

Department of Health Care Policy and Financing

**AGENDA
FY 2008-09 Joint Budget Committee Hearing**

**Wednesday -- December 12, 2007
1:30 p.m. to 5:00 p.m.**

I. 3:30 to 5:00 p.m. Questions for Department of Health Care Policy and Financing

A. *Mental Health Capitation Program*

- 1. The current contracts with the Behavior Health Organizations (BHOs) will expire at the end of FY 2008-09. In the rebid of the BHO contracts, does the Department anticipate adding anti-psychotic prescription drugs as a required service for the new contracts? What would be the advantageous of doing so? What would be the disadvantageous? If moved into the capitation program, how would the Department ensure the savings from the drug rebate program are not lost?**

RESPONSE:

The Department does not anticipate adding antipsychotic prescription drugs as a required service for the new Behavioral Health Organization contracts. This is based on findings from previous examinations of the feasibility of moving psychotropic medications, of which antipsychotic prescription drugs is a subset, to these contracts. "Antipsychotic prescription drugs" describes a class of drugs believed to be effective in the treatment of psychosis, a symptom of mental illness. This drug class is a subset of medications known as "psychotropics", i.e. medications affecting mental activity, behavior, or perception.

Currently medications for Medicaid Members are covered by the Medicaid fee-for-service program or by the managed care organization for clients in managed care plans. The Department has identified the following as advantages and disadvantages of moving psychotropics to the Behavioral Health Organization contracts.

Advantages of moving psychotropic medications to the Behavioral Health Organization contracts:

An advantage would be that we are giving the Mental Health capitation program the responsibility for what are primarily mental health medications. The Behavioral Health Organizations, who represent the primary prescribers of psychotropic medications, would have responsibility for the control over costs, utilization, prescribing guidelines, etc. In addition, managing psychotropic medications would provide and enhance opportunities to employ more varied resource management tools. Examples of this would be decreasing the use of benzodiazepines (a group of tranquilizers with addictive properties) through better abuse surveillance and the development of more effective non-medication treatments for anxiety, or requiring the use of certain generic antidepressants in the absence of compelling reasons to use a brand name.

Disadvantages of moving psychotropic medications to the Behavioral Health Organization contracts:

The Behavioral Health Organizations were initially interested in the inclusion of psychotropic medications in their contract. However, analysis of the data on psychotropic medications determined that there are a large number of non-mental health providers prescribing the medications. This finding raised concerns that it would be very difficult for the Behavioral Health Organizations to manage the use of these medications if the prescribing providers were outside of their direct control. Major efforts beyond the scope of their contract would be needed in order to coordinate care and manage costs under this scenario.

The Department explored whether it would be possible to identify these medications based on the prescribing physician and therefore include only those medications prescribed by a psychiatrist in the Behavioral Health Organization rates. The Behavioral Health Organizations would either be required to manage all prescribers of the medications or the responsibility for managing the medications could remain in the fee-for-service or physical health care managed care programs.

Another disadvantage is concern by Behavioral Health Organizations that if they were to publish best practice guidelines or drug protocols suggesting changes in psychotropic prescribing practices, some primary care physicians would discontinue prescribing these medications for their patients. These physicians may instead require the patients to access medication management through the Behavioral Health Organizations, potentially disrupting the clients' continuity of care. Also, consumers and advocates have expressed concerns regarding availability and access if these drugs are removed from the fee-for-service program.

If moved into the capitation program, how would the Department ensure the savings from the drug rebate program are not lost?

If psychotropic medications were moved to the capitated Behavioral Health Organization program, capitation rates could be adjusted to accommodate costs associated with providing this service. However, savings from the drug rebate program would be lost, as federal law prohibits drug rebate savings under full risk contracts.

Savings from the drug rebate program could potentially be maintained if these medications were not managed under the capitation contract, but instead were managed under a separate, non-risk administrative agreement with the Behavioral Health Organizations. The Department has serious concerns about how this type of proposal would be viewed by the Centers for Medicare and Medicaid Services.

It should also be noted that as the Department moves toward increasing the number of managed care plans and clients enrolled in managed care, the drug rebate savings will significantly decrease.

