department operations. The CFO develops our financial and operational strategy, and generates actionable analytics tied to that strategy.

BUDGET DIVISION

The Budget Division presents and defends our budgetary needs to Colorado executive and legislative authorities and monitors our caseload and expenditures throughout the fiscal year. Additional Division functions include preparing fiscal impact statements for proposed legislation and ballot initiatives, performing our federal reporting, and coordinating with other State agencies on budgetary issues presenting mutual impact.

The Budget Division is also tasked with working closely with the Centers for Medicare & Medicaid Services (CMS) to ensure that we are maximizing available federal funds for Medicaid and Child Health Plan *Plus* (CHP+). In addition, the Division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

CONTROLLER DIVISION

The Controller Division oversees the accounting functions of the Department. The Division ensures proper recording and reporting of Department revenues, and that expenditures comply with generally accepted accounting principles and state and federal rules and regulations. The Division is comprised of:

- the Operations Unit, which is responsible for recording of cash receipts, accounts receivable, accounts payable, and payroll;
- the Financial Reporting and Cash Management Unit, whose cash management functions include reporting for State and federal cash as well as private grants and non-Medicaid federal grants; and
- the Medicaid and Provider Fee Unit.

PAYMENT REFORM SECTION

The Payment Reform Section develops rate-setting methodology and implements managed care rates for contracted health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers. The Section monitors and updates rates paid for home and community-based services. The Section is also responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics.

SPECIAL FINANCING DIVISION

The Special Financing Division administers programs that provide funding to hospitals and clinics that serve uninsured and underinsured individuals, and provide coverage for individuals not eligible for Medicaid or Child Health Plan *Plus* (CHP+). The Division is also responsible for developing Colorado Medicaid provider fee structures: developing fee models, coordinating stakeholder and board review, and submitting them as Colorado Medicaid State Plan amendments to the Centers for Medicare & Medicaid Services for approval.

AUDITS AND COMPLIANCE DIVISION

The Audits and Compliance Division assists in ensuring Department compliance with state and federal law, identifies and recovers improper payments to providers, and conducts preliminary investigations of fraud. The Division is comprised of the Program Integrity Section, the Audit Information Management Section, and the Eligibility and Claims Review Section.

The Program Integrity Section holds primary responsibility for detection and deterrence of provider fraud, waste, and abuse. The Section's Claims Investigation Unit monitors provider compliance with rules and statute in billing Medicaid. Functions include identifying possible fraud, conducting preliminary investigations of fraud and referring providers to law enforcement when appropriate, identifying and recovering overpayments and terminating provider participation when appropriate.

The Audit Information Management Section monitors Department compliance with federal and state laws, rules, regulations, policies and procedures. The Section also performs county-related compliance review functions and supports county investigations of member fraud. The Section specializes in the use of data analysis to identify inappropriate payments, and supplies data to the Audits and Compliance Division.

The Eligibility and Claims Review Section manages federally required programs such as Medicaid Eligibility Quality Control (MEQC), Payment Error Rate Measurement (PERM), and the Recovery Audit Contract

(RAC). These programs review the accuracy of eligibility determinations and/or conduct claims review to recover improper payments made to providers. The section also includes the Predicative Analytics Program manager who is responsible for determining the most effective approach for implementing a prepayment claims review model.

FINANCIAL ANALYTICS UNIT

The Financial Analytics Unit develops financial reporting and analytics tools that support value-based purchasing – the practice of selecting which medical services Medicaid pays for based on quality and cost factors. Tools created by the Unit provide a foundation for discussions between the Department and providers about how to improve quality and lower costs. For example, Provider Report Cards deliver snapshots that quantify quality and cost, and a Financial Reporting Template enables providers such as Regional Care Collaborative Organizations to submit financial data for analysis and discussion.

STRATEGY SECTION

The Strategy Section is responsible for developing and articulating our strategy, mission, and goals. The Section provides strategy-related guidance throughout the Department; develops, edits, and produces public-facing reports including our Department Performance Plan; and collects, manages, and publishes Department performance data. The Strategy Section leads our Lean Community, which is responsible for implementing a culture of continuous improvement throughout the Department. It facilitates Lean process improvement initiatives for groups and administrative units throughout the agency. In partnership with the Workforce Development Section, it presents an in-depth Culture of Improvement Academy training for Department employees on a quarterly basis.

