

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2009-10 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 16, 2008

9:00 am – 12:00 noon

HEALTH CARE POLICY AND FINANCING

9:00-9:20 INTRODUCTIONS AND OPENING COMMENTS

1. How does your requested decision item for Mental Health tie to the Department's goals?

RESPONSE:

Appropriation of the funds requested in Decision Item 2 helps the Department reach its goals by securing the funding necessary to meet the mental health needs of program eligible clients. As stated in the Department's Strategic Plan, one of the Department's key goals is to "...improve health outcomes for all clients and ensure that the health care the Department purchases are medically necessary, appropriate to the population, and cost-effective."

The Department strongly believes that promoting and ensuring the mental health of our clients is as important as promoting and ensuring the physical health of covered clients. Mental and behavioral health needs differ by eligibility category ranging from serving clients with serious and persistent mental illness to those with mild and episodic conditions. The mental health program has accomplished a number of activities to improve client access to mental health care, increase the accountability and efficiency of the program and promote integrated, client-centered care. Through stakeholder input and formal site visits, barriers to mental health care have been identified and the behavioral health organizations have implemented measures to reduce or eliminate those barriers. Measures have included modifying client intake processes, conducting outreach to isolated individuals in nursing facilities, addressing facility accessibility issues and establishing expanded service hours. The Department and the behavioral health organizations have sought to increase accountability by ensuring that encounter data is received and processed in the Department Medicaid Management Information System and by establishing new performance measures for the program. Having encounter data and regular reporting on measures such as inpatient utilization, inpatient length of stay, hospital readmissions, penetration rates and adult and family perception of care will improve accountability and efficiency. The Department and the behavioral health organizations have worked to promote coordination and integration of care by bringing physical health plans and the behavioral health organizations together to address how care can be better coordinated. The work group of behavioral health and physical health care plans has also completed performance improvement projects targeted at studying the care coordination documentation in client medical records and heightening awareness of the need for coordination/integration.

In an effort to ensure the highest quality services, encourage innovation and improve the mental health and functioning of our clients, the Department has written a request for proposals that is designed to respond to current national and local trends in mental healthcare reform and to incorporate information and feedback from a wide range of Colorado stakeholders and other sources. These sources include Governor Bill Ritter's Colorado Promise and Building Blocks for Health Care Reform plan, recommendations from the Blue Ribbon Commission on Healthcare Reform, the House Joint Resolution 07-1050 Behavioral Health Task Force, the Mental Health Planning and Advisory Council (MHPAC), the Department's Mental Health Advisory Committee (MHAC), and research and recommendations from independent health care consultants contracted by the Department to assist with program evaluation.

In addition to tracking services and activities, the Department is interested in maximizing mental health and behavioral health outcomes. The request for proposals adopts recommendations developed by MHPAC as guidelines for a "System of Care" approach to providing behavioral health services. The recommendations include:

- **Persistent Commitment to Adults, Youth, Children & Families.** Safety. Services and supports are developed and implemented to best ensure the safety of the child, youth, adult, family, and community.
- **Person-Centered.** Services and supports are provided in the best interest of the individual to ensure that the individual's and family's needs are being addressed.
- **Family-Community Focused.** The child is viewed as a part of the whole family. The adult is viewed as a part of the community. Systems, services and supports are based on the strengths and needs of the entire family or community. Adults, youth, children and their families shall participate in discussions related to their plans, have opportunities to voice their preferences and ultimately feel that they own and drive the plan.
- **Individualized.** Plans and supports for adults, youth, children and their families are tailored to the unique culture, beliefs and values, strengths, and needs of each child, adult and family member. Funding sources must be flexible to support individualization.
- **Culturally Competent.** The system of care is culturally competent, with systems, agencies, programs, and services that are responsive to the cultural, racial, spiritual (religious), gender and ethnic differences at the system and individual level.
- **Strengths-Based.** Services and supports are based on identified strengths of the adult, child, youth, family, and community.
- **Early Access.** Services and supports should have a prevention and early intervention focus to facilitate wellness for the individual and family.
- **Community-Based.** Services and supports are provided in the most appropriate and least restrictive environment and in the home community of the adult, youth, child or family.

