

**AGENDA and RESPONSES**  
**FY 06-07 Joint Budget Committee Hearing**  
**Medicaid Mental Health Community Programs**  
**Tuesday, December 13, 2005**  
**Department of Health Care Policy and Financing 2:00 – 3:20**

**1:30 – 1:35 General Introductions and Overviews**

**2:00 – 2:40 Department of Health Care Policy and Financing and Department of Human Services – Mental Health Program**

**1. To what extent is the Department fulfilling its obligation to provide service to the citizens of the state?**

RESPONSE:

The Department of Health Care Policy and Financing (the Department) is the single state agency that operates the Colorado Medicaid Mental Health Community Programs which provide mental health care to full Medicaid recipients in Colorado, including women and children, disabled individuals, the elderly, and youth in foster care. The program is meeting current obligations by providing a comprehensive array of mental health services designed to meet the needs of Medicaid clients.

Colorado’s Medicaid Mental Health Community Programs are comprised of a statewide, capitated managed care program and the fee-for-service payments. The managed care program divides the state into five (5) service areas. In each area the program is managed by a Behavioral Health Organization, which must provide or arrange for the following state plan services, as necessary: inpatient hospitalization, outpatient program services, psychiatric services, medication management, rehabilitation services (individual, individual brief, group and partial day therapeutic contacts), psychosocial rehabilitation, clinic services-case management, emergency services, residential care and school-based services. In addition, Behavioral Health Organizations are required to provide a package of 1915 (b) (3) waiver (alternative) services which may include home-based services for children and adolescents, intensive case management, assertive community treatment, respite care, vocational services, clubhouses and drop-in centers, recovery services, prevention and early intervention services, and specialized services for addressing adoption issues.

**2. If the need is being fully met, who is bearing the costs of meeting the need? Is the cost being borne by the State or another entity (citizens, counties, municipalities, etc...)?**

RESPONSE:

The Department is meeting the needs of Medicaid clients that are covered under the Medicaid Mental Health Community Programs through the comprehensive continuum of

services offered. All Medicaid clients are automatically enrolled in the Medicaid Mental Health Community Programs and with the Behavioral Health Organization in his/her region. If a Medicaid client would like to access mental health services he/she may do so by contacting the Behavioral Health Organization directly. For FY 03-04, the Medicaid caseload for mental health was 348,140. Approximately 11% of the caseload, or 38,303 clients, have accessed services through the regional Behavioral Health Organizations. All program expenditures are covered by 50% state funding and 50% federal match funding.

At the inception of the capitated mental health program in 1995 the expectation was that the flexibility of the program and resulting increased public mental health system capacity would allow for the provision of services to indigent clients. Increased federal scrutiny of the program in recent years has reduced the capacity to serve indigent clients and those costs are now increasingly being borne by the community mental health centers/clinics.

**3. If the need is not being fully met, what resources are necessary to meet the need? Develop a proposal to either reduce the service or increase the funding over a period of five years to bring our service in line with the obligations of the Department.**

RESPONSE:

Behavioral Health Organizations must provide or arrange for the provision of all medically necessary mental health services to their enrollees seeking those services who are determined to have a mental health diagnosis that is covered under the Medicaid Mental Health Community Programs. Challenges in meeting the mental health needs of all Medicaid Mental Health Community Program enrollees include, but are not limited to, the following: a) some diagnoses, especially childhood disorders, are not covered under the Medicaid Mental Health Community Programs; and b) the coordination of Behavioral Health Organization services with physical health providers is frequently a challenge. An important aspect of the coordination challenge between Behavioral Health Organization services and physical health providers is related to mental health prescription drug utilization management.

Currently the Department is exploring opportunities to expand the range of individuals and diagnoses covered under the Medicaid Mental Health Community Programs and to establish a more integrated approach to mental health care through the streamlining bill and the Colorado Family Care Program.

**4. Are there investments that can be made up front that will have the effect of decreasing costs and improving outcomes within an area of service over a period of three years?**

RESPONSE:

There are several interventions that the Department can explore to increase the likelihood

of decreasing costs and improving outcomes over a period of three years. They include, but are not limited to, the following: a) management of mental health medications; b) enhanced care coordination for individuals served in the Medicaid Mental Health Community Programs; and c) disease management for the most prevalent serious mental illnesses.