2. **Please comment on staff's recommendation to either: (1) move the actual expenditure authority for anti-psychotic prescription drugs from the Medical Services Premiums line item to the Mental Health Division; or (2) eliminate the "informational-only" appropriation for anti-psychotic drugs in the MH Division with the requirement that the Department continue to report on these expenditures. Which would the Department prefer and why?**

RESPONSE:

The Department prefers the second option, eliminating the informational-only appropriation. The Department's November 1, 2007 Budget Request for Medicaid Mental Health Community Programs specifically included a request to eliminate this appropriation. Anti-psychotic pharmaceuticals are paid for through the Department's Medical Services Premiums Long Bill group. Clients can receive anti-psychotic prescriptions from either their physical health or mental health provider. Pharmaceuticals are dispensed by either a pharmacy or a health maintenance organization. For this reason, the Department believes that expenditure authority belongs in the Medical Services Premiums Long Bill group, and not the Medicaid Mental Health Community Programs Long Bill group.

If, however, expenditure authority for anti-psychotic pharmaceuticals was moved to the Medicaid Mental Health Community Programs Long Bill Group, the Department would require significant administrative changes to properly account for expenditure. For example, when a client is enrolled in a health maintenance organization, a portion of the monthly capitation is for anti-psychotic pharmaceuticals. That capitation is paid from the Medical Services Premiums Long Bill group. In order to account for the portion of the capitation which was for anti-psychotic pharmaceuticals, the Department would be required to change the rate setting process, and devote significant staff time to determining the portion of monthly expenditure for these drugs, and perform manual accounting adjustments for each capitation subgroup, accounting for such issues as retroactive changes in client eligibility. The Department does not believe that the benefits from changing the location of the expenditure authority justify the significant administrative burden that would be incurred.

The Department will continue to report on anti-psychotic pharmaceutical expenditure in its Budget Requests for Medical Services Premiums.

3. **Because early caseload reports do not indicate the decline in caseload that the Department's request indicates, does the Department anticipate that both the FY 2007-08 and FY 2008-09 estimates for Mental Health capitation will be revised upward in February 2008? If not, why not?**

RESPONSE:

The Department's caseload projection for Medicaid Mental Health Community Programs in its November 1, 2007 Budget Request was 360,765 (November 1, 2007 Budget Request, Section F, Exhibit DD, Page DD-1). Through October 2007, the Department's actual average monthly caseload for mental health was 364,634, a difference of 1.07%. The Department does not believe there is sufficient information at this time to conclude that either the final average monthly caseload or the final total expenditure will differ significantly from the forecast from the November 1, 2007 Budget Request. However, the Department will reforecast both mental health caseload and expenditure in its February 15, 2008 Budget Request.

- 4. What is the implementation status of S.B. 07-002? Will the Department be able to track this caseload separately from the rest of the foster children caseload? Does the Department have any expenditure data for this population yet? Does the Department believe that the capitation rate for foster children under 18 should be the same rate applied to young adults over 18? Will the service needs and delivery be the same for this population?**

RESPONSE:

SB 07-002 was implemented effective July 1, 2007. There has been a manual process in place while the automated systems have been readied. The Medicaid Management Information System has been ready to accept the new codes indicating the client is eligible under the provisions of SB 07-002 since October 30, 2007. Initially, the Department of Human Services indicated that the Trails system (the foster care eligibility system) was programmed and installed for these clients on August 28, 2007. The Department was recently informed by Department of Human Services that the Trails programming was not complete and will not be ready until January 2008. The Department and Department of Human Services are continuing the manual process until the Trails system is ready. Once the system changes are completed, clients who were not enrolled under the manual process, will be automatically enrolled and any claims submitted with a date-of-service on or after July 1, 2007 will be processed by the Medicaid Management Information System.

Once the Department of Human Services' Trails system updates are in place, clients who are eligible will be marked with a special code that will allow the Department to track the caseload separately from other foster care children. The Department does not have any expenditure data for this population at this time. The interim manual process tracks clients outside the Medicaid Management Information System. Once the Trails system updates are complete, clients who have been enrolled using the manual process will be transferred to the Trails system. Expenditure and enrollment data will be available at that time from the Medicaid Management Information System.