The system of care is community-oriented with the location of services, management and decision-making responsibility resting at the community level.

- **Natural Supports**. Adults, children and families are supported by family and community social networks and community resources (e.g., service organizations, faith-based organizations and businesses). Services build on and strengthen these natural supports.
- **Collaborative**. Collaboration between agencies, schools, community resources, youth and families is the basis for building and financing a local comprehensive and integrated system of care that supports easy access to needed services and supports for children, families and adults.
- **Adult, Family, Youth, and Professional Partnership**. Adults, families and youth are partners with professionals at all levels of assessment, planning, implementation and governance of the system of care.
- **Outcome-Based and Cost Responsible**. Services and supports are outcome-based with clear accountability and cost responsibility. The system values and funds outcome and quality management. This accountability includes prudent and effective use of public and private funds. As communities find ways to reduce the use of restrictive care, the funding is retained in the community and reinvested in the prevention and early intervention that has made these improvements possible.
- **Transition-Sensitive**. Children, families, and adults should be ensured smooth transitions through all major changes in their lives. Major changes may include but are not limited to transitioning from youth to adult behavioral health services, moving from an institutional to a community living situation or the reverse, parental separation, changing behavioral health care providers, loss or gain of a major life role, loss or gain of employment, transitioning from supported to independent living or the reverse, and bereavement.

In addition to these recommendations, the Department's request for proposal emphasizes a community behavioral health focus, coordinated, team-based, member-centered care, and outcome measurement.

Community Behavioral Health Focus

The Department embraces the goals and objectives of *HealthyPeople 2010* (<http://www.healthypeople.gov/>). *HealthyPeople 2010* defines mental health as: "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity." The Department expects its contractors will identify the frequencies and severity of behavioral health needs in their Member populations, and will have a proactive plan for promoting their population's behavioral health. In particular, the Department expects its contractors to distinguish the different behavioral health needs of the disabled adult, non-disabled adult, waiver populations, dual eligible population and children.

Coordinated, Team-Based, Client-Centered Care

The Department seeks to maximize the well-being and health of each Member for the resources applied. The Department expects its contractors to not only excel in its individual functions, but also excel at coordinating its activities with other stakeholders. The Department expects its BHOs to be able to foster coordinated and team-based care by their contracted providers with other behavioral health care providers, physical health care providers, long-term care providers, waiver services providers, pharmacists, county and state agencies, and other provider organizations. The Department expects Members to be involved in the creation of their care plans and for those plans to be clearly communicated to Members. While the notion of a “medical home” is a powerful and useful concept, the Department also supports the idea of a “health neighborhood”, i.e. stakeholders working together to optimize the health status of individuals and the community as a whole. Over time, the Department will foster team-based, coordinated care through health information exchanges, electronic personal health records, aligning incentives, and fostering stakeholder dialogue; however, the responsibility for care coordination must be shared by the Department and its behavioral health partners.

Outcomes Emphasis

Traditionally, health care purchasers focus on defining covered populations, defining benefits, ensuring adequate provider networks, setting rates and promoting access to care. Increasingly, the Department is focusing on the outcomes and performance associated with the provision of behavioral health services. The Department will partner with the BHOs on improving the comprehensive behavioral health status of the populations served and performance-based contracting. Examples include:

- requiring the behavioral health plans to provide evidence-based and promising practices for adult, child and adolescent populations, such as screening for depression post-partum and referring to treatment;
- requiring the behavioral health plans to measure performance against important aspects of each selected practice, such as lowering the adolescent suicide rate; and
- establishing an incentive system where payments are based on reported outcomes of selected measures.

The Department has greatly benefited from the considerable input from clients, advocates, local and state agencies, policy experts, academics and interested citizens in evolving our programs to better serve clients cost-effectively to promote health, functioning and self-sufficiency.

2. Please justify why the additional General Fund for the Mental Health program must be funded in FY 2009-10 and why it cannot be postponed until FY 2010-11.