The Future of the Goebel Program (page 76)

**16. Which department is lead on answering the question posed in the footnote on what would be considered a supplemental payment in the Goebel program? Which department should be lead in the future on the program, after the court order? If the Medicaid program is going to be governed by CMS requirements, what statutory changes should be considered to clarify the responsibilities between the two departments?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

With the passage of HB 04-1265, the General Assembly directed the Department of Human Services to retain responsibility for the Goebel program. The Department of Health Care Policy and Financing is responsible for administering funding for Medicaid services.

Primary responsibility for the Goebel program lies with the Department of Human Services, which is corroborated in Section 26-4-123(3), C.R.S. (2005) of the statute.

To the extent that there are issues dealing with Medicaid funding, the Department of Human Services would need to include the Department of Health Care Policy and Financing in addressing those issues. The Department of Health Care Policy and Financing would, therefore, be involved in addressing how reimbursement rates for services to Medicaid-eligible Goebel clients can be structured under federal Centers for Medicare and Medicaid Services guidelines.

The same division of responsibility should be observed in the future. The Department of Human Services should maintain primary responsibility for the Goebel program. The Department of Health Care Policy and Financing should have responsibility for administering funding for Medicaid services. The Department of Health Care Policy and Financing feels that statutory change would help clarify the need for collaboration between the Departments on reimbursement rate methodology for Medicaid-eligible Goebel clients.

**17. If the current Goebel Medicaid payments are moved into the BHO capitation rate, what responsibilities will Colorado Access (the Denver BHO) have for the Goebel population? Can a Goebel payment be put into the capitated rate and still targeted to a special population like Goebel? Given that state wideeness is a Medicaid requirement, would not all areas of the state with hard to serve clients be able to argue for an enhanced “Goebel-like” payment – without the obligation**

**of litigation?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

If the Goebel Medicaid payments are moved into the Behavioral Health Organization capitation rates, the Colorado Access Behavioral Health Organization is required to provide, or arrange for the provision of, medically necessary services to enrolled Medicaid clients. Colorado Access must also meet all administrative contract requirements including, but not limited to, care coordination, access, network adequacy, quality assessment and performance improvement, consumer affairs, and utilization management.

To the extent that Goebel services are determined to be state plan and 1915 (b) (3) waiver alternative services the funding for those services can be included in the overall capitation rate for Colorado Access. The funding for those services, however, cannot be targeted toward a specific client population based on geographic location or point in time. Funding and services must be directed toward clients based on medical necessity.

Statewideness is a Medicaid requirement; however, all Behavioral Health Organizations are currently required to provide medically necessary services to enrolled Medicaid clients under their contracts. There are no Goebel like payments being made to other Behavioral Health Organizations. If an existing Behavioral Health Organization were to request an enhanced payment, it would call into question whether the Behavioral Health Organization is meeting current contractual requirements to provide medically necessary services to all eligible clients.

**18. What is the criteria for being considered a supplemental payment or, conversely, being considered not to be a supplemental payment? Can the State create a new program that does not meet supplemental payment criteria and that would also appropriately provide these services to the Goebel clients after the Court Order?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

There are no federal Medicaid regulations that describe criteria for supplemental payments. Federal regulations require that payments under risk contracts are actuarially sound, developed according to generally accepted actuarial practices, appropriate to the populations to be covered, and actuarially certified. Any payment made to a risk based contractor outside these federal regulations for payments under a risk based contract is referred to as a “supplemental payment.” Medicaid payments under Goebel are a supplemental payment because they were not developed and certified with other mental health program rates. Furthermore, payments made on a service specific, claim-by-claim basis are not considered supplemental payments. Individual claim payments could be made to a risk contractor if they directly provide a service that is distinctly different than the services under the risk contract and are otherwise allowable under federal Medicaid regulations.

An alternative to a payment that is outside the federal regulations for payments under a risk based contract is to bring the Goebel expenditures into Colorado Access' capitation rate as described above.

