Colorado's Medicaid Mental Health Services Program: Issues & Future Direction

Submitted to the:

Managed Care/Behavioral Health Section
Benefits Division
Department of Health Care Policy and Financing
State of Colorado

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I. Executive Summary

The Colorado Department of Health Care Policy and Financing (HCPF) contracted for a time-limited project to assist the Benefits Division in furthering its knowledge of managed behavioral health care. The goals of the project were to: assess the strengths and weaknesses of the current Mental Health Services Program ("Program"), advance the sophistication of the Program, generate increased interest in the Program, and outline different service delivery models that incorporate managed care principles, integrated health care and improved access, quality and cost-effectiveness. Key policy publications to guide Colorado's direction include the New Freedom Commission on Mental Health report, "Achieving the Promise: Transforming Mental Health Care in America" (2003), the USDHHS Substance Abuse & Mental Health Services Administration's response document, "The Federal Mental Health Action Agenda: First Steps" (2005), Governor Bill Ritter's "Colorado Promise" (Ritter, 2006), and "Improving the Quality of Health Care for Mental and Substance-Use Conditions" (Institute of Medicine, 2006), written by the Committee on Crossing the Quality Chasm.

Information for the project was gathered from:
- a review of electronic and hard copy documents within HCPF, including recent audit reports provided by external organizations,
- research and review of publications from behavioral health policy and consulting firms,
- research on programs and innovations in selected states,
- a review of managed behavioral health care organization and accreditation websites,
- a review of relevant task force, commission and committee mandates, reports and recommendations,
- a review of recently published academic literature on behavioral health care trends, and
- interviews with experts and/or stakeholders internal and external to HCPF.

Data from these sources were consolidated, and "convergent" data (consistent information that was provided through multiple sources) were prioritized for reporting.

Managed Behavioral Health Care Trends

Primary national trends in managed behavioral care are discussed, including:
- Efforts to better coordinate and integrate mental health and substance abuse services
- Efforts to better coordinate and integrate behavioral and medical/surgical care
- Efforts to better coordinate and integrate health care services among state agencies
- Increasing consumer and family involvement
- Interest in blended/braided funding streams
- Evidence-based practices (EBP) promulgation
- Increased focus on information technology (IT) enhancements
- Provider performance expectations and financial incentives, and
- Increasing focus on early intervention, prevention and "wellness".

Additional topics of increasing interest nationally include cultural "competence" of providers and programs, ways to address the obstacle that homelessness presents to

cost-effective care, establishment of workforce development plans, problems presented by transitions among care systems, and telemedicine.

The Current Program: Strengths and Areas for Development—Audit Reports

Several recent audit reports related to services provided by the current Program were reviewed. The most consistent commonalities among the audit findings suggest that the following areas in the Program need strengthening

- Greater completeness, consistency and accuracy of encounter, CCAR and other data that are or can be used to assess and manage the Program, assist with rate setting, allow confident analysis of the Program and permit useful Program planning;
- Greater standardization of performance from the behavioral health organizations (BHOs) on a range of measures; and
- Establishment of specific and standardized contractual performance standards for BHOs and a corresponding ongoing monitoring process to address BHO performance in meeting them.

The Current Program: Strengths and Areas for Development—Interview Data

A series of interviews were conducted with individuals "internal" and "external" to the Department of Health Care Policy and Financing to solicit their views on Program strengths and areas for improvement. Views between "internal" and "external" interviewees were quite similar. Primary program strengths were seen as the service array, increased flexibility presented by capitation compared to the fee-for-service structure, preservation of the "safety net" providers, increasing focus on the resilience/recovery model with more involvement from consumers and families, and a recently more collaborative style at HCPF.

The most frequently mentioned areas for Program improvement included addressing a need for:

1. Improvements in performance expectations/accountability of the BHOs and community mental health centers (CMHCs), including the establishment of clearer, standardized and more specific performance requirements and benchmarks across BHOs, and application of consequences for meeting or not meeting them. This area for improvement was mentioned by far the most often of any topic addressed by the interviewees;
2. Better delivery system continuity: This was the second most commonly mentioned problem. Specific "disconnects" that were mentioned included systems/payment strategies for mental health and substance use disorders, and gaps in service for the community of individuals with neurologically based disabilities;
3. A more effective relationship between the Division of Mental Health, Behavioral Health Services (DMH/BHS) in the Department of Human Services (DHS), and the Managed Care/Behavioral Health Section of HCPF;
4. Better coordination of behavioral and "physical" health care;

5. Greater inclusion of consumers' and families' input, and enhancement of peer services;
6. Improved services for individuals with Autism, Traumatic Brain Injury, Fetal Alcohol Syndrome and Developmental Disability;
7. A more complete array of wraparound services and greater consistency of BHO comprehensive case management;
8. Better provider access, especially to medication prescribers;
9. A more sophisticated rate structure (a group has been convened to work on this issue);
10. A more adequate basic database; and
11. An improved substance abuse service component.

Also mentioned were:

12. Better grievance processes;
13. More focus on prevention;
14. More focus on evidence-based practices (EBPs);
15. A better way to address problems with the fee-for-service "opt-out" option;
16. An increase in the number of people eligible for Medicaid;
17. Reduction in the administrative burden on providers, especially non-CMHC providers; and
18. Reduction in the administrative burden on consumers.

External State Task Force Activity

External State Task Force, Commission and Committee activity related to behavioral health was reviewed. These groups included the Governor's Behavioral Health Cabinet Policy Work Group, the Colorado 208 Blue Ribbon Commission, the JHR 07-1050 Task Force, the Subcommittee on Medication, Housing and Public Benefits/Task Force on the Mentally Ill in the Criminal Justice System, HB 04-1451 activities, the Colorado Collaborative Management Program and Colorado Prevention Leadership Council, SB 07-211 activity, and M.I.N.D.S. To varying degrees, the work of these groups intersects with interests of the Mental Health Services Program, and should be considered in Program strategy.

Alternative Delivery Models

Every state's modifications of a conceptual "model" are dictated by their own particular state agency, delivery and benefit structures, funding situations and political environments. Consequently, they are not easily generalized. Key variations among managed behavioral health care delivery models are found in components of overall administrative oversight, day to day program management, direct delivery of services and payment strategies. Common overall Medicaid managed behavioral health care state models today include:

1) Integrated: The state capitates general health managed care organizations (MCOs), which are responsible for the provision of all health care, including behavioral health, within the same overall organization, with the ability to consolidate all health care data.
2) "Carve in": The state capitates general health MCOs, which may subcontract to a specialty managed behavioral health organization (MBHO). This model only would be rightly termed "integrated" if there were a common information system capability and shared risk between the organizations.

3) Mixed: Limited behavioral health services are integrated within the general health MCO, but specific populations are carved out to a MBHO specialty organization.
4) "Carve out": The state capitates general medical/surgical health care to a general medical MCO and behavioral health care to an MBHO, with mechanisms of collaboration between the organizations. Most typically, the MBHO "carve out" is: a) one statewide vendor, or b) regional vendors that may include locally-based and/or national vendors, or c) county-based systems.
5) Managed Fee-for-Service: The state implements a number of managed care tools, typically through a contract with a managed care vendor, and pays providers on a traditional fee-for-service basis.

There is no clear consensus on the whether it is preferable to "carve in" or "carve out" behavioral health from administrative or structural standpoints. However, there is consensus on the importance of the use of formal mechanisms to more closely align, coordinate, and "integrate" the delivery of behavioral and general medical/surgical care. In the establishment of state managed care systems, it is important to be thoughtful of the potential impact that various managed care arrangements may have on relevant "safety net" providers.

Selected State Program Innovations

Many promising state innovations are reported in the literature, presented at conferences and were noted by interviewees for this project. Perlman and Dougherty's 2006 review, "State Behavioral Health Innovations: Disseminating Promising Practices," is summarized in this regard. Some states have program features that may be of particular interest to the Colorado Medicaid Mental Health Services Program, because they have been referenced by multiple authors, interviewees, or both, and are illustrative of the application of forward-looking managed behavioral health care principles. Six such state initiatives are profiled in Appendix C of the report, from the states of Arizona, Massachusetts, New Mexico, Texas, Washington, and Wisconsin.

Managed Behavioral Health Care (MBHC) Vendors

Local and national vendors representing "carve out", "carve in" and "integrated" models are briefly profiled. Their status with regard to the Colorado Division of Insurance, Department of Regulatory Agencies, the National Committee for Quality Assurance and URAC (formerly the Utilization Review and Accreditation Commission) is noted.

Recommendations

The following recommendations are discussed. They are drawn from all sources of information gathered during this project, but emphasize convergent data from national trends, audit findings, and interviewee input. It is important to consider what immediate or intermediate steps taken now can improve the Program, as well as pave the way for longer term initiatives. Conversely, consideration should be given to actions that are important to avoid now, so as not to create obstacles to the accomplishment of longer term initiatives.