RESPONSE:

The Department pays for the Medicaid Community Mental Health Services Program under a full risk capitated contract. Under this contract, the Department pays contracted Behavioral Health

Organizations on a per-member basis. Costs for this program are primarily driven by the capitation program, which incurs expenditure based on the rates paid to the Behavioral Health Organizations. The forecasted rates have increased slightly, reflecting the increased cost of health care. Additionally, current caseload forecasts project a 40,645 member increase in caseload over the next two years.

Decision Item 2 responds to these twin cost drivers by requesting funds appropriate to meet the anticipated need. In addition, DI-2 requests adjustments to the Department's appropriation for mental health fee-for-service expenditures, similarly projected to increase due to increased caseload in FY 2008-09 and FY 2009-10.

Federal regulation requires that if mental health benefits are to be provided, the program must provide those benefits to most of the Medicaid eligible population (excluding partial-dual-eligibles and non-citizens). Additionally, federal regulations require that the Behavioral Health Organizations be paid actuarially sound rates.

In order to meet the federal requirements outlined above, the program must pay an actuarially certified rate to the Behavioral Health Organizations based on Medicaid Mental Health encounters and financial history. Program expenditures are also subject to changes in caseload, regardless of the level of appropriation granted the Department. As caseload increases the program will expend based on that caseload. If caseload grows at a rate greater than the current appropriation anticipates, the Department must continue to pay capitations to keep the program in federal compliance.

If appropriations are not adjusted based on the most current forecasts available, the Department risks generating excessive overexpenditure over the course of the fiscal year. This will complicate the budget process in future years as the State looks to find revenue in those future years for money already spent in past years.

(Please note the Department of Health Care Policy and Financing will discuss all Common Questions asked by the Committee on December 17, 2008 at their main hearing. The questions above will relate only to the HCPF Mental Health program.)

9:30-9:50 REPROCUREMENT OF THE BEHAVIORAL HEALTH ORGANIZATION CONTRACTS

- 3. Please explain the delays and difficulties that the Department has encountered during the current RFP process for BHO contracts. Update the Committee on the new issuance of the RFP in December and the new timeline anticipated for signing new contracts. Also update the Committee on any changes to the RFP released in December compared to the RFP released in November.**

RESPONSE:

The Community Mental Health Services Program is in the final year of a five year contract. One of the Department's major focuses this year has been procurement of a new contract for FY 2009-2010 and subsequent years. As part of this process, a draft request for proposals was published in June 2008 for public comment. Feedback was received via e-mail, fax, and in three public forums held around the state. Much of this feedback was incorporated into the final request for proposals, which was scheduled for publication in September 2008.

The Department has an interest in supporting competition for the new behavioral health contract in an effort to provide the best possible quality and value to Colorado Medicaid members and the State. It is important to note that the proposals are fixed price and competition allows for evaluation of varying approaches to achieving outcome and promoting innovation and service. Since these contracts are fully capitated, it is also very important that contractors for the Program have appropriate regulatory oversight to ensure financial stability. To that end, Department staff met with representatives from the Division of Insurance this summer to determine if the request for proposals licensure requirements could be broadened to include entities other than Health Maintenance Organizations and limited services licensed provider networks. The consensus from those meetings was that there were no other licensure options appropriate for this program. Therefore, the language from the 2004 request for proposals limiting bidders to Health Maintenance Organizations or limited services licensed provider networks was allowed to stand. The Department made final preparations to post the request for proposals on the State's BIDS system.

At the end of September before the request for proposals was posted, a State hiring freeze was announced, requiring that any solicitation that included a personal services agreement be reviewed for exemption from the freeze. The Department's exemption request for the Behavioral Health Organization solicitation was completed and submitted on October 10, 2008. The request for proposals was officially exempted from the freeze on October 31, 2008. The request for proposals was published the following Thursday, November 6th. On November 14th, a protest was submitted by Magellan Behavioral Health of Colorado. The protest charged that the request for proposals unfairly and inappropriately limited competition for operation of the Mental Health Program to Health Maintenance Organizations and limited services licensed provider networks.

In response to the protest, staff requested a review by the Attorney General's office and were advised that the Department needed to collaborate with the Division of Insurance on contractor licensure requirements. Staff met with representatives from the Division of Insurance and received guidance that, in addition to Health Maintenance Organizations and limited services licensed provider networks, indemnified insurance companies were also licensed entities and could be considered qualified bidders for the Mental Health Program.