**19. What services are currently being provided under Goebel? Are these services allowed under Medicaid capitation?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

The following table lists the services being provided under Goebel. Although a definitive review has not been completed for certain categories of Goebel services listed under A. and B. below, the Department is confident that the services qualify for federal match under Medicaid capitation. Further review will be necessary to determine if the remaining services listed in C. qualify for federal match. The Department does not yet have the data necessary to determine if these services listed in C. are being provided to Medicaid eligibles.

A. Services allowable in the Medicaid mental health capitation program under state plan authority	Inpatient Hospital
	65 and Over Psychiatric
	Outpatient Services
	Psychiatrist
	Rehabilitation
	Partial Long Day
	Partial Short Day
	Group
	Individual
	Individual Brief
	Psychosocial Rehabilitation
	Clinic Services, Case Management
	Medication Management
Emergency	
B. Services allowable in the Medicaid mental health capitation program under 1915(b)(3) waiver authority	Residential services
	Home-based Services
	Intensive Case Management
	Assertive Community Treatment
	Vocational Services
	Clubhouses and drop-in Centers
	Recovery Services
C. Services that require further review by the Department	Housing Services
	Undefined Services to Individuals who are Homeless and Mentally Ill
	Substance Abuse Treatment
	Benefits Acquisition
	Client Trust Fund

**20. What is a good legal strategy for continuing to show good faith with the Court and with the program?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

Department of Human Services to answer this question.

**21. Do the Goebel clients constitute a clear classification of client type based on the needs or services they receive? Could Goebel be a capitation carve-out? Is there any type of waiver option for this group?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

Given the existing definition of Goebel clients, they do not constitute a clear classification of client type based on services they receive. The plaintiffs are “all persons with chronic mental illness who at any time after April 1, 1981 have resided within the Northwest Catchment Area of the City and County of Denver and who at any time of such residency have been provided some evaluation, care or treatment under the Colorado Care and Treatment of the Mentally Ill Act (either as a voluntary or an involuntary patient) from any mental health program funded through the Colorado Department of Institutions.” The Goebel settlement mandates services to approximately 1,600 of the plaintiffs who are the most disabled and in need of high intensity services at any point in time, based on a needs assessment conducted by the Mental Health Corporation of Denver. Therefore, individuals receiving Goebel services are not a group of specific individuals.

In order for the Goebel population to be excluded from the Medicaid Mental Health Community Programs, the Department would need to identify the Goebel population as a distinct classification and submit a waiver amendment to the Centers for Medicare and Medicaid Services (CMS) listing the Goebel population as a population that is excluded from the Medicaid Mental Health Community Programs. The Department has no experience with how the federal authority would evaluate the request to remove the Goebel population from the current statewide mental health waiver. The Department anticipates that CMS would ask the Department to demonstrate why the Goebel population represents a distinct classification that should be exempted from the program. The Department is not aware of any waiver option that could be pursued specifically for the Goebel population. Furthermore, recent experience with CMS has shown the Department that they are reluctant to approve limited individual waivers for states. The federal authority would undoubtedly request that a Goebel waiver request be included within the Medicaid Mental Health Community Programs waiver.

**22. Have there been any systemic changes that have resulted in enhanced services being provided in northwest Denver than used to be the case at the time of the lawsuit?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

Department of Human Services to answer this question.

**23. Is a statutory change necessary to address the projected status of the Goebel program?**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING RESPONSE:

The Department believes that a statutory change to address the projected status of the Goebel program is advisable although not strictly necessary. Any statutory change should reflect the Department’s responsibility for developing reimbursement rate methodology that takes into account service costs for Medicaid-eligible Goebel clients, as well as any changes that might be needed to reflect the Department of Human Services’ responsibility for Goebel clients into the future.

Child Placement Agencies (CPAs) (page 83)

**24. What services will be included in the capitation rate? How are these services similar or different to what was included in the CPA program?**

RESPONSE:

Medicaid mental health services that were included in payments to Child Placement Agencies that are allowable Medicaid state plan services or 1915 (b) (3) waiver services will be included in the capitation rate. Analysis of the services, as detailed in the table below and in the response to Question # 25, indicates that the majority of services provided by the Child Placement Agencies are allowable. The capitation rates will need to be increased to account for all services except for inpatient hospital, emergency services, and medication management. Those three services, although provided directly by the Child Placement Agency program, were already being paid for under capitation payments from the Medicaid Mental Health Community Programs, Mental Health Capitation Payments.