1. Establish clearer, more specific BHO contractual performance requirements and consequences for meeting or not meeting them.
2. Related to recommendation # 1, establish a process to achieve greater statewide consistency of Program standards and processes, and a method for systematic monitoring of performance.
3. Make meaningful data collection and analysis a priority.
4. Establish a consistent, structural way to work collaboratively with Behavioral Health Services, DHS, on areas of similar accountability and where synergies and efficiencies might be created.
5. Continue efforts to improve Medicaid funding for substance abuse services and incorporate managed care methodologies into its administration. Develop a work group to make recommendations with regard to the administrative and programmatic "integration" of substance abuse and mental health services.
6. Establish more substantial and consistent mechanisms for increased consumer and family input into Program development and evaluation, particularly at the service delivery (CMHC/BHO) level.
7. Allow suspension rather than termination of benefits while inmates are incarcerated and support the "Quick Start" initiative in order to promote the timely re-establishment of Medicaid benefits after release.
8. Until the feasibility of a plan for more comprehensive "integration" of behavioral health and general medical/surgical health is assessed, increase the focus on meaningful collaboration among mental health, substance abuse and general medical/surgical service administrators and providers.
   a. Establish clear requirements of MCO, BHO and substance abuse treatment providers regarding care management and collaboration across service settings. Include performance measures specifically related to the effectiveness of general medical/surgical and behavioral health coordination for both general medical MCOs and BHOs.
   b. Investigate the potential impact of implementation of the CPT "Health and Behavior Assessment and Intervention" billing codes.
   c. Establish clearer Shared Services Protocols for the effective delivery of services for autism, traumatic brain injury and fetal alcohol syndrome. Continue to refine the recently written protocol for DD/MI.
   d. Provide incentives for BHOs and MCOs to co-locate their providers in high volume settings.
   e. Investigate what capabilities the current IT system has to track medical cost offsets from specific behavioral medicine programming, with consideration of how identified savings should be used.
9. Consider alternative BHO structures for addressing complaints and grievances, with more arm's length from the CMHCs. Evaluate the feasibility of other potential mechanisms to address the conflict of interest perception of CMHC controlling interests in BHOs.
10. Evaluate how the Department might become a stronger advocate with CMS for rational Medicaid programming.
11. Begin a standardization process among BHOs, MCOs and BHS/DHS with regard to paperwork such as consent forms, prior authorizations, and other common paperwork.
12. Explore whether there are CMS-allowable ways for Medicaid Program services to be used to bolster housing supports for Medicaid recipients who

are, or who are at risk of becoming, homeless—a situation that interrupts the most effective use of Medicaid (and other) resources. Research how Medicaid services might be used to bolster more comprehensive "wraparound services."

13. Establish an implementation plan for an integrated information technology system that can share data across behavioral health—both mental health and substance abuse—and general medical/surgical care organizations that serve Medicaid recipients.

14. Work toward a Statewide "integrated" model for general medical/surgical and behavioral health care. Such a broader service-based initiative would need to be guided by strategic and implementation plans with careful consideration to multiple components, including protection of the funding portion devoted to behavioral health, attention to "safety net" issues, provider network expansion, greater standardization of processes and paperwork, improved data collection and analysis, payment case mix adjustments, provider training issues, and data privacy/sharing concerns, among others.

15. Be a proactive partner in the HJR07-1050 implementation plan. Include a contractual requirement that the behavioral health managed care organization(s) work with HCPF and other groups identified by HCPF (such as a possible HJR07-1050 Task Force successor) to work toward the Task Force goals.

Some additional considerations relative to the recommendations include:

▪ "Build or Buy": Does HCPF have sufficient resources to implement recommendations that might be adopted? If resources are not available to implement effectively, an initiative should not be undertaken.

▪ If behavioral health administrative and delivery services eventually are incorporated with general medical/surgical services, how will the strong emphasis on consumer and family-driven care in behavioral health fare with the "medical model"? How will the issue of data privacy vs. holistic care be bridged?

▪ Will there be enough qualified providers? For example, most traditional behavioral care therapists are not trained in behavioral medicine, and not all have the disposition to practice this subspecialty.

▪ With regard to longer term planning, should the Division (and partners) embark on a carefully thought out, staged and implemented broader plan, or start first with one or more "pilot(s)"?

▪ To what extent might it be effective to establish greater "integration" of behavioral health and general medical/surgical administration within HCPF, that is, co-locate staff, modify selected meetings to have joint presence, and so on?

The increased interest in behavioral health in Colorado provides exciting opportunities to improve the cost-effectiveness and outcomes for Medicaid members. For the Medicaid Mental Health Services Program, there are a number of actions that can be taken in the shorter term that do not have to wait for longer term, broader initiatives. However, some of the recommendations clearly are complex and surely would be implemented more slowly—over many years and in conjunction with other broad State initiatives. Whatever specific actions are taken by the Benefits Division with regard to the next steps in Program improvement, they will need to be taken with the longer term vision in mind. Regular objective assessments must be made of progress and mid-course corrections determined. All states have needed such flexibility.

II. Introduction

The Colorado Department of Health Care Policy and Financing (HCPF) contracted for a time-limited project to assist the Benefits Division in furthering its knowledge of managed behavioral health care. The goals of the project were to:

- Assess the strengths and weaknesses of the current Mental Health Services Program ("Program"),
- Advance the sophistication of the Program,
- Generate increased interest in the Program, and
- Outline different service delivery models that incorporate managed care principles, integrated health care and improved access, quality and cost-effectiveness.

Within the field of behavioral health, there are many policy-related documents that offer specific recommendations for enhancement of the overall quality and effectiveness of national and state behavioral health programs. Key publications that are available to guide Colorado's direction include:

- The New Freedom Commission on Mental Health report, "Achieving the Promise: Transforming Mental Health Care in America" (2003), and the USDHHS Substance Abuse & Mental Health Services Administration's response document, "The Federal Mental Health Action Agenda: First Steps" (USDHHS SAMSHA, 2005), which outline numerous strategies and actions that can be taken to improve national and state mental health systems. Although the reports focus on overall mental health systems and are not specific to Medicaid, the recommendations have direct relevance to Colorado's Medicaid Mental Health Services Program. The reports also do not focus on "behavioral health," that is, both mental health and substance abuse services. However, a Commission subcommittee addressed the topic of co-occurring disorders.
- Governor Bill Ritter's "Colorado Promise" (Ritter, 2006), which includes goals related to improving the quality and cost-effectiveness of Medicaid, a focus on prevention, improvements in service accountability, investment in technology, behavioral health promotion and better integrated health systems.
- " Improving the Quality of Health Care for Mental and Substance-Use Conditions" (Institute of Medicine [IOM], 2006), written by the Committee on Crossing the Quality Chasm, which adapts the IOM report on improving general medical health care to mental health and addictive disorders. This report puts forth a comprehensive strategy and action plan for delivery organizations and providers, purchasers, and governments with regard to improvements in behavioral health services.

Together, these documents provide a combination of Colorado priorities and blueprints for implementation of program and process improvement strategies. The latter document in particular offers a concrete, step-by-step plan, based on empirical research and significant expert input. The context of the current project included the backdrop of these national and state priorities and strategies, as well as recognition of the numerous task forces, committees and interest groups focused on one or more goals related to improving behavioral health services in the State of Colorado.

III. Method

For this project, Colorado's Medicaid Mental Health Services Program was viewed broadly, and not constrained to the 1915(b) waiver per se. For example, currently the Program technically does not include managed substance abuse services—a substance abuse benefit has only recently been included in the fee-for-service model. Yet substance abuse services are such an important part of behavioral and general health care that they have been routinely considered in assessment of the current overall Program. Similarly, long term care services for Medicaid-covered mentally ill individuals provided through the Home and Community-Based Services (HCBS) waiver were addressed where relevant. Services provided under the 1915(b) waiver comprise the Mental Health Services Program per se, however, and so are the primary services that were addressed.

As required by the project specifications, research included a review of:

- strengths and weaknesses in the current Program,
- current information on behavioral health managed care, including private and public sector trends,
- the work of relevant external task forces and committees,
- results of interviews with selected experts and state personnel with a knowledge of the current program and/or national trends, and
- information on vendors in the managed behavioral health arena.

Information was gathered from:

- a review of electronic and hard copy documents within HCPF, including recent audit reports provided by external organizations,
- research and review of publications from behavioral health policy and consulting firms,
- research on programs and innovations in selected states,
- a review of managed behavioral health care organization and accreditation websites,
- a review of relevant task force, commission and committee mandates, reports and recommendations,
- a review of recently published academic literature on behavioral health care trends, and
- interviews with experts and/or stakeholders internal and external to HCPF.

Data from these sources were consolidated. "Convergent" data, that is, consistent information that was provided through multiple sources, were prioritized for reporting.

The project began in late November, 2007 and was completed by mid-February, 2008. Results from the project culminated in this report, provided to the management staff of the Managed Care/Behavioral Health Section, Benefits Division of HCPF, as well as a related training session for staff. The report outlines information and issues addressed through the course of the project, summarizes the Program analysis and makes recommendations for enhancing the Program.

Findings from the project research are organized and discussed in the following sections:

Managed Behavioral Health Care Trends
The Current Program: Strengths and Areas for Development—Audit Reports
The Current Program: Strengths and Areas for Development—Interview Data
External Task Force Activity
Alternative Delivery Models
Selected State Program Innovations
Managed Behavioral Health Care (MBHO) Vendors
Conclusions and Recommendations

At the same time that this project was active, the Benefits Division also was studying its Medicaid "physical" health structure and programming. Since both "physical" (general medical/surgical) and "behavioral" health structures, programs and outcomes have significant effects on each other, points of information exchange regarding the two processes were established throughout this project.