The Department believes that the service needs and delivery will be the same for this population compared to the rest of the foster care caseload. First, both the new caseload and the existing caseload are entitled to the same Medicaid benefits and use the same medical necessity criteria. Secondly, the Department's data for other groups of eligibles suggests no dramatic change in utilization or cost of services received by clients upon turning 18 years of age. Standard practice in capitated rate setting is to set a separate rate for an identifiable population that has a material and statistically significant difference in expected cost. Because service needs and delivery are expected to be the same for this population relative to the remainder of foster care, the Department would not expect a significant difference in cost for this new population and would not establish a separate capitation rate. Should the data show that this population has significantly different average costs than the rest of the foster care population, the Department would adjust this rate at that time.

5. Does the Department believe forecast accuracy for the MH capitation program would improve if caseload was forecasted for each BHO multiplied by the contract rate in place for that BHO for the current FY and estimated contract rate for the next budget year?

RESPONSE:

The Department is currently investigating the possibility of revising the forecast methodology for the Mental Health Capitation Program in order to increase the accuracy of Budget Requests. Among the options being considered is an individual forecast for each behavioral health organization (BHO). At this time, however, the Department has not yet reached any conclusions as to what changes it will implement in the forecasting methodology.

The Department remains committed to ensuring that its Budget forecasts are as accurate as possible. As seen in the Department’s prior Budget Requests, and including the November 1, 2007 Budget Request, the Department adjusts forecast methodology as it deems necessary to enhance the accuracy of the forecasts. The Department anticipates this process to continue in its Mental Health Capitation Program forecasts.

6. What error rate does the Department believe is an appropriate performance measure when forecasting the original Mental Health Capitation program?

RESPONSE:

As stated in the Department’s Strategic Plan in its November 1, 2007 Budget Request, the Department has set a performance measure to reduce the difference between the Department’s spending authority and actual expenditure for Medicaid services to 1.0% in FY 07-08. Although this is a Department-wide measure, the Department believes that 1.0% is an appropriate performance measure when forecasting the Mental Health Capitation Program. Historically, the Department’s February forecasts for the Mental Health Capitation Program have varied between -1.39% and 3.09%, although the Department only has limited history in projecting Mental Health expenditure. These figures are shown in the table below. In each successive year, the Department’s forecast has been closer to the final actual than the previous year.

Mental Health Comparison - Final Request to Actual					
Fiscal Year	Request Source		Final Request	Actual	Percent Difference
	Date	Page			
FY 04-05	2/15/2005	Schedule 6, Page 1	\$144,737,680	\$149,346,526	3.09%
FY 05-06	2/15/2006	Schedule 6, Page 1	\$167,136,214	\$164,839,222	-1.39%
FY 06-07	2/15/2007	Schedule 13, Page 1	\$183,033,996	\$184,640,568	0.87%

There are a large range of issues that can affect the final expenditures for the Mental Health Capitation Program. Under cash accounting, expenditure is recorded in the period in which the claim is paid, leading to a large measure of uncertainty in budget forecasts. For example, a capitation for dates of service in FY 06-07 paid in FY 07-08 will be recorded against the FY 07-08 appropriation.

This is also true of recoupments, settlements, or other requirement payments (such as payments which were made for the Goebel lawsuit). Such payments do not always follow well-defined expenditure patterns.

Additionally, month-to-month variation in caseload can be unpredictable. For example, in September 2007, non-retroactive caseload suddenly decreased by 3,308 clients. In the next month, caseload increased by 4,073. While such events can be incorporated into trend models, if such an event happens in the last two months of a fiscal year, it can have a significant impact on the total expenditure. Such events cannot be incorporated in either the Department's February 15th Supplemental Budget Requests or the Figure Setting process. Because of the unpredictability of caseload and expenditure patterns, the Department does not support a tighter performance measure than 1.0%.

7. Does the Department have any concerns about the level of service the BHOs are providing to Medicaid clients under the current capitation rates? Does the Department have any concerns on whether falling caseloads have put any BHO's at risk of financial loss during FY 2007-08 or FY 2008-09?.