A. Services allowable in the Medicaid mental health capitation program under state plan authority	Clinic Services, Case Management
	Emergency
	Family Therapy
	Inpatient Hospital
	Medication Management
	Outpatient Services
	Psychiatrist Services
	Psychiatric Treatment
	Rehabilitation
	Group
	Individual
	Individual Brief
	Partial Long Day

	Partial Short Day
	Other State Plan Services costs
B. Services allowable in the Medicaid mental health capitation program under 1915(b)(3) waiver authority	Assertive Community Treatment
	Home-based Services
	Residential Services
	Respite Care
	Vocational Services
	Other 1915(b)(3) Waiver Services costs

**25. What is the specific cost and financing sources for the Department’s proposal to Centers for Medicare and Medicaid Services?**

RESPONSE:

The table below details the cost to the Behavioral Health Organization from the FY 03-04 encounter data for Child Placement Agency services. This information will be used to establish the capitation rates for FY 05-06. Assuming that the Centers for Medicare and Medicaid Services approves the increase in the capitation rates to account for the Child Placement Agency services on April 1, 2006, the adjustment to the rates would be \$1,286,051 in FY 05-06 (an annual amount of \$5,144,204). This adjustment for FY 05-06 is based on actual FY 03-04 Medicaid mental health expenditures by Child Placement Agencies This adjustment for FY 05-06 is based on actual FY 03-04 Medicaid mental health expenditures by Child Placement Agencies trended forward to FY 05-06 using a 0.0% trend for FY 04-05 and a 3.25% cost of living adjustment for FY 05-06. The adjustment for FY 06-07 is \$5,455,329 and includes the 2.71% increase in Behavioral Health Organization expenditures from the Department’s November 15, 2005 FY 06-07 Budget Request. The adjustment for FY 06-07 is \$5,283,612 and includes the assumed 2.71% increase in Behavioral Health Organization expenditures from the Department’s November 15, 2005 FY 06-07 Budget Request.

If this funding is added to capitation, the appropriation for Child Placement Agency services should move from the Division of Child Welfare – Medicaid Funding line item to the Medicaid Mental Health Community Programs, Mental Health Capitation Payments line item. The funding split for Medicaid funded Child Placement Agency services are at 50% General Fund and 50% federal financial participation. In reviewing the Division of Child Welfare – Medicaid Funding line item, the Department can find no county funding. The line item is 100% State and federal funding.

If approved by the Centers for Medicare and Medicaid Services and the Office of State Planning and Budgeting, a budget action would be required to change the amounts and change the line items.

**FY 03-04 Allowable Child Placement Agency Services**

<b>Service description</b>	<b>Cost</b>
Case Management	\$569,830
Medication Management	\$104,179

<b>Service description</b>	<b>Cost</b>
Outpatient	\$701,469
Psychiatric Treatment	\$815,772
Psychiatrist	\$7,450
Rehabilitation-Brief	\$907
Rehabilitation-Group	\$227,296
Rehabilitation-Individual	\$785,549
Rehabilitation-Partial Long	\$256,151
Rehabilitation-Partial Short	\$260,556
Vocational services	\$298
Assertive Community Treatment services	\$263
Residential services	\$36,252
Home based services	\$32,763
Respite care	\$7,899
Family therapy	\$117,661
Other State Plan Services	\$134,261
1915 (b) (3) Services	\$1,085,647
<b>Total</b>	<b>\$5,144,204</b>
<b>FY 05-06 Total Cost with 3.25% Cost of Living Adjustment</b>	<b>\$5,311,391</b>

**26. What will be the relationship of the county and the BHO if the payments are in the capitation rate? How does this compare to the prior operating relationship?**

RESPONSE:

If Medicaid mental health Child Placement Agency service expenditures are included in the Behavioral Health Organization capitation rates, there will be no change to the relationship between the Behavioral Health Organizations and the counties. The Behavioral Health Organizations would continue to work with the counties and the Child Placement Agencies to provide medically necessary services to enrolled clients.