Policy, Communications, and Administration Office

The Policy, Communications, and Administration Office manages Department functions associated with government affairs, communication and media relations, client services, legal affairs and internal operations. It provides leadership and guidance regarding external communication and relations, legal affairs, and organizational development. Office staff represent the Department before external stakeholders that include policy makers, county partners, advocates, and the press. The work of the Policy, Communication and Administration Office crosses the Department and facilitates and supports the work of all staff.

The Office is comprised of the External Relations Division, the Client Services Division, the Operations Section, the Grants Unit, the Federal Policy and Rules Officer, the Engagement and Development Division, and the Legal Division.

EXTERNAL RELATIONS DIVISION

The External Relations Division is comprised of the Government Relations and Partner Outreach Section and the Communications Section.

The Government Relations and Partner Outreach Section is responsible for creating our legislative agenda, informing legislators and the Governor’s Office about our legislative priorities, and advocating for passage of Department initiatives. It maintains relationships with members of the state General Assembly, their staff, the Governor’s office, and other leaders and stakeholders across the state. The Section’s Partner Outreach staff conduct educational, and collaboration-oriented outreach to county leadership, local public health, community partners, and other stakeholders including Connect for Health assistance sites.

The Communications Section develops and coordinates communications plans, products, and activities for external audiences. It is responsible for representing the mission and accomplishments of the Department to a range of external audiences including policy makers, clients, and stakeholders.

OPERATIONS SECTION

The Operations Section is responsible for department-wide safety and security, office administration, facilities management, and real estate services. Its office administration functions include ensuring coordination and compliance of standard operating procedures; event planning and coordination; office supplies oversight; and coordinating Department support staff and special projects. The Section houses the Governor's Citizen's Advocate, and is responsible for managing problems, disputes and issues pertaining to high needs Colorado Medicaid clients that reach federal and governor levels.

The Section performs key security functions including managing physical security; oversight of our public reception function and first point of contact, including identification badge issuing and compliance; and creating and managing our Emergency Action Plan and Continuity of Operations Plan.

GRANTS UNIT

The Grants Unit requests and secures grant funding to pursue pilot program initiatives and strategic projects not funded through the regular budget process. Funding secured by the Unit also assists legislative directives requiring gifts, grants, or donations for implementation. Functions include:

- coordinating and overseeing use of funds from grants received,
- maintaining relationships with private foundations and federal project officers,
- working with Department staff to match funding needs with potential funders,
- responding to funding solicitations, and
- working with the executive team and management to prioritize projects related to grant funding.

FEDERAL POLICY AND RULES OFFICER

The Federal Policy and Rules Officer is our legal expert regarding compliance with federal rules and regulations. The Officer is responsible for managing our State Plan and drafting amendments. The Officer also oversees coordination of our rule-making body, the Medical Services Board, and provides assistance to staff in drafting proposed rules.

ENGAGEMENT AND DEVELOPMENT DIVISION

The Engagement and Development Division is comprised of the Human Resources Section and the Workforce Development Section.

The Human Resources Section is responsible for filling Department staff positions in accordance with State rules and procedures. Functions include:

- recruitment, testing and selection,
- position classification,
- salary administration,
- dispute resolution,

- performance management, and
- administration of annual compensation/benefits.

The section guides and assists Department managers and staff in their use of the State personnel system, and delivers workplace training on topics including sexual harassment, violence in the workplace, and maintaining a respectful workplace.

The Workforce Development Section is responsible for creating and delivering facilitated and e-learning employee engagement and professional development training to benefit the Department and its workforce. The Section also provides consultation and coaching for managers, employees and teams.

CLIENT SERVICES DIVISION

The Client Services Division provides a high level of communication and assistance to all clients who contact the Department. The Division's Member Contact Center serves as the major focal point for callers who require assistance with questions about eligibility and program information and who need help navigating a complex health care system. The Division's Education and Design Unit produces and conducts training regarding our policies and initiatives for a variety of internal and external customers. The Division's Eligibility Training Section provides training to counties and contracted agencies where Coloradans sign up for Medicaid and receive eligibility services (point of entry sites).

LEGAL DIVISION

The Legal Division is comprised of the Appeals Section, the Americans with Disabilities Act Coordinator, the Privacy Officer, and the Benefits Coordination Section. The Division is responsible for HIPAA and ADA training and compliance. The Division also acts as records custodian and coordinates Colorado Open Records Act requests. Additional functions include:

- managing and coordinating external data requests through our data review board,
- managing our privacy database,
- coordinating our relationship with the Attorney General's office,
- providing analysis and guidance to Department personnel regarding regulatory and legal issues,
- monitoring the impacts of federal health care reform, and
- through its Benefits Coordination Section, preventing or recovering Medicaid payments made for medical care from responsible third parties, including private health plans, and trusts and estates. The Benefits Coordination Section also administers our Health Insurance Buy-In program.