RESPONSE:

The Department has processes in place to monitor aspects of service provision, e.g. access to care, penetration rate, and appeals of service denials, on an ongoing basis. When monitoring reveals deficits or trends that are problematic, they are addressed with the Behavioral Health Organization in the form of a corrective action plan and then monitored for improvement. Specific service issues or problems brought to the Department's attention are reviewed on a case-by-case basis and addressed with the appropriate Behavioral Health Organization. Based on these monitoring efforts, the Department does not have any overall concerns about the level of service provided under the current Behavioral Health Organization contract.

However, the Department is aware that the current contract may not address the entire spectrum of services needed by Medicaid consumers. The Department is currently identifying services not covered under the existing Behavioral Health Organization contracts for possible inclusion in the 2009 request for proposals.

Only one plan has approached the Department regarding falling caseloads. The plan did not indicate concerns regarding financial loss, but did express a desire to understand the trend, in an effort to understand potential risk. Regarding falling caseloads, each Behavioral Health Organization provides annual certification of both actuarial soundness and financial adequacy for the capitation rates. These certifications state that the capitated rates are sufficient to support contract services. However, capitation contracts inherently are accompanied by risk. The Department expects the actuaries employed by the Behavioral Health Organizations to consider these risks when providing their rate certifications. Falling caseloads typically result in fewer members needing services. Unless the caseload numbers fall to the minimum critical mass necessary to sustain managed care services and overhead, financial stability should not be affected.

7a. Does the Department have any concerns that the Centers for Medicare and Medicaid Services (CMS) will disallow certain BHO services in the future. If so, which ones and why?

RESPONSE:

At this time, the Department does not have any concerns that the Centers for Medicare and Medicaid Services will disallow certain Behavioral Health Organization services in the future. Services provided by the Behavioral Health Organizations are specifically provided for in the state plan and 1915(b) waiver and have been approved by the Centers for Medicare and Medicaid Services through their review and approval of the contracts. These psychiatric inpatient, outpatient, and psychosocial rehabilitation services are identified in the state plan, 1915(b) waiver, and Behavioral Health Organization contract that requires the approval of the Centers for Medicare and Medicaid Services.

8. How might changes to the mental health capitation program affect the state's network of mental health services for the indigent? How will such questions be addressed as the RFP for the re-bid of the capitation program is developed?

RESPONSE:

The Department does not anticipate that changes to the mental health capitation program (the Community Mental Health Services Program) will affect the state's network of mental health service providers for the indigent. The changes to the Community Mental Health Services Program that the Department is considering are concerned with increasing competition, improving access to and the quality of care and addressing any gaps in services that currently exist within the Program. The Department is fully committed to making the changes identified above, while maintaining and supporting the existing safety net programs and services. We recognize the critically important part that the Community Mental Health Centers, Federally Qualified Health Centers, and other Essential Community Providers play in providing services to the Medicaid, indigent and other non-Medicaid populations.

The current capitation program contract requires that Behavioral Health Organizations include Essential Community Providers in their networks and offer contracts to all Federally Qualified Health Centers located in the Contract Service Area. The 2009 request for proposals will include these requirements, and potentially others, to ensure that safety net providers are not negatively impacted by changes to the structure or content of the program. In addition, these providers are often responsible for alternative mental health services and community-based services not typically provided by commercial managed care organizations. As these services will be required in the rebid of the capitation program, it will be essential that the Community Mental Health Centers and other safety net providers contract their services to Behavioral Health Organizations that are selected in that bid.

- 9. To what extent do the \$16.0 million in non-Medicaid costs reported in child welfare services reflect costs that could or should have been covered by the Medicaid capitation program? Can the Department of Human Services determine this?**

RESPONSE

The Department is not in possession of information relating to the \$16.0 million in non-Medicaid costs in child welfare services referenced above. We are therefore unable to assess how much, if any, of these costs could or should have been covered by the Medicaid mental health capitation program. The Department would be open to assisting the Department of Human Services to answer this question by providing information such as covered mental health services, covered diagnoses, and any other available information needed to answer this question.