**27. If the payments are included in the capitation rate, what level of control will the General Assembly have with respect to funding this program from year to year?**

COMBINED RESPONSE QUESTIONS 27 AND 31:

As the Committee is aware, the Centers for Medicare and Medicaid Services (CMS) has increased its scrutiny over rate setting in the past couple of years. The Department continues to work with CMS to understand and define the exact expectations for rate adjustments. Federal regulations dictate that capitation rates must be set in accordance with actuarially sound principles. Actuarially sound principles for rate setting include guidelines for rate increases and decreases. These guidelines imply that rate increases may be a result of an increase in the amount of services the managed care plan provides or cost of living adjustments that are justified and reasonable. Rate decreases require a

decrease in services. An example of the actuarially sound rate change is a rate change based on the increases or decreases in the amount and scope of services covered under the risk based contract or adjustments for cost of living. To the extent the General Assembly can adjust rates within these restrictions it can continue to have some control over the funding for these services.

**28. What counties will participate? Since a Medicaid program must be statewide, is there a possibility that additional counties would seek to participate? If so, where would the funding come from?**

RESPONSE:

The eight (8) counties that historically received Medicaid mental health Child Placement Agency payments are Adams, Arapahoe, Boulder, Denver, El Paso, Jefferson, Larimer, and Pueblo.

The Department's position is that the Medicaid mental health services provided by Child Placement Agencies are a statewide program because they are available across the state; currently there are eight participants. The Department is not excluding other counties from participating.

The Department would not have to increase the mental health capitation rate every time a Child Placement Agency seeks to enter into an agreement with the Behavioral Health Organization to serve Medicaid clients, unless the Department could demonstrate that the service expenditures for these clients were excluded from the initial rate development.

Medicaid clients in counties outside the eight Child Placement Agency counties are currently getting mental health services through Behavioral Health Organization programs. New or existing Child Placement Agencies could form and enter into agreements with the Behavioral Health Organizations. Since it is the contractual obligation for Behavioral Health Organizations to provide medically necessary services, any new agreements with the Child Placement Agency would represent a shift in the delivery mechanism, not necessarily an increase in services or a need for additional funding.

**29. When will the Joint Budget Committee know more about the program and funding for CPAs? Why is the Department proceeding with a state plan amendment without getting approval for such from the Joint Budget Committee?**

RESPONSE:

The Department is in the process of finalizing a proposal for inclusion of the payments for services to children in the Child Placement Agencies into actuarially certified rates for the Behavioral Health Organizations. When the issue first arose, the Department participated in a meeting that included Department of Human Services' staff, Joint

Budget Committee staff, county department of human/social services directors, and Behavioral Health Organizations. A workgroup was formed as a direct result of this meeting and the workgroup members have provided input on the proposal. Once Department management has completed its review and approval of the proposal, the Department will share it with all affected stakeholders, including the Joint Budget Committee. On a technical note, the proposal is a waiver amendment and not a state plan amendment. It has always been the Department's policy to pursue the necessary federal approval to administer its programs as required by legislative or budget action, as required for effective operation of the programs, or as required to maintain compliance with federal program participation requirements. In those circumstances that do not directly arise from legislative action but have a budget impact, the matter is brought before the Joint Budget Committee for approval.

Medicaid Behavioral Health Organization Budget (page 88)

**30. What drove the FY 2004-05 overage specifically? (Can the Department research this issue and provide a response to the JBC at a future date?)**

RESPONSE:

Preliminary analysis shows approximately 20% of the overage is due to the inclusion of the institute costs into the capitation rate beginning on January 1, 2005 while at the same time paying institute rate refinance costs for dates of service before January 1, 2005 separately from capitations. A complete analysis of the overage will be completed by January 27, 2006.

**31. The August 13, 2003, federal balanced budget act (BBA) rules made changes that have an important impact on mental health capitation. One of these changes is the methodology for providing rate increases – as compared to other “community providers”. What does this mean for making legislative rate increases in this new managed care environment?**

RESPONSE:

See response for question number 27 above.