IV. Managed Behavioral Health Care Trends

Many managed behavioral care health trends are discussed in the literature, noted on a variety of managed behavioral, public health and health consulting websites, and referenced by experts in the field. It is generally recognized that the effects from the significant decrease in inpatient psychiatric beds has resulted in an increase in community-based behavioral health care needs. Many communities still lack access to a complete continuum of care, especially higher-end and intermediate-level supported care that was intended to replace the traditional inpatient hospital care and that is essential for optimal managed care. Consequently, many state initiatives relate to the development of appropriate programs to fill this gap. In addition, there are many and increasing state initiatives designed to improve measures of quality and outcomes. These efforts are so varied and numerous that it is not feasible to catalogue them completely. However, within this context, there are a number of trends that are commonly noted by multiple sources and are summarized below.

Efforts to Better Coordinate and Integrate Mental Health and Substance Abuse Services

Most states provide substance abuse benefits within a Medicaid managed care arrangement, primarily within the general medical managed care organizations (MCOs), but also in carve out managed behavioral health care organizations (MBHOs) (Maglione & Ridgely, 2006; Mauery et. al., 2006; USDHHS, 2006). National managed behavioral health companies typically have managed both mental health and substance abuse services for years, and the National Committee for Quality Assurance (NCQA) has standards specifically related to the integration of mental health and substance abuse services. There is growing recognition that evidence on outcomes demonstrates that truly integrated care is the preferred mode of treatment for individuals with co-occurring disorders. This approach provides treatment for the particular mix of mental illness and substance use disorders together, at the same time, in the same location, usually by a treatment team with mental health and substance abuse treatment expertise present

simultaneously. Most private-sector managed care organizations have specialized providers or treatment programs available for these individuals. Contract specifications to this effect have been implemented in a number of state public sector programs (Mauery et. al., 2006). Minkoff (2001) makes the case that co-occurring disorders are so prevalent that this integrated model should be routinely available, and systemic changes at the highest structural and administrative levels are needed to accomplish it.

Efforts to Better Coordinate and Integrate Behavioral and Medical/Surgical Care

There has been an increased recognition of the implications of the fact that most people suffering from psychiatric problems seek help in primary medical care settings, and that many severely and persistently mentally ill individuals have other chronic medical conditions, the interplay of which significantly impacts their general health status. In addition, evidence continues to accumulate to demonstrate a medical cost-offset effect of certain behavioral health services. For quality of care, administrative, and cost-effectiveness reasons, there is an increasing desire for health plans to improve the coordination of all aspects of care, increasingly focusing not only on better coordination of mental health and substance abuse care, but also of behavioral health with general medical/surgical care (Bartels et. al., 2005; LaBrie, R. A. et. al., 2007; Mauer, 2006a & b; Stroul, Pires & Armstrong, n.d.). Care coordination strengths and weaknesses can exist in different models (for example "carve in" and "carve out"). However, since individuals with mental illness often are seen in both medical and behavioral service settings, care coordination is very important for this group, especially since medication is often used as part of the treatment regimen. For successful collaboration or "integration", it is critical that both the medical and behavioral care systems actively participate.   Specifications about such collaboration and/or integration increasingly are finding their way into contracts (Mauery et. al., 2006; Perlman & Dougherty, 2006; USDHHS, 2006).

Efforts to Better Coordinate and Integrate Health Care Services Among State Agencies

Many states have been attempting to improve collaborations between their Medicaid and mental health agencies, and in some, structural changes have been made in order to facilitate regular collaboration. "To the extent that the trend toward mental health services being funded by Medicaid continues, restructurings may result in more mental health authorities being co-located along with Medicaid within larger health structures" (Verdier, Barrett & Davis, 2007, p. 3; see also USDHHS, 2006).

Increasing Consumer and Family Involvement

Most sources identify more inclusion at all levels from consumers & families as a current trend, sometimes referring to this element as "consumer empowerment" or "consumer engagement" (Perlman & Dougherty, 2006; Stroul, Pires & Armstrong, n.d.; USDHHS, 2006). Ways in which this inclusion is achieved include:
-- direct involvement in program planning, development and evaluation,
-- enhanced choice of providers and services, with preferences incorporated in treatment plans,
-- increased education to consumers and families about options for their care,
-- increased focus on consumer-run treatment support services,

-- involvement of consumers and consumer advocacy organizations in the crafting of state waiver applications, and
-- involvement of consumers in the crafting of State RFPs for managed care contracts (Mauery et. al., 2006: Sabin & Daniels, 1999).

Managed behavioral health organizations generally have been more likely than general medical managed care organizations to involve consumers and families in these ways (Pires, Armstrong, & Stroul, 1999, cited in Mauery et. al., 2006).

Interest in Blended/Braided Funding Streams

Many states are examining how to "blend" or "braid" funding streams in order to improve the efficiency of dollars spent and help overcome typical fragmentation of care due to isolated funding streams that are paired with different agencies (Perlman & Dougherty, 2006; Stroul, Pires & Armstrong, n. d.). "Blended" funding typically combines dollars on the front end by directing multiple funding streams to a common, pooled account that then is used flexibly as a consumer's needs require. "Braided" funding typically uses a common administrative mechanism to "mix and match" funds from various sources to meet a consumer's needs, but does not completely pool these funds. "Braided" funding may create additional administrative burdens, as tracking of the dollars is necessary. However, "braiding" may provide greater accountability for each funding source (Mauery et. al., 2006).

Evidence Based Practices (EBP) Promulgation

There is sustained interest in finding ways to promulgate evidence-based practices (Barry, 2004). Many sources appear frustrated that the lag between the establishment of treatment efficacy and best practice implementation appears unnecessarily long. Managed behavioral health care organizations have adopted various methods to assist with EBP implementation, including contract specifications, incentives, distribution of clinical guidelines and /or algorithms, and so on (Mauery et. al., 2006). However, for long term success in the implementation of EBPs, a long term commitment to positive relationships with providers, and to training, supervision and oversight, is necessary (Marton, Daigle & de la Gueronniere, 2005; USDHHS, 2006).

Increased Focus on Information Technology (IT) Enhancements

> The essence of managed behavioral health care is far more complex than putting providers at risk. Indeed, most of the case studies in the private sector show that managed care is primarily about information systems and managed-care tools such as utilization review… (Sturm, 2000, p. 4).

It has become clear that much more sophisticated IT is required if states are to implement many of the initiatives that they want to pursue (Barry, 2004). Private national managed care firms typically invested in such technology years ago, but states tend to report that they do not have even basic behavioral health care data or staff required for planning, analysis and decision making. Consequently, the trend is to establish strategies to obtain greater sophistication in this realm, including exploration and implementation of electronic medical records and shared technology across

systems (Manderscheid, 2006; Stroul, Pires & Armstrong, n.d.; Sturm, 2000). Many states have begun electronic health record initiatives (USDHHS, 2006).

Provider Performance Expectations and Financial Incentives

There is some tendency for states to become more targeted and specific in their performance expectations of vendors (Stroul, Pires & Armstrong, n. d.), with consideration of financial incentives for meeting or beating targets (Perlman & Dougherty, 2006). Managed care organizations that have done work in the public sector have been encouraging of this trend (Savela, Robinson & Crow, 2000). Among other states, Iowa and Massachusetts have incorporated pay for performance in their Medicaid mental health programs, and other states are examining these types of provider arrangements to reward "good" providers (Mercer, 2006).

Increasing Focus on Early Intervention, Prevention and "Wellness"

In the interest of stemming down-stream costs by the provision of cost-effective strategies at the front end, prevention programs are receiving increased attention (Barry, 2004; Coolidge, 2007). With regard to the early recognition and prevention of mental illness and substance use disorders, Nitzkin & Smith (2004) delineate the following services that have shown "the greatest promise":
1) Screening of:
-- pregnant women for use of tobacco, alcohol, and illicit drugs;
-- children and adolescents for behavioral disorders;
-- adolescents for tobacco, alcohol, depression, and anxiety;
-- adults for depression and anxiety, and use of tobacco and/or alcohol;
2) Home visitation for selected pregnant women and some children up to age 5;
3) Psychoeducation:
-- to increase early ambulation of surgical patients;
-- to increase adherence to prescribed regimens of care for patients with chronic diseases;
-- to decrease somatization; and
-- supplemental educational services for vulnerable infants from disadvantaged families.
Others have made similar observations, fueling a greater emphasis in this area (Mauery et. al., 2006; USDHHS, 2006).

Other Trends:

Other commonly referenced trends in managed behavioral and public programs, including Medicaid, include:

- **Greater attention to the reduction of racial and ethnic disparities in access to and quality of care, including the selection and development of "culturally competent" providers;**
- **Increasing recognition of the impediment that homelessness presents to cost-effective behavioral health care and initiatives to address this obstacle;**
- **Establishment of workforce development plans designed to improve the availability of qualified providers;**

- **Greater attention to gaps caused by individuals transitioning from one to another system of care; and**
- **Telemedicine as a way to provide greater access in underserved areas.**

(USDHHS, 2006; see also Barry, 2004; Mauery et. al., 2006; NASMHPD, 2005; Perlman & Dougherty, 2006; Stroul, Pires & Armstrong, n. d.)

V. The Current Program:
Strengths & Areas for Development

Audit Reports

The current Colorado Medicaid Community Mental Health Services Program provides mental health care under a 1915(b) Managed Care/Freedom of Choice Waiver from the Centers for Medicare and Medicaid (CMS). Statewide management of the Program is through the Managed Care/Behavioral Health Section of the Benefits Division, Department of Health Care Policy and Financing. Five nonprofit Behavioral Health Organizations (BHOs) are capitated for the management and delivery of services in their geographic areas: Access Behavioral Care (ABC), Behavioral HealthCare, Inc. (BHI), Colorado Health Partnerships, LLC dba Colorado Health Networks (CHN), Foothills Behavioral Health, LLC (FBH) and Northeast Behavioral Health, LLC (NBH). The community mental health centers (CMHCs) that comprise the primary provider networks for each of the BHOs have varying degrees of controlling interests in the BHOs and are subcapitated for services. The BHOs contract with other community providers in order to maintain adequate network access and expertise.