Because of the Department's desire to obtain a definitive answer prior to granting the protest, the Department negotiated a withdrawal of the protest by Magellan with the understanding that the

request for proposals would be withdrawn, revised, and republished in the near future. The revised request for proposals was published on December 12, 2008 with a proposal submittal deadline of February 18, 2009. Contractor selection is anticipated to occur the week of March 23, 2009. Contract negotiation is expected to occur in the 6-8 weeks following successful award. The new contract will be effective July 1, 2009 through June 30, 2010, with four optional renewal years to run through June 30, 2014.

The request for proposals was withdrawn solely for reconsideration of bidder qualifications in response to the protest. During the revision process, however, it was decided that bidder feedback received during the initial question and answer period could be used to clarify the Department's intent in some areas, thereby making it easier for potential bidders to respond. The Department also decided to publish a supplemental Question and Answer document along with the revised request for proposals to aid bidders in preparing their responses. Substantive changes are limited to the following:

- Bidder requirements were changed from requiring licensure as a Health Maintenance Organization or limited services licensed provider network to requiring appropriate Colorado licensure. This change effectively permits indemnified insurance companies to bid, in addition to Health Maintenance Organizations and limited services licensed provider networks.
- Annual enrollment figures were updated using FY 2007-08 claims data.
- The requirement for all Behavioral Health Organization senior staff to be Colorado-based was revised to require that only the Chief Executive Officer/Executive Director/Contract Manager position, the Office of Member and Family Affairs Director, and the Outcomes or Quality Improvement Director must be Colorado-based.
- Publication of capitated rates by service area that are 3% higher than the mid-range of rates published in the actuarial certification.

An important and recurrent theme is how mental health services can be more effectively integrated with other health and social service programs. The new request for proposals contains requirements for improved and enhanced services throughout the Mental Health Program. It also contains three service options that the Department may exercise if funding is appropriated in the future. The request for proposals places increased emphasis on coordination of support services needed by mental health clients, as well as on assisting clients to access physical health care services. Co-location of mental and physical health providers is encouraged. Behavioral Health Organizations will also be required to improve the provision of supportive services to clients experiencing transitions, for example, youth with mental illness who are transitioning to the adult mental health system and people transitioning to/from institutional to community living arrangements. Behavioral Health Organizations will be active partners as the Department moves ahead with proposed Medicaid reforms.

If funded, option #1 in the request for proposals would integrate the current fee-for-service outpatient substance use disorder benefit into the Program to be managed by the Behavioral Health Organizations. Research shows that a high percentage of individuals with mental illness

also have a co-occurring substance use disorder, and that integrated treatment of these disorders is more effective than treating each disorder separately. The second option contains requirements for enhanced care coordination of mental health, physical health and any supportive services required by Medicaid clients. It also requires coordination with other state and local agencies that may be involved with the client and his/her family. The third option involves the addition of screening, outreach and other activities designed to identify and serve at-risk populations within the service area who are not already accessing covered services.

Contracts will be awarded for administration of the Mental Health Program in the current five geographic service areas. Offerors may bid on more than one service area, but must submit separate, unlinked proposals for each area desired. As the Mental Health Program is based on per member capitated rates within an actuarially sound rate range, Offerors do not bid against each other on the basis of price. Rather, each Offeror must agree to provide the services proposed for the rate range offered by the Department. Proposals will be scored on the strength of the programs and services proposed.

4. Since the Department will be reissuing the RFP to allow more bidders to participate, how will the Department ensure that funding will not be reduced to the mental health safety net?

RESPONSE:

The procurement for the Medicaid community mental health services program has always been issued as competitive bid and has sought to maximize competition and ensure the best quality of services available. The current request for proposals is not a competition on price, but on the quality, comprehensiveness and innovation of the services offered. Bidders will be asked to propose the most comprehensive and innovative package of services for the rate provided in the solicitation. The Department's primary objective with this type of procurement is ensuring that the mental health needs of our clients are met in the most cost-effective and innovative way.