**32. Please explain the basis for the 2.71 percent BHO increase, including the Department's model. Why was 3.0 percent not requested, as it was for community providers? Could not 3.0 percent be justified to Centers for Medicare and Medicaid Services?**

RESPONSE:

The Behavioral Health Organization increase is the Department's best estimate utilizing actuarially based principles at the time of the development of the Department's

November 15, 2005 FY 06-07 Budget Request. The growth rate of 2.71% is based on various forecast factors, including the Department's trended cost analysis, the Medicare Economic Index from the Centers for Medicare and Medicaid Services, and the U.S. Department of Labor's Bureau of Labor Statistics consumer price index for local medical costs.

The Department's trended cost analysis examined trended mental health cost factors, including those for state plan services at community mental health centers, non-state plan services as approved in the Department's federal 1915 (b) waiver, Colorado mental health institutes, and payments for psychiatric procedure codes to non-community mental health center providers. When cost factors were not available for FY 05-06 or FY 06-07, the Medicare Economic Index factor from the Centers for Medicare and Medicaid Services was used for the appropriate time period. Utilizing the Behavioral Health Organization's encounter data, weighted values were associated with each of the cost factors to determine the overall 2.71% increase. Using the Department's model, a 3.0% increase cannot be justified to the Centers for Medicare and Medicaid Services. Note, last year community providers were appropriated a 2.0% rate increase while Behavioral Health Organizations received a 3.25% rate increase. This was justified to the Centers for Medicare and Medicaid Services because it took into account years of no rate increases.

When actual rates are calculated for FY 06-07, more recent information will be available and the estimate may change.

**33. Why was the Medicare Economic Index (MEI) rate of 2.0 percent used? Is this figure considered to be an accurate assessment of medical inflation? If the 2.71 percent ends up being too low next year, would the Department seek a supplemental to increase it?**

RESPONSE:

The Department's FY 06-07 Budget Request for the Mental Health Capitation Payments is an estimate based on actuarially sound principles. This estimate will be revised in the spring of 2006 when actual Behavioral Health Organization's capitation rates are calculated for FY 06-07. The Medicare Economic Index is a Centers for Medicare and Medicaid Services approved inflator that is used in other rate setting methodologies such as Federally Qualified Health Centers, the inpatient hospital upper payment limit and Medicare's inpatient hospital base rate. The Medicare Economic Index is an inflator that can be applied to rates that are comprised of many service types, such as a managed care rate. The federal government utilizes the Medicare Economic Index as a measure of increasing costs of providing medical services. Since managed care rates require federal approval, the use of the Medicare Economic Index as an inflator increases the likelihood of approval. On a technical note, the Medicare Economic Index of 2.7% was used for FY 05-06 and 2.2% for FY 06-07.

The capitated rates are actuarial projections of future contingent events. Actual Behavioral Health Organization costs may differ from these projections. The Behavioral Health Organization should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates and/or rate ranges before deciding whether to contract with the State.

The Department would not seek a supplemental to reconcile to actual Behavioral Health Organization's costs because there is no federally approved reconciliation process for risk based contracts.

Recoupments (pg. 92)

**34. Recoupments are now part of the on-going per capita Medicaid mental health base (as they are part of the Medical Services Premiums base). In response to JBC comments and other issues, the Department has stepped up its assessment process in order to eliminate what had been a two year lag. FY 2005-06 now has a two-year assessment built into it.**

RESPONSE:

The Department has completed calculation of the FY 03-04 recoupments, and the figures are currently undergoing internal Departmental review. The Department will calculate FY 04-05 recoupments in the spring of 2006. As indicated, this year the Department now calculates recoupments every six months.

**35. Medicaid fee-for-service is a small but volatile budget area for which these is not much information readily available. What is the programmatic and statutory criteria for inclusion in this area and what is the basis for the increases, including the FY 2004-05 overage? (Can the Department respond to this query with detail at a future date?)**

RESPONSE:

Fee-for-service expenditures are generated by Medicaid clients who are not enrolled in a Behavioral Health Organization. Fee-for-service expenditures may also be generated by clients with diagnoses that are not covered by the Department's contract with Behavioral Health Organizations.

One of the reasons clients are not enrolled in Behavioral Health Organizations is that they are allowed to request individual exemptions. Twenty four (24) clients have been granted individual exemptions since the inception of the capitated mental health program in 1995. The Department must approve individual exemption requests, which must meet the requirements at 10 C.C.R. 2505-10, Section 8.212.02.