The Benefits Division's Quality Section and the contracted External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), perform technical and quality compliance reviews of the BHOs. As the State's designated Mental Health Authority, the Division of Mental Health (DMH)/Behavioral Health Services (BHS), within the Office of Behavioral Health and Housing, Department of Human Services (DHS), provides clinical quality review and oversight of the community mental health centers that comprise the core of the BHO provider networks.

As one way to evaluate the current Mental Health Services Program strengths and, especially, areas for development, it is instructive to look at recent external audit reports, with particular attention to commonalities among the findings. This section summarizes significant findings from three such reports. The 2006 Mercer audit and the 2006-2007 review performed by the Program's EQRO focus specifically on the Medicaid Mental Health Services Program. In addition, the 2007 CMS audit of the Mental Illness Home and Community-Based Services Waiver was reviewed even though from administrative and funding perspectives, it is considered to be a separate program. The latter report was included because: 1) conceptually, the services are within the broader scope of mental health services to Medicaid recipients; 2) this "carve out" of a level of care for mentally ill individuals has practical implications for the functioning of the Program; and 3) the audit findings have commonalities with the other reports and so are instructive overall.

The summaries below do not present exhaustive compilations of all findings, but rather emphasize findings that are convergent with other sources (such as interviewee and task force information) and the trends discussed previously. The Department and/or BHOs or other providers (including Single Entry Point (SEP) agencies) have action plans in development or in place to address the findings.

Medicaid Mental Health Rates, Department of Health Care Policy and Financing Performance Audit, November 2006 (Mercer, 2006)

This report describes findings from an audit requested by the State Auditor, focusing on evaluation of the Program rate setting methodology. It also "reviewed processes for utilization management (UM) and quality and assessed the controls" with regard to medical necessity, access, and service data submitted to the State. The audit was conducted from June through November, 2006. Primary findings and recommendations to the Department included:

- Set appropriate contractual standards for the BHOs to follow regarding UM, and monitor BHO UM practices (a number of more specific elements were recommended in this arena);
- Use data analysis to assist in tracking rate parity among BHOs and investigate trends and issues;
- Require telephone access monitoring systems from the three BHOs that did not have them;
- Require BHOs to monitor third party recoveries for payments made to all providers, including "internal", that is, community mental health centers;
- Devise mechanisms to obtain more consistent and accurate reporting of encounter data in HIPAA-compliant codes (for example develop a comprehensive encounter data reporting manual);
- Overhaul the rate setting methodology to reduce inequities based on unsupportable CMHC variations in unit pricing (To accomplish this, the Program needed to obtain more reliable and valid encounter data, which requires improvements in the UM programs and data);
- Change state statutes to be consistent with federal changes in order to allow better rate methodology;
- Establish and enforce consistent quality standards for the BHOs/CMHCs, since an "absence of Department-promulgated requirements" was noted.

Also, the report expressed a concern regarding CMHCs' controlling interests in the BHOs.

2006-2007 External Quality Review Technical Report for Behavioral Health Organizations (HSAG, 2007)

Health Services Advisory Group, Inc. is HCPF's contracted EQRO. Evaluation of the Program by an EQRO is an arrangement that is required by CMS rules, in order to promote general quality of services, especially along the lines of access to services, data validity, consumer rights and other performance measures.

The prior period 2005-2006 report (HSAG, 2005)[1] made a series of recommendations, including:
-- Develop performance measures and required standards for the BHOs;
-- Measure improvement relative to these standards over time;
-- Implement ongoing monitoring of performance relative to care coordination, utilization management, case management records and service denial processes;
-- Review data code and verification procedures to improve the encounter data accuracy;
-- Develop an electronic case management system, with clinician training; and
-- Establish and/or improve provider credentialing processes, enrollee materials and BHO internal compliance programs.

The 2006-2007 External Quality Review Technical Report for Behavioral Health Organizations reported that the BHOs generally made significant improvements in the areas designated for such in the 2004-2005 report, including in the areas of data integration, control processes and analysis, performance measure documentation, credentialing processes and standards, practice guidelines and other tools and functions related to utilization management.

The 2006-2007 review findings included the following:
- There were still general problems of incomplete, inconsistent and inaccurate encounter and CCAR data. Encounter data audits showed a number of inaccuracies in fields when data were compared with the medical record.
- There were wide performance variations among the BHOs, particularly in the areas of provider credentialing, delegation and related issues, member rights and responsibilities, utilization management, handling of grievances and appeals, and documentation of services.
- Not all BHOs took action and implemented timely interventions when problem areas or problematic trends were identified.

Recommendations included that "where applicable", the BHOs:
- Continue to actively oversee and monitor the receipt, completeness, timeliness and accuracy of encounter and CCAR data from their providers, placing all providers who do not meet standards on a plan of corrective action and providing additional education about data collection during the medical record review process.
- Reexamine the State's specifications to ensure that submitted encounter and claims data fulfill all requirements.
- Conduct an analysis as to the causal factors leading to "low rates" for the quality-related performance measures, especially for Consumer Perceptions of Outcome and Positive Change in Problem Severity-Adults.

In addition to the recommendations provided to the BHOs, HSAG also identified State-level areas for improvement. These recommendations included:
- Reevaluate the data collection and reporting of the Mental Health Statistics Improvement Program (MHSIP) survey to be more in line with the other performance measures, and shorten the turnaround time for performance measure reporting and comparisons.

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[1] During the prior period there were eight, rather than the current five, BHOs.

- Review the sample size requirements for the MHSIP survey to ensure that the appropriate sample size is being used for future reporting at the CMHC level.
- When developing new performance measures in the future, work closely with the Division of Mental Health/BHS to document all aspects of source code specifications and methodology. Cross-train staff to ensure consistency with calculations.
- Ensure that for CCAR reporting, results are broken out and shown separately for Medicaid and non-Medicaid consumers.

2007 CMS Final Report on the Home and Community-Based Services (HCBS) Waiver, Colorado Major Mental Illness (MI) Waiver Program (USDHHS CMS, 2007)

The MI HCBS services are provided under a separate CMS waiver and are overseen by the Community Based Long Term Care Section within HCPF. Since the services are not provided under the auspices of the Community Mental Health Services Program or BHOs, they are not considered technically to be a part of the Mental Health Services Program. However, the services are critical to the continuum (and thus the quality and cost-effectiveness) of care of certain individuals served by the Program, and there are findings with certain commonalities to those of the other audits that are instructive for the Program. Recommendations included:

- Develop a process to analyze data and look for trends and issues;
- Improve quality of care oversight and monitoring of Single Entry Point Agencies (SEPs);
- Enhance training to the SEP agencies, especially with regard to a model of rehabilitation and recovery for the Alternative Care Facilities;
- Establish CMHC/BHO accountability for their portion of service delivery (for example, it was found that some CMHC/BHOs did not work collaboratively with the SEP agencies and did not provide the services it was thought that they should provide; and improvements in exchange of information in the interest of appropriate and timely services to consumers was needed)[2];
- Improve consistency of expectations & monitoring among SEPs;
- Review the information submission requirements (do something with it, or do not require it); review the information available (and not) to SEPs to allow greater financial accountability.

Consistencies Among the Reports:

The most consistent commonalities among these three audit and review reports suggest that the following areas in the Program need strengthening:

- Greater completeness, consistency and accuracy of encounter, CCAR and other data that are or can be used to assess and manage the Program, assist with rate setting, allow confident analysis of the Program and permit useful Program planning;

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[2] The CMS Final Report: 1915(b) Managed Care Waiver Review, Colorado Medicaid Mental Health Program, February 18, 2005 also emphasized a need for increased performance oversight of the eight BHOs at that time (USDHHS CMS, 2005).

- ▪ Greater standardization of performance from the BHOs on a range of measures; and
- ▪ Establishment of specific, standardized contractual performance standards for BHOs and a corresponding ongoing monitoring process to address BHO performance in meeting them.

VI. The Current Program:
Strengths & Areas for Development

Interview Data

As another way to obtain information on the status of the current Mental Health Services Program, selected key stakeholders were interviewed concerning their views of the Program's current strengths, gaps and problems, longer term changes that are needed, and related topics. The lists of questions asked are presented in Appendixes A1 and A2. Interviewees were chosen to represent individuals familiar with the Program who were likely to have a range of perspectives, given their business, program and/or advocacy alliances as well as personal experiences. The interviewees included individuals "internal" and "external" to the Department of Health Care Policy and Financing, although the larger group was "external". The complete list of interviewees is attached as Appendix B.

By design, most of the interview time was spent on the elicitation of views on Program gaps, problems and desired future direction rather than strengths, and it follows that areas for development will be given more attention in this report. The summaries on strengths and areas for development again emphasize those for which there were convergent data, that is, similar views expressed by more than one respondent, rather than an opinion idiosyncratic to only one interviewee. However, since the interviewee list was limited, certain individual comments that were particularly insightful or convergent with other data sources are included also at the end of this section.