- 10. Are the Departments of Human Services and Health Care Policy and Financing considering changes to the delineation of Medicaid costs and responsibilities between BHOs and the counties for children receiving foster care services? Should more costs be carved out of the capitation program and moved under county control? Should some costs currently under county control be moved into the mental health capitation program? How do the departments propose to ensure that children in foster care receive appropriate mental health services? How might this be reflected in the re-bid of the Medicaid mental health capitation program?**

RESPONSE

Children and youth placed out of the home by the foster care system are Medicaid-eligible. Community Mental Health Program services are available to the vast majority Medicaid-eligible children through the Behavioral Health Organizations by community mental health centers and other network providers. Services include those in the State Plan, mandated by the Centers for Medicare and Medicaid Services, and alternative services, contracted by each Behavioral Health Organization. For the small number of children who receive both child welfare services and reside in a child care facility, the Centers for Medicare and Medicaid Services continues to question the states' service delivery models.

The Department met with the SB 07-064 Task Force on Foster Care and Permanence in November 2007. Since then, the Department has been working on responses to a large number of questions from the task force concerning services provided to youth and families involved in out-of-home placements. Questions and concerns voiced by task force members have been forwarded to the committee working on the 2009 request for proposals for the Community Mental Health Services program.

It is too early in the request for proposals process to have made decisions on changes to the way in which the Departments of Human Services and Health Care Policy and Financing interface to provide the spectrum of services needed by children and families in the foster care system. The Department will continue working with the Task Force on Foster Care, as well as the HJR1050 Task Force on Mental Health, to better meet the mental health needs of Colorado's children.

11. Do you expect to include counties and child welfare providers in meetings on how the Medicaid capitation program may be modified when the program is re-bid?

RESPONSE:

Yes, the Department welcomes input from all stakeholders and interested parties on this issue. During the upcoming request for proposals process, stakeholders will have the opportunity to participate in statewide public forums before the final request for proposals is posted. To facilitate this opportunity, the Department will notify the Department of Human Services as information becomes available, and will allow ample time for the Department of Human Services to share this information with their county partners.

12. Is CMS looking at this issue?

RESPONSE:

The Centers for Medicare and Medicaid Services continues to question the states' service delivery models for children in out-of-home placements who need mental health services.

13. Have you considered any changes to the Medicaid mental health capitation program that might help ensure that individuals with developmental disabilities receive appropriate services? Do you expect to include developmental disability providers/community centered boards in meetings on how the Medicaid capitation program may be modified when the program is re-bid?

RESPONSE:

Yes. A potential change being considered for mental health capitation involves expanding the scope of the program to provide services to anyone who meets medical necessity criteria, regardless of the existence of a "covered diagnosis". If implemented, this change would allow for the provision of behavioral health services to persons with developmental disabilities in situations where the presence of a mental health diagnosis is difficult to ascertain. Such a change would result in a corresponding cost increase, as eliminating the diagnosis-based requirement would expand services across additional populations.

Also, in June 2007, the Department approved and distributed Practice Guidelines for the Behavioral Health Organizations to use in the assessment and treatment of persons with developmental disabilities which were incorporated by reference in the FY 07-08 contract. These guidelines were developed by a Task Force composed of stakeholders from the Behavioral Health Organizations, Community Centered Boards, The Legal Center for People with Disabilities, community disability advocates and family members.

The guidelines seek to ensure that every person with a developmental disability receives a complete assessment to ascertain the existence of a co-occurring mental health diagnosis, an appropriate intervention plan and coordination of care between the mental health providers and other care providers involved with the client.

The Behavioral Health Organizations are currently in the process of providing training to their contracted mental health centers regarding implementation of the practice guidelines. A meeting between the Colorado Developmental Disabilities Council, the Colorado Behavioral Healthcare Council, disability advocates and the Department is planned in February 2008 to review the progress in utilization of the guidelines and to provide any further recommendations concerning increasing access to behavioral health services for persons with developmental disabilities.

As previously indicated, the Department will involve developmental disability providers and community centered boards in the development of the request for proposals.