A thorough analysis of the Medicaid fee-for-service expenditures will be completed by January 27, 2006.

**36. Please provide five year trend information on Medicaid anti-psychotic pharmaceuticals.**

RESPONSE:

The table below is a ROUGH projection of expenditures for antipsychotic drugs. The projected total expenditures are net of drug rebate. Due to complexities in the Medical Services Premiums Long Bill group, no other service category is projected in this way. Antipsychotic expenditures are projected only as requested by the Joint Budget Committee so that the number can be reflected in the Medicaid Mental Health Community Programs Long Bill group as Cash Funds Exempt for informational purposes.

As the Committee is aware, the Medicare prescription drug benefit (Part D) will be implemented on January 1, 2006. At that time, the Department will no longer be responsible for most prescription drugs for clients that are Medicaid and Medicare eligible. The Department will not have information on the actual reduction due to implementation of the Medicare prescription drug benefit until after it is implemented. The impact of this change will be discussed in more detail at our main Hearing on January 5, 2006.

In the table below the Medicare Modernization Act adjustment assumes a 53.43% reduction in historic expenditures for FY 05-06 and FY 06-07, the same percentage used to reduce FY 05-06 in the Department's November 15, 2005 Budget Request (page EF-7).

This does not represent a sophisticated view of where the program will be in five years, as it does not include program policy changes, economic changes, and/or impacts on enrollment and eligibility. The projection is intended to give an overview of where Medicaid expenditures might be if the past is a predictor of the future.

The FY 06-07 projected total expenditure has been corrected since the Department's November 15, 2005 Budget Request. This information is provided on an informational purpose only; the Department's appropriation and request are based on total Acute Care Services, found in Exhibit F, page 1-3.

**ROUGH Projection of Medicaid Antipsychotic Drug Expenditures Post Rebate**

<b>Fiscal Year</b>	<b>Total Expenditure</b>	<b>Annual Change</b>
<b>FY 00-01</b>	\$14,964,575	
<b>FY 01-02</b>	\$19,641,077	31.25%
<b>FY 02-03</b>	\$23,290,708	18.58%
<b>FY 03-04</b>	\$32,711,522	40.45%
<b>FY 04-05</b>	\$36,754,448	12.36%
<b>FY 05-06 Estimate</b>	\$31,743,329	-13.63%

<b>FY 06-07 Projection</b>	\$28,553,280	-10.05%
<b>FY 07-08 Projection</b>	\$30,558,686	7.02%
<b>FY 08-09 Projection</b>	\$33,921,709	11.01%
<b>FY 09-10 Projection</b>	\$37,284,732	9.91%
<b>FY 10-11 Projection</b>	\$40,647,756	9.02%

**37. What changes in Medicaid mental health pharmacy management has the Department made since the FY 2005-06 December 7, 2005, hearing responses on this subject?**

RESPONSE:

The Department has refrained from initiating large scale changes to its pharmacy management, including the mental health prescription drugs, pending the effects of the Medicare Modernization Act.

The Department contracts with Health Information Designs, Inc. and has recently contracted with the Business Research Division of the University of Colorado to assist the Department and the Drug Utilization Review Board in pharmacy management. The contract with the Business Research Division is to provide studies and reports on drug utilization practices, effectiveness of antipsychotic drug medications and treatments, and to identify historical patterns of prescribing practices. Through these activities, the Business Research Division monitors treatment patterns to check consistency with the client's health status and provider's prescribing habits, and educates providers on potential problems when necessary.

The Department is in the process of acquiring RxExplorer, a tool for facilitating optimum use of prescription drugs so that client benefits are maximized while costs are minimized.