Summary of Program Strengths

1) Service Array: Although not universal, the interviewees generally believed that there is a good overall service array in the Program, including good use of "alternative" services such as club houses. Generally, the Program is perceived as having made progress on the establishment of services as an alternative to hospitalization, although more efforts are seen as needed. Several interviewees commented that individuals covered by Medicaid, especially people with severe mental illnesses, get the best services of any system, including private insurance plans. Although access to services was noted as a problem in rural areas, it was reported that "most consumers in the metro area are very happy" with the services that they are offered.

2) Increased Flexibility: There is a "certain flexibility in the capitation arrangement that was not there before," as compared to the fee-for-service structure. This flexibility was seen as helpful to the provision of appropriate and efficient care.

3) Preservation of the Safety Net Providers: The structure of the current Program is seen as preserving the service "safety net" for underserved populations.

4) Greater Focus on Resilience and Recovery and Involvement of Consumers and Families: The Program is seen as having improved its focus on a longer term perspective of consumer resilience and recovery, rather than merely crisis-oriented care. Correspondingly, there has been improvement in the involvement of consumers in the development and management of their treatment plans (although there also is room for improvement). It was noted by one interviewee that "those [consumers] in true partnership with their provider are really happy."

5) Improvements in Collaborative Style at HCPF: HCPF is seen as getting information out to stakeholders more often than in the past, soliciting input more often, asking for specific suggestions and producing more accurate summaries of focus group feedback. Managed Care/Behavioral Health staff are seen as somewhat more accessible than in the past.

Summary of Program Gaps and Areas for Improvement

Many issues were addressed as areas for possible improvements—areas for particular emphasis varied with the business, program and/or advocacy affiliation and personal experiences of the respondents. No topic was mentioned by every interviewee. However, the list below generally is sorted by frequency of mention by multiple interviewees—the most commonly cited issues presented first, moving to those that were discussed by more than one person, but not as often cited overall. There were no significant differences between "internal" and "external" interviewees with regard to overall topics raised.

Most Frequently Mentioned Needs:

1) Improvements in Performance Expectations/Accountability of the BHOs and CMHCs: This area for improvement was mentioned by far the most often of any topic addressed by the interviewees. It was commonly noted that the BHOs are highly variable in many ways with regard to their strengths and weaknesses. The close organizational relationship between the BHOs and their community mental health center providers was seen as a problem by a significant portion of the interviewees (including recognition of this perception by some BHO representatives), with a number of interviewees feeling that this "conflict of interest" is an obstacle to BHO enforcement of performance standards for the CMHCs.

The problems identified by respondents could be divided into three main areas, which were the need for:
   a) HCPF to establish clearer, standardized and more specific performance requirements and benchmarks across BHOs, especially with regard to access, network adequacy, credentialing, case management/continuity of care, implementation of evidence-based practices, use of the Institute beds and responsiveness to consumer complaints,
   b) Greater enforcement of these standards by the establishment of consequences for meeting/not meeting them, including penalties for not meeting basic

performance requirements and financial incentives for implementation of model programs, and

c) More consistent oversight to evaluate performance and apply consequences.

While some expressed the opinion that the organizational interdependence of the BHO/CMHC relationship is in itself untenable, others thought that "safeguards" could be built in to minimize the conflict of interest problem, such as independence of management staff between the organizations and requiring grievances to be dealt with by the BHOs instead of the CMHCs. A couple of the respondents noted DMH's responsibility to credential CMHCs, but did not feel that this mechanism really promoted completely the type of performance accountability that is needed.

2) Better Delivery System Continuity: This was the second most commonly mentioned problem. While to some extent, system fragmentation is a broader issue than just the Medicaid Mental Health Services Program, there are aspects that are immediately relevant to the functioning of the Program. With regard to the broader system issues, interviewees urged HCPF representatives to be actively involved in State collaborative efforts to organize service delivery around a consumer, rather than around particular settings or isolated payment streams. As one respondent stated, "Be at the table."

Aside from the broader initiatives, there are a number of "disconnects" that were mentioned by interviewees that do not or may not require such a long term effort, and could more immediately improve the Program. Specific "disconnects" that were mentioned included separate delivery systems/payment strategies for mental health and substance use disorders, and gaps in service for individuals with developmental disabilities (DD). The "medical home" concept was recognized as one way to try to establish a central point of accountability for a consumer's care. However, interviewees also noted that even currently where accountability theoretically exists for providing care coordination or management, it does not always occur. Substantive performance requirements for the BHOs/CMHCs for care coordination and management was mentioned as one way to address the issue, outside of a more comprehensive systemic change. Other ways that were mentioned to improve coordination of care included establishment of a common electronic medical record, inclusion of more services in the continuum of care within the same capitation and creating one triage location for consumer complaints (at least between the HCPF Medicaid Mental Health Program and the DMH/BHS).

Observations were made by a couple respondents on the historical split in orientation between DMH and HCPF of "program" and "finance", respectively. It was suggested that HCPF should take a broader view, incorporating relatively more attention to clinical and programmatic elements, and more actively collaborate with other agencies on how to prevent program transition gaps.

3) A More Effective Relationship Between the Division of Mental Health, Behavioral Health Services (DMH/BHS), in the Department of Human Services (DHS), and the Managed Care/Behavioral Health Section of HCPF: Although many interviewees volunteered unsolicited opinions on this topic, they also were specifically asked about their perceptions of this relationship. Most (both internal and external) thought that the two operational units neglected to take advantage of synergies related to expertise, programs and resources. Several respondents added that they thought this

"disconnect" applied to the Department of Public Health & Environment as well. Resulting problems for the Medicaid Mental Health Services Program (and other) consumers included:

▪ Confusion around the two systems, for example the process for filing a complaint,
▪ Diffusion of responsibility for holding CMHCs accountable in contract and oversight,
▪ Multiple forms (for example, medical release forms, intake forms, complaint protocols, critical incident protocols, etc.),
▪ Different sets of service and reporting standards for Medicaid and non-Medicaid services (to some extent, but not completely, driven by federal requirements),
▪ Lack of good sharing of information on Medicaid members,
▪ Duplication of on-site provider monitoring,
▪ Work not getting done due to lack of resources, when resources are available via State "partners", who are interested in the same topic and could be used to do the work, and
▪ Lack of a common strategic vision/direction that guides accomplishments.

4) Better Coordination of Behavioral and "Physical" Health Care: Opinions on this topic ran the gamut from recommending that one general health organization be capitated for both general medical/surgical and behavioral health services, to uncertainty about how to best deal with this issue, to identification of multiple ways that a behavioral health specialty "carve out" and the corresponding "physical" health provider could collaborate and integrate service delivery.

Proponents of the integrated or "carved in" (one primary vendor) model espoused views such as the following:
▪ Separate capitation is the single biggest obstacle to health service integration.
▪ Contractual protections can be made to assure that an appropriate percentage of the capitation goes to behavioral health services.
▪ The key to real integration is a common data system, so that data mining can be done and services can be truly coordinated. However, for business reasons, historically it has been nearly impossible to get a behavioral health care "carve out" vendor to use the general health vendor's intake, claims, etc. systems.

Proponents of the "carve out" (specialized behavioral health care vendor) model espoused such views as the following:
▪ Historically, when behavioral health care was merged with the general medical HMOs, the financial support for such services was inadequate.
▪ There are ways to promote collaboration between the systems, but to be most effective, such performance expectations need to be placed equally on both organizations.
▪ There are newly allowed (by CMS) CPT codes that promote the integration of behavioral health interventions in the service of improved medical care. Currently some CMHCs are providing these services on-site in medical settings—they are just not getting reimbursed.
▪ Currently the physical health side is nearly completely "unmanaged".

5) Greater Inclusion of Consumers' and Families' Input, and Enhancement of Peer Services: Interviewees who commented on this topic generally thought that there needed to be increased participation by consumers and family members on CMHC and BHO boards in order to enhance environments and processes to improve access to and

continuity of care. For example, getting consumer feedback on proposed written communications and treatment setting "rules" could result in a more realistic perspective regarding how these items would be perceived by individuals receiving services. Up front feedback by consumers and family members also could help the organization to anticipate better the practical consequences of policy decisions. The model of Client Boards in addition to the Professional Boards was suggested, as was the creation of a Statewide Consumer Council, similar to that established for the DD community.

Peer services were explicitly mentioned by a number of interviewees. The general sense was that there are too few peer services and there are no consistent standards for them (including credentialing requirements). Building capacity in these services was seen as important in and of itself, as well as to support the trend toward "consumer-directed" care.

Several respondents expressed disappointment at the experience of having had Program representatives solicit consumer, family and stakeholder input, but then seeing no evidence that this input was incorporated into the decisions that were made. "Continual focus groups give input, all say the same thing, then something different happens."

6) Improved Services for individuals with Autism, Traumatic Brain Injury, Fetal Alcohol Syndrome and Developmental Disability: Autism was recognized as a problematic diagnosis by a number of respondents. A couple individuals acknowledged the significant financial issues associated with the current treatment of choice. Several interviewees noted that there are not many providers that have expertise in DD/MI issues. A couple interviewees noted that there are few if any adequate resources for individuals with Traumatic Brain Injury. A lack of appropriate services for individuals with Fetal Alcohol Syndrome also was mentioned. These four populations in general are seen as inadequately served, tending to get "bounced" among systems. Several individuals noted that there is no type of formal Mixed or Shared Services Protocol to help establish physical health/behavioral health provider accountability for services and outcomes. (In June 2007, the "BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD)" was published by HCPF in an attempt to address these issues for individuals with DD and MI.)