5. Will the contractors be required to contract with Community Mental Health Centers?

RESPONSE:

Yes, Contractors will be required to contract with Community Mental Health Centers. Specifically, the request for proposals states "The Offeror's provider network shall include Community Mental Health Centers and other providers. The provider network shall not be limited to Community Mental Health Center providers, but shall also include essential community providers, other private/non-profit providers, as well as providers with experience in serving individuals with complex needs, e.g. individuals with dual diagnoses and those with chronic physical conditions in addition to mental health needs."

- 6. If a contractor enters into a partnership, sub-capitation, or fee-for-service arrangement with the Community Mental Health Centers, how will the Department ensure the rates paid to the Centers cover the CMHC's costs?**

RESPONSE:

The Medicaid community mental health services program is a full risk, capitated, managed care arrangement with the selected vendors. Similar to practices in the physical health managed care arena, the Department does not dictate or otherwise get involved in, the subcontracts negotiated by our managed care entities. The community mental health centers have negotiated a variety of successful arrangements with the existing vendors. Since the behavioral health vendors are required to contract with the local community mental health centers, the Department believes that the community mental health center will not sign a subcontract if it is not favorable to the community mental health center.

- 7. If a contractor does not contract with the Community Mental Health Center(s) in their area, how will the Department ensure the contractor provides necessary services and does not cost shift these expenses to the state General Fund or community covered services.**

RESPONSE:

Contractors are required to contract with Community Mental Health Centers in their respective service areas; therefore, the Department does not anticipate provision of necessary services or cost-shifting will be an issue.

- 8. Please present the Department's future vision for the Medicaid Mental Health Program including:**
- a) How mental health services could be better integrated with other health and social service programs; and**

RESPONSE:

The Department has drafted a request for proposals that has the primary objective of promoting the health and functioning of our clients. In an effort to achieve greater health and functioning, the Department envisions a program that is focused on community behavioral health needs, that promotes coordinated, team-based, member-centered care and is outcome oriented. The request for proposal asks vendors to propose how they can integrate mental health services with other health and social services. Options for integration will range from offering a medical home within the behavioral health setting to the co-location of mental health professionals in the primary care health settings. While the Department has a vision for the future of the Medicaid mental health program in

particular, the Medicaid program is taking its cues from current national and local trends in health care reform. The vision for public behavioral health system in Colorado will not be decided by one state department. Instead, that public policy will be driven by the Governor's behavioral health council. Integration and streamlining of state agency programs will rely heavily on implementation and coordination of services and programs at the local level. Representatives from seven state departments the behavioral health council. The council is lead by Karen Beye from the Department of Human Services. Other departments represented on the cabinet include, the Department of Health Care Policy and Financing, the Department of Public Health and Environment, the Department of Corrections, Department of Youth Corrections, Department of Local Affairs, the Department of Education and Office of State Planning and Budgeting.

All departments will be important partners in the transformation of the healthcare system.

- b) What other treatments would be available if the Department expanded services from behavioral health “covered diagnosis” to include other mental health needs.**

RESPONSE:

The covered diagnosis requirement was initially included in consideration of the amount of mental health care delivered by primary care providers, and to provide clear lines of accountability for mental health treatment of Medicaid clients by the Behavioral Health Organizations. Due to the difficulty, at times, in determining the cause of behavioral problems, the question of expanding or removing the covered diagnosis requirement has been raised. The Department has an interest in maximizing the health outcomes of our clients not only in terms of their physical health, but equally in terms of the mental health of our clients. Our interest is not just those clients with severe and persistent mental illness, but also those with episodic illness and those without a mental health diagnosis who are faced with behavioral health challenges that impact their overall health and functioning. In order to maximize the mental health and functioning of all client populations there must be greater integration and/or coordination of care between the mental and physical health care systems. To that end, the Department envisions moving toward a system where the provision of care is not dictated by a covered diagnosis but by the clients' presenting needs. The Department recognizes that this is a long-term goal. It will be a deliberate process that will span several years. Efforts toward this goal will take into account decisions made and the successes of efforts for Medicaid reform on the physical health arena. Changes of this magnitude would require significant time and the involvement of a large number of stakeholders, including physical health plans and other state and local agencies, and changes to funding streams, data systems, and potentially procurement of the Community Mental Health Services Program.