**38. Does the Department agree with the rough assessment of potential Medicaid mental health pharmacy savings estimated by the Behavioral Health Organizations? How does Colorado's current baseline for pharmacy costs and management compare with Missouri prior to Missouri's pharmacy management?**

RESPONSE:

The Department believes that Colorado's current baseline for pharmacy costs and management is significantly lower than Missouri's prior to implementation of their pharmacy management program. Missouri's Medicaid pharmacy programs differ from Colorado's across a number of comparisons. One instance of comparison is that prior to the implementation of Missouri's pharmacy management program, they did not have a dose-optimization utilization control. Colorado has already established a dose-optimization utilization control through our prior authorization criteria. In addition, Missouri's reimbursement to pharmacies is higher than Colorado's, as they reimburse at average wholesale price minus 10.43%, compared to Colorado's reimbursement which is

average wholesale price minus 13.5% for brand name drugs. Further, Colorado has made significant efforts in drug utilization review through contracts with Health Information Designs, the Business Research Division of the University of Colorado, and the Drug Utilization Review Board.

In part due to the investments already made with Health Information Designs and the Business Research Division in fostering understanding of the Department's pharmacy data, the Department believes it advisable to carefully consider a number of potential mental health prescription drug utilization control program administrators before entering into any partnership.

**39. Would the Department be willing to provide the BHOs with the data so that they may begin an assessment of the potential utilization control savings opportunities?**

RESPONSE:

As stated in the response to Question # 38, the Department does not presume that the Behavioral Health Organizations are the only entities that should be considered to administer a utilization control program for mental health prescription drugs. Certainly the Department is willing to provide the data to its contracted partner in a utilization control program, whether that partner be a Behavioral Health Organization, one of the Department's current drug utilization review contractors, or a new partner such as the firm conducting Missouri's program. If the pursuit of a utilization control program for mental health prescription drugs would require a competitive procurement process, the Department would be remiss in providing data to only one group of the potential bidding entities prior to award of a contract. During recent discussions the Department is considering whether it would be appropriate to contract with a single Behavioral Health Organization to manage mental health prescription drugs for the entire state.

**40. What would be the administrative cost of the educational intervention by the BHOs? If implemented, should this cost be discretely appropriated or contained within the net pharmaceutical appropriation? (Staff would recommend a discrete appropriation for transparency and to maintain legislative appropriation primacy.)**

RESPONSE:

Currently the Department's pharmacy unit has two utilization review contracts that can be used to model or estimate the Behavioral Health Organization proposal. The current contracts provide studies and reports on drug utilization practices, effectiveness of antipsychotic drug medications and treatments and the education of practitioners on common therapy problems to improve prescribing and dispensing practices. Although pieces of the utilization review contracts are unrelated to the Behavioral Health Organization proposal, the Department estimates that \$51,000 of the contracts can be attributed to educational intervention. Since the Behavioral Health Organization

pharmacy management would likely exceed current efforts in both scope of work and volume, the Department's current contractual expenditures should be viewed as a baseline. The Behavioral Health Organization proposal, if fully funded, would be significantly higher than the base.

The Department would require funding for the administrative cost if this or any pharmacy management program is implemented. The Department would expect the funding to be appropriated into a new line item in the Department's Executive Director's Office Long Bill group to maintain a separation between administrative and service costs. The impact of the savings would remain in the Medical Services Premiums' Long Bill group.

**41. What are the considerations in having the BHOs manage non-BHO pharmacy costs (e.g., stimulants dispensed by physicians)?**

RESPONSE:

The Department believes that it would be potentially challenging for the Behavioral Health Organizations to be financially responsible for the prescribing behavior of physicians who are outside the public mental health system. The Department presumes that physicians outside of the public mental health system may have limited access to training and education in the appropriate prescribing of mental health prescription drugs and will lack any incentive to cooperate with utilization control initiatives sponsored by entities with which the physician has no formal relationship.

**42. What would be the plans for building pharmaceuticals ultimately into the capitation base? Last year, the Department stated that it would consider a contract incorporating pharmaceuticals into the capitation base after MMA (Medicare Modernization Act).**

RESPONSE:

There has been a change in leadership in the Department and the Department is taking the opportunity to revisit plans contemplated by the previous management. The implementation of the Medicare Modernization Act, scheduled for January 1, 2006 is still very much a change to the Department's prescription drug coverage responsibilities that must be taken into account. Current leadership believes that the Department would benefit from having some utilization experience under the Medicare Modernization Act, as well as information that would be available from a mental health prescription drug utilization control program before including pharmaceuticals into the capitation base and putting the Behavioral Health Organizations at financial risk for those costs.