7) A More Complete Array of Wraparound Services and Greater Consistency of BHO Comprehensive Case Management: These two issues are included together due to the importance of their interplay with regard to the ability to perform cost-effective, managed care. Full wraparound services that include the use of clergy, teachers, police, mentor programs, consumer-run services, job support services, housing supports and use of nontraditional tools (such as cell phones with texting for medication reminders) are missing in most state programs, according to several interviewees. Also, there is a need for more flexibility in the use of funds to support such approaches. However, even within current requirements, some interviewees expressed the opinion (and shared their experiences) that the BHOs/CMHCs do not engage in enough care coordination of multiple services "both within and outside of their own walls," to truly support continuity of care. The transition from a high-intensity level of care (for example hospital or foster care) back to the community was cited as a situation that sometimes lacks appropriate care/case management. Similarly, transitions from youth to adult services often create

gaps, typically with little to no assistance to consumers and families from the Program or its providers in terms of basic consumer/family proactive education on upcoming challenges and resources. "No one does referrals anymore—when a [consumer] loses their Medicaid, they are just told to go to another place for service." A need for more flexibility in BHO prior authorization requirements for homeless individuals also was noted, as it is extremely difficult if not impossible to gather all the desired information. Responsiveness to this issue was noted as highly variable among BHOs. Similarly, a lack of focused case management, that is, services for subsets of specific, identifiable highest-risk individuals was mentioned. To a great degree, these types of services are the essence of managed behavioral health care.

8) Better Provider Access: A number of interviewees noted that there were access issues for necessary services, especially timely access to prescribers generally, psychiatrists, child specialists and, in rural areas, "culturally competent" providers (a factor that influences whether a consumer will seek or continue in treatment). Comments were made about waiting lists to see prescribers, month long wait times for initial evaluation and commencement of services, and the unavailability of walk-in services. One "CMHC" was quoted allegedly as stating that they were "closed to Medicaid clients." Several respondents voiced the opinion that there need to be "more private providers in the system", noting, for example, that there are more psychiatrists and child specialists available in the community, but they are not contracted with the BHOs. One interviewee expressed the opinion that there are too many lower credentialed counselors in the system at the expense of higher-trained providers.

9) A More Sophisticated Rate Structure: The antiquated rate structure was mentioned by both internal and external interviewees as being "unfair" and inadequate. The structure "does not support value purchasing". It is not seen as risk adjusted. "There are no incentives for quality." It was stated that it relies on incomplete and faulty data. It was acknowledged that a work group has been convened with DMH, HCPF and provider representatives which has the goal of coming up with a more defensible future rate setting methodology.

10) A More Adequate Basic Database: Closely related to the rate structure problems, interviewees noted the lack of a comprehensive, valid and reliable data collection system for the Program. In addition to problems with the establishment of rates, this problem affects the Program's ability to analyze the effectiveness of services, whether consumers are getting the proper array of services, where there are gaps in service, whether BHOs/CMHCs are meeting performance requirements and Program needs in general. "One of the biggest problems is getting good data—a lot of the people who are ending up in ERs and in the jails are on Medicaid—how do they get there?", one interviewee queried.

Good data are needed by categories—for example, Medicaid consumers split out from the general CMHC population receiving services. These data are needed for tests of statistical significance in EQRO performance improvement initiatives and for other reasons. It was noted that coding and tracking the transaction sets allowed by HIPAA needs improvement. Several respondents commented that service data collection via encounters is not always appropriate to EBPs. Some kind of "program data" may be a much more appropriate way of judging service delivery for wraparound programs (such as Assertive Community Treatment) and prevention programs. Some services currently are falling out of the encounter data because it is not feasible to do CCARs on every

service, for example, preventive, psychoeducational and early intervention services, where consumers are put off by the data gathering and providers do not see it as time or cost-effective.

11) An Improved Substance Abuse Service Component: Several respondents noted the inadequate provider rates for substance abuse treatment services. Others commented about the lack of incentive to do the EBP of integrated treatment programming for those with co-occurring disorders, and the tendency for these consumers to get "bounced back & forth" between mental health and substance abuse providers.

Needs Also Mentioned:

12) Better Grievance Processes: Several interviewees commented that there are unresolved problems with the grievance processes, citing that some consumers continue to "fear retaliation" (via, for example, reduced access to services) if they pursue a complaint.

13) More Focus on Prevention: The need for greater focus on prevention services also was mentioned. One interviewee expressed the opinion that the current payment and data collection (CCAR) structures are obstacles to provision of such services.

14) More Focus on Evidence-Based Practices: The concept of evidence-based practices was referenced by a number of interviewees. A couple respondents specifically indicated the need to focus more explicitly on promoting and implementing EBPs, particularly since treatment outcomes need to improve across the Program. This is an area where clear direction, enforcement and incentives are needed.

15) A Better Way to Address Problems with the Fee-For-Service "Opt Out" Option: A couple respondents noted problems with a member being able to "opt out" of managed care through the FFS mechanism.

16) An Increase in the Number of People Eligible for Medicaid: This issue was mentioned by several interviewees. It was noted that in some other states, such as Massachusetts, eligibility is based on a "means test," not the presence of a disability. To convert to the means test was seen as a way to do more cost-effective preventive and intervention services, as well as ameliorate the on-again off-again gaps in coverage that present quality and continuity of care problems.

17) Reduction in the Administrative Burden on Providers, Especially Non-CMHC Providers: One recommendation was that the State require the BHOs to use the same paperwork (for example intake forms, prior authorization forms, etc.). A number of comments related to "business infrastructure immaturity", and this term was mentioned by some as a specific problem area. In addition to the problem of non-standardized paperwork among BHOs and those issues related to BHO performance and data (item numbers 1 and 10 above), problems were described in the counties with eligible individuals being assigned to the wrong BHO.

18) Reduction in the Administrative Burden on Consumers: An example offered by one interviewee was that when the CBMS system went live, "it was supposed to provide an automated notice to the State" of when an individual obtains SSI, so that Medicaid

enrollment would happen automatically. This linkage has never materialized, so it is up to the consumer to obtain Medicaid, which creates a number of obstacles for a person with mental illness. Another example offered was that there are "too many steps" for consumers in a process such as "transferring from an outside pharmacy to an inside pharmacy" (related to the implementation of formularies).

VII. External Task Force Activity
(Status as of December 2007/January 2008)

Governor's Behavioral Health Cabinet Policy Work Group

The Governor's policy staff has convened a meeting of key Cabinet members with the goal to examine the State's current mental health system and ways to enhance it. Participating agencies include: Corrections, Education, Health Care Policy & Financing, Human Services, Local Affairs, Public Health & Environment and Public Safety, as well as the Offices of State Planning & Budgeting, and Policy & Initiatives. This group has agreed to meet regularly to examine ways to better fund and coordinate behavioral health policy and services across the multiple State departments. The group has coordinated with the JHR 07-1050 Task Force which has been studying ways to accomplish similar goals. The "Behavioral Health Cabinet" meets some of the functions contemplated by the JHR 07-1050 "Commission" that was proposed to implement its recommendations. However, it does not have the much broader representation from stakeholder groups that is desired by the Task Force. The "Behavioral Health Cabinet" is in the process of determining qualifications for a staff position to assist in implementation of the JHR07-1050 recommendations.

208 Blue Ribbon Commission

The Blue Ribbon Commission for Health Care Reform was created to study and establish health care reform models for expanding general health care coverage for Coloradans and to decrease overall health care costs. Of the original 31 proposals that were submitted, the Commission selected four to undergo technical "modeling" analysis. The Commission also developed a fifth proposal of its own. The Commission includes among its guiding principles "Align incentives to provide high-quality, cost-effective and coordinated care" and "Emphasize wellness, prevention, health education and consumer empowerment".

At the time of review for this project, not all of the selected proposals clearly included behavioral health, that is, both mental and substance-use disorder benefits:

1) A Plan for Covering Coloradans (Committee for Colorado Health Care Solutions, 2007) includes parity for mental health and substance abuse treatment.
2) Healthy Solutions for Colorado (Colorado State Association of Health Underwriters, 2007) includes "drug, alcohol and wellness" program incentives, but no specific mention of mental health benefits.
3) A Colorado Health Services Program (Health Care for All Colorado Coalition and the Colorado Nurses Association, 2007) includes mental health and substance-use benefits.

4) <u>Better Health Care for Colorado</u> (Service Employees International Union and the Colorado Association of Public Employees, 2007) mentions "behavioral health services for duals" and "basic mental health services", but no specific mention of substance-use benefits.

5) <u>Proposal 5</u> (Colorado Blue Ribbon Commission for Healthcare Reform, 2008b) includes parity for mental health benefits, but no specific mention of substance-use benefits.

The Commission's November 19, 2007 draft Summary of Approved Recommendations to the General Assembly included a recommendation for parity of mental health benefits in a Minimum Basic Benefit Plan. The Final Report with recommendations was presented to the General Assembly in January, 2008. Although there were numerous recommendations relating to promotion of "evidence-based medicine", "prevention and chronic care management", "wellness and preventive behavior" and facilitation of services for people transitioning out of corrections and other settings, there was not a clear corresponding recommendation for substance-use disorder benefits (Colorado Blue Ribbon Commission, 2007; 2008a).