Office of Community Living

The Office of Community Living provides direction and strategic oversight of Colorado Medicaid's programs, services, and supports for older adults, and children and persons with disabilities. The Office implements our efforts to transform the long-term services and supports system into a person-centered system that ensures responsiveness, flexibility, accountability, and person-centered supports for all eligible persons.

The Office is comprised of the Division for Intellectual and Developmental Disabilities and the Long Term Services and Supports Division.

DIVISION FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

The Division for Intellectual and Developmental Disabilities (DIDD) leads efforts for the direction, funding and operation of individualized and flexible supports enabling people with intellectual and developmental disabilities to live everyday lives in the community. The Division oversees three Home and Community Based Services waivers serving individuals with intellectual and developmental disabilities: the state-funded Supported Living Services Program, the Family Services and Supports Program and Loan Fund, and Preventive Dental Hygiene services.

LONG TERM SERVICES AND SUPPORTS DIVISION

The Long Term Services and Supports Division oversees eight Medicaid-funded Home and Community Based Services (HCBS) waivers, the Program of All-inclusive Care for the Elderly (PACE) and the Nursing Facility (NF) and Hospital Back-Up (HBU) State Plan benefits. The Division is responsible for managing two consumer-directed service delivery models which enable qualifying individuals to self-direct their care.

Glossary

ACA — Affordable Care Act

ACC — Accountable Care Collaborative

ADA — The Americans with Disabilities Act of 1990 requires that state and local government entities do not discriminate against people with disabilities in their programs, services, and activities.

BHO — behavioral health organization

BIDM — The Business Intelligence and Data Management (BIDM) system, one of the three systems in COMMIT

Capitation — provider payment arrangement based on the number of enrolled individuals assigned to the provider, per period of time, whether or not those individuals seek care

CBMS — Colorado Benefits Management System

CDASS — consumer directed attendant support services

Centers for Medicare & Medicaid Services — See CMS.

CHP+ — Child Health Plan *Plus*

CMS — The Centers for Medicare & Medicaid Services, the federal agency overseeing the Medicaid program. CMS is part of the U.S. Department of Health and Human Services (HHS). CMS works in partnership with state governments to administer the Medicaid and the State Child Health Insurance programs.

COMMIT — Colorado Medicaid Management Innovation and Transformation, the Department's four-year project to design, develop, test and implement systems to replace the 20-year-old Medicaid Management Information System (MMIS) and other information technology components.

CORHIO — Colorado Regional Health Information Organization, a nonprofit partnering with the Department on technology projects related to health information exchange.

DD — developmental disability

ED — emergency department

EHR — Electronic Health Record

EPSDT —Early and Periodic Screening, Diagnostic and Treatment benefit providing comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

FCR — first call resolution

FQHC — federally qualified health center

FY — fiscal year

HCBS — home and community based services

HCPF — Colorado Department of Health Care Policy & Financing

HIPAA — Health Insurance Portability & Accountability Act of 1996

HIT — health information technology

HMO — health maintenance organization

interChange — The Colorado interChange is one of the three computer systems included in COMMIT, and relates to payment of claims.

IT — information technology

KPI — key performance indicator. The KPIs form the basis for incentive payments designed to encourage ACC providers to use services and practices that improve health outcomes.

LTSS — long-term services and supports

MMIS — Medicaid Management Information System

MLR — medical loss ratio, the proportion of premium revenues an insurance provider spends on clinical services and quality improvement

NAL — Nurse Advice Line

Passive enrollment — being automatically enrolled in a benefit

PBMS — Pharmacy Benefit Management System, one of the three systems in COMMIT

PEAK — Program Eligibility Application Kit

PCMP — primary care medical provider

PMPM — per member per month

PACE — Program of All-Inclusive Care for the Elderly

RCCO — Regional Care Collaborative Organization

SLS — supported living services

State Plan — A Medicaid and CHP+ state plan is an agreement between a state and the federal government describing how that state administers its Medicaid and CHP+ programs. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

Waiver — A program that sets aside Medicaid state plan requirements in order to provide a specified member population with needed services