JHR 07-1050 Task Force

The "1050" Task Force's charge was to study mental health and substance abuse services in order to coordinate State agency efforts, streamline services provided, and maximize federal and other funding sources. The Task Force contracted with the Center for Systems Integration (CSI) to conduct national and Colorado research, provide staff support, and write the final report in partnership with NPM Consulting (NPM) and the Western Interstate Commission on Higher Education (WICHE).

One of the mechanisms the Task Force used to determine stakeholder opinions was a Q-sort survey. Among other information elicited by the survey, the results showed that most survey respondents promoted increasing substance abuse funding to be in parity with mental health funding. Also, survey participants did not want a fee-for-service model implemented more widely. The basic recommendations of the Task Force were for the State to establish:

-- a Commission with decision-making authority to implement the Task Force recommendations, "with leadership from the three branches of state government, adult and youth consumers and families, providers, and communities",
-- shared outcomes with the aim of shared funding across agencies,
-- alignment of service areas (for example, counties vs. judicial districts vs. BHO "catchment" areas),
-- joint auditing across systems,
-- joint budget planning across Departments,
-- integrated behavioral health policies, rules, and regulations (especially for mental health and substance abuse services),
-- financing reform to support an integrated system (for example consistency of rates, maximization of federal funding),
-- electronic cross-system data collection, sharing, and evaluation (including consistency of screening tools and an electronic health record),
-- cultural competency in service provision (including consistency of data collection),

-- consumer, family and youth Involvement (including development of consistent standards), and
-- workforce development strategies (including training support for "integrated" services). (McHugh et. al., 2007/2008).

Subcommittee on Medication, Housing and Public Benefits/Task Force on the Mentally III in the Criminal Justice System (TFMICJS)

This subcommittee performs as a subgroup of the broader interdisciplinary Task Force, which has been meeting for a number of years with the aim of jointly solving problems related to mentally ill individuals in the criminal justice system. At the time of review for this project, initiatives promoted by this Subcommittee included:
-- "Quick Start" legislation to assist inmates in applying for public benefits before their release,
-- a proposal to add HCPF as a member of the larger Task Force, and
-- legislation that would suspend, rather than terminate, Medicaid benefits when an offender becomes an inmate, in order to reduce the gap in health care access that occurs when benefits are terminated until reapplication. Local counties are in favor of this bill and it appears that there is significant statewide support for the initiative.

HB 04-1451 Colorado Collaborative Management Program, and the Colorado Prevention Leadership Council

Although they do not focus on Medicaid per se, these two initiatives both are designed to promote coordinated planning, implementation and evaluation of quality prevention, early intervention and treatment services for children, youth and families in Colorado. They are closely aligned. The Prevention Leadership Council has met with the executive directors of the state agencies and is working on information sharing among all agencies, crossing the lines of mental health and substance abuse treatment. There are other initiatives, including:
-- Memoranda of Understanding among various state departments to coordinate services and support "integrated" programs at the local level,
-- data sharing agreements across state departments that are needed in order to enhance long-range integrated and comprehensive planning around common priorities, and
-- engagement of key fiscal and program staff in State departments to address ways to integrate and braid funding across multiple state departments.

SB 07-211

Among other elements, this legislation ("Improvement to Health Care for Children") established an advisory committee "to develop and oversee the implementation of a plan to provide health coverage for all low-income children in Colorado by the end of 2010." It also requires HCPF to "develop clinical standards and methods for collecting, analyzing, and disclosing information concerning clinical performance", "review the data generated" and "make recommendations concerning strategies to improve health outcomes."

M.I.N.D.S.

The M.I.N.D.S. (Mental Illness Needs and Deserves Success) grassroots initiative is patterned after the successful California Proposition 63, a ballot initiative that generated millions of dollars in revenue to support services for the mentally ill, as a result of a tax on individual incomes above $1 million. Since there are ballot initiatives being considered by other groups and limited taxpayer tolerance for tax initiatives, this group has been talking with other groups in order to determine whether they will pursue an effort to get this issue on the ballot at this time.

VIII. Alternative Delivery Models

There are many health system "models" and variations on models in use throughout the nation that attempt to use managed care principles, coordinate and/or "integrate" care and improve access, quality and cost-effectiveness compared to the traditional fee-for-service approach. Every state's modifications of a conceptual "model" are dictated by their own particular state agency, delivery and benefit structures, funding situations and political environments, and so are not easily generalized (Gold & Mittler, 2000; Mauery et. al., 2006; Verdier, Barrett & Davis, 2007). While a complete inventory of other states' approaches was beyond the scope of this project, review of the literature as well as interview data produced some more general themes and information that is informative. These themes will be discussed in four sections addressing: variations on managed behavioral health care organization models, common state Medicaid managed behavioral health care models, the "carve in/carve out" debate and the role of "safety net" providers.

Variations on Managed Behavioral Health Organization (MBHO) Models

Although these features do not exhaust all possible components that vary among MBHOs, some of the key variations are found in:

-- Overall administrative oversight
-- Day to day program management
-- Direct delivery of services
-- Payment strategies

These categories are not mutually exclusive—they are used here for convenience. Most of the features can be (and are) "mixed and matched" depending on the special interests of the purchaser. For Colorado's program presently, the overall administrative oversight is provided by the Managed Care/Behavioral Health Section of the Benefits Division, HCPF, and to some extent, the five BHOs. The day to day program administration is performed by the BHOs. The direct service delivery is provided by community mental health center and other providers. The BHOs are capitated on a full risk basis for mental health services only, not substance abuse treatment services or pharmacy. [3]

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[3] Although a relevant consideration, the topic of pharmacy integration was beyond the scope of this project. However, the inclusion of pharmaceuticals in the overall capitation is a relevant one, and poses potential challenges in both "carve out" and "integrated" models.

Overall administrative oversight:

High level oversight functions typically include determination of broad program structure, policies, standardized protocols, and so on. The term "overall administrative oversight" is somewhat oversimplified, as there can be a range of high-level functions that can be considered in this category. The ultimate payer (for example, private or public company, benefits organization, state, etc.) may retain some of these functions, or may delegate all or most to another organization, most typically a national managed care firm. Almost all of the functions theoretically can be again "carved out" to yet another entity, while one organization still retains overall accountability. For example, state or nationwide provider credentialing is a function that sometimes is subcontracted to a national credentialing specialty company.

Day to day program management:

Day to day program management typically includes the managed care tools—utilization review, analysis and management; oversight for appropriate service access; outcome assessment; quality management activities; claims processing; provider network management; and related activities. As with higher level administrative oversight, some of these functions, such as claims processing, may be delegated to other organizations. There may be one statewide program management entity (vendor), or multiple entities, commonly organized by county or larger geographic regions. The program management organizations may be responsible for mental health only, behavioral health (both mental health and substance abuse services—most typical in a "carve out" arrangement), both behavioral and general medical/surgical care (without pharmacy) or "all" health care, including pharmacy. Pharmacy often is "carved out" to its own management company. With some exceptions, in the private sector, behavioral health program management has been "carved out"—with behavioral health services managed separately from general medical/surgical services management. If the management of both are "integrated", typically it has occurred within the traditional staff HMO model (for example, Kaiser and Group Health Cooperative of Puget Sound).

Direct delivery of services:

The provider network may be closely affiliated with the management organization, either because the providers are on staff with the managed care organization (the traditional staff model HMO) or because there is another organizational relationship with the managed care organization (such as the relationship between the Colorado BHOs and CMHCs). More commonly (especially in the private sector), there is organizational independence between the managed care organization and the providers of care. With some exceptions (usually in inpatient medical settings), most often the behavioral and general medical service locations have been separate, regardless of the presence or absence of managed care.

Payment strategies:

The managed care organization may be paid in one or more of several ways:
Administrative Services Only (ASO): On an Administrative Services Only (ASO) basis, the organization is paid a defined amount for administrative services and takes no

financial risk for the cost of services, which remains with the payer. In some ASO arrangements, the vendor may risk a portion of its administrative fee, or have incentive bonuses (or penalties) related to certain performance requirements.

<u>Full Capitation:</u> In this arrangement, the managed care organization assumes the financial risk for all service costs. Administrative fees typically are rolled in to the capitation payments.

<u>Shared Risk, "Soft Capitation" and Risk "Corridor" Arrangements:</u> In these arrangements, the managed care organization assumes partial risk for services, but has protection against losses over a certain amount. The organization also may share in financial margins/profit.   The financial risk may be shared on a straight percentage or graduated basis. In arrangements that present risk, there may be "stop loss" provisions. That is, when the organization's financial losses reach a certain limit, the organization is no longer liable for the expense. It reverts to the payer and/or stop-loss insurance.

Providers may be paid through a subcapitation, case rates (partial risk arrangement), or on a discounted fee-for-service basis, or they may be employed by the managed care organization.

Regardless of the structural differences, managed care features include tools such as a selected contracted provider network, a contracted full continuum of care (and impetus to develop or enhance this continuum if it is inadequate), utilization review, case/care/disease management, overutilization/underutilization analysis and strategies to address them, expectations for 24/7 access, coordination and/or integration mechanisms and strategies with general medical health care, specific accountability for outcomes (usually in the form of clearly delineated performance benchmarks, such as telephone Abandonment Rates, Average Speed of Answer, etc.) and cost-effectiveness (that is measured) as a result of application of these tools.

Common State Medicaid Managed Behavioral Health Care Models

The models described below do not include all variations that exist in the states, and not all states have managed Medicaid behavioral health care. Rather, they are general models that appear to be most typical of the basic structures being used (with numerous idiosyncratic variations). This information is abstracted primarily from the USDHHS, HRSA 2004 Partial Update to State by State Profiles "Medicaid Funded, Public Sector, Managed Behavioral Health Care Payors[sic]" and Gold and Mittler's (2000) analysis of behavioral health care structures in seven states with Medicaid managed care systems. While undoubtedly there have been some changes in the past several years, they would be unlikely to dramatically affect this summary of basic models at this point. Some states are working on pilots and many states are working on versions of "transformational" systems. These initiatives may affect their models in the future.   It is worth noting that stable "[m]anaged care plans experience a learning curve, with improved performance over time" (Sturm, 2000, p. 1).

Basic Medicaid managed behavioral health care state models today include:

1) **Integrated:** The state capitates general health managed care organizations (MCOs), which are responsible for the provision of all health care, including behavioral health, within the same overall organization, with the ability to consolidate all health care data.

2) **"Carve in":** The state capitates general health MCOs, which may subcontract to a specialty managed behavioral health organization (MBHO). This model only would be rightly termed "integrated" if there were a common information (or electronic feed or data warehouse) system and shared risk between the organizations.

3) **Mixed:** Limited behavioral health services are integrated within the general health MCO, but specific populations are carved out to a MBHO specialty organization.

4) **"Carve out":** The state capitates general medical/surgical health care to general medical MCOs and behavioral health care to one or more MBHO(s), with mechanisms of collaboration between the organizations. Most typically, the MBHO "carve out" is: a) one statewide vendor, or b) regional vendors that may include locally-based and/or national vendors, or c) county-based systems.

5) **Managed Fee-for-Service:** The state implements a number of managed care tools, typically through a contract with a managed behavioral health care vendor, and pays providers on a traditional fee-for-service basis.

The role of primary (medical) care physician (PCP) case management may constitute a variation on some of the models above, for example, there may be a primary care "gatekeeper" who must make the referral to specialty behavioral health care services. Because this approach was seen as a barrier to appropriate access, this model has become less prevalent. Variations also occur in the states with regard to whether substance abuse services are "integrated" within the general medical/surgical health plan or within behavioral health plan. States differ as well in the extent to which they include community mental health centers in capitation arrangements, primarily due to concerns about their ability to manage financial risk (Mauery et. al., 2006).

The "Carve In/Carve Out" Debate

The question of how to best align, coordinate and/or integrate general "physical" and behavioral health management and services is an important one, given the known interplay between them. This interplay manifests itself in the well-documented effects of psychological and behavioral factors on general "physical" health, the array of chronic "physical" medical problems experienced by consumers with mental and substance-use disorders and the consistency with which behavioral health problems present and are treated within primary medical care settings, as well as the strong behavioral component in maintaining "wellness" and general medical regimen adherence. While not all behavioral interventions necessarily do so, there is a substantial literature on the medical cost offset associated with some well-managed and delivered behavioral health services (Blount et. al., 2007; Levant, et. al., 2006).

"Carved out" specialty managed behavioral health care organizations developed originally as a way to focus expertise on behavioral health in a way that typically did not occur in a general MCO. "Carve outs" had the benefit not only of specialized professional expertise, but also were able to protect the behavioral health benefit to a certain degree, often expanding benefits and service options. Over time, national specialized MBHO's became more operationally and financially successful.

As competition in the managed health care marketplace has placed more pressure on premiums and on general health MCOs to achieve efficiencies, and as MCOs have desired to have more control over all their expenditures, information, and processes, some began to re-examine the "carve out" methodology. The term "carve in" originally was used by MBHOs to refer to new ways of aligning and coordinating the behavioral health services with the general "physical" health MCO, while maintaining the viability of the MBHO. The term also is used by some to refer to a "re-integrated" HMO, that is, one that manages and provides behavioral health as well as general "physical" health services within one organization (although typically still in two separate operational units which may or may not use the same information system).

To restrict the discussion to merely a "carve out" or "carve in" dichotomy can be oversimplified, as there are a number of levels at which general "physical" and behavioral health care can be coordinated and/or "integrated":

Administrative—As one example, only one organization may be accountable and capitated for all services, and maintain the overall structure to manage all care. The organization may manage and even provide all the care, or there may be one or more close contractual partnership(s) with associated organizations, using formal Mixed Services, Shared Care and/or multidisciplinary Disease Management Protocols. There may be joint activities such as shared incentives and outcome measures.

Structural—For example, all the organizational features above may be present, but there also may be one claims system that enables one to look holistically at the costs of a case, one electronic medical record that enables collaborative information sharing among team members, one medical "home" etc. If there is one capitation, or a shared capitation, this setting can be the easiest one in which to pay providers on a service, rather than diagnostic, basis (although the benefit plan still can have a list of covered and non-covered diagnoses).

Service Delivery—At the point of service, all care is coordinated through mechanisms such as:
-- co-location of general medical and behavioral health personnel
-- integrated treatment teams
-- consultation/liaison services
-- joint practitioner case conferences, Grand Rounds, and other training
-- integrated practice guidelines
-- a joint medical record
-- easy communication and referral mechanisms, and consultation "hotlines"
-- provision of "behavioral medicine" services, and
-- other ways to deliver holistic health care.
Compliance of health care providers is essential and can be difficult to obtain in practice due to cultural practice differences, segregated academic training programs, identification with separate professional guilds, and other issues.

From administrative and structural standpoints, the literature exposes a range of views on the advisability of fully "integrating" behavioral managed care within a general medical managed care organization or "carving" it out. Potential advantages of the "carve out" are seen as:
▪ Greater behavioral care management expertise
▪ Protection and better accountability of funding for behavioral care expenses

- Expanded treatment service continuum, especially for higher needs consumers, for example, adults with serious and persistent mental illness and children with serious emotional disturbance
- More likely coordination with other non-health systems, such as social services and juvenile justice
- Greater consumer orientation

Potential disadvantages are seen as:
- Higher administrative costs[4]
- Problems coordinating care across separate health care systems
- Issues of accountability for neurologically related diagnoses for which the services of choice often are behavioral management (rather than treatment), even in the presence of Mixed Services or Shared Care Protocols

Potential advantages of the administrative and structural "integrated" model are seen as:
- Lower administrative costs[5]
- Less stigma for consumers obtaining behavioral health care services
- Greater ability to view holistic data related to the complete care of a consumer
- A simpler system for consumers to navigate
- Simpler ways to construct joint financial incentives

Potential disadvantages are seen as:
- A risk of losing hard-won improved behavioral health benefits and focus on behavioral health
- A lack of sufficient specialized behavioral health and related expertise
- Privacy issues for behavioral health care consumers who may not wish all their health care information to be shared by all their providers

(Gold & Mittler, 2000; Mauery et. al., 2006; Olfson et. al., 1999; Rothbard et. al., 2002).

The 2000 SAMSHA State Survey from the Health Care Tracking Reform Project (Stroul, Pires & Armstrong, n.d.) noted that at that time, there were significantly more carve out than integrated models being used by the states. Among the various models, there was an increasing trend to use for-profit managed care organizations. "Community-based, nonprofit agencies [were] the least likely type of entity to be used as MCOs (p. 3)." Among other differences, carve outs were more likely than integrated plans to: include broad service coverage, include home and community based services, have expanded service availability, include system of care values, use funding streams from multiple agencies, tie bonuses or penalties to performance related to behavioral health care, have improved access, use alternatives to hospitalization, focus on cultural competence, and involve families. Their study found "little difference" between carve outs and integrated plans with respect to coordination between physical and behavioral health care.

Gold and Mittler (2000) studied seven states with Medicaid managed care, and performed more in depth analyses of three with behavioral health carve outs (Maryland, Tennessee and Oregon). They concluded:

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[4] To rightly evaluate this issue, one needs to consider the inverse relationship that can occur in managed care between administrative and service costs. For example, utilization management activities can produce administrative cost, but at the same time lower direct service costs.
[5] See Footnote 4.

> In all three States, coordination across separate systems for medical and behavioral care created problems for people. In two (Maryland and Oregon), there was the further challenge of coordinated mental health (the carve out) with chemical dependency (not carved out). Maryland also had to coordinate "primary" and specialized mental health services.

> But State policy, even within a carveout, will influence how easy it is to coordinate care for people. Designing financial incentives to encourage rather than discourage coordination is important (p. 97).

The authors describe a number of strategies and tools that can improve coordination, such as aligned financial incentives, shared care protocols, physician orientations and provider "crosswalks". They note, however, that confidentiality issues, "program-specific data systems that can't 'talk to each other'" and other "data constraints" present impediments to coordination. LaBrie et. al. (2007) stress the importance of "integrated" assessment and outcomes measurement tools that look at overall, rather than only behavioral or general medical, health.

From their study of carve in vs. carve out managed behavioral health care plans, Sabin & Daniels (1999) concluded that debate on this topic is not helpful nor particularly relevant, stating:

> Anyone who has practiced in a solo fee-for-service setting…knows that with a modicum of effort, it is possible to collaborate with general health clinicians, the social service sector, and other key participants in the care process. Anyone who has practiced in an integrated setting…knows that it is possible for clinicians in adjoining offices to collaborate poorly (p. 1280).

A survey report produced for The Robert Wood Johnson Foundation (Edwards, Garcia & Smith, 2007) looked at thirteen different state initiatives that are designed to better coordinate and "integrate" the delivery of behavioral and general medical/surgical services. Their findings show that states have a wide range of such approaches. However, on the basis of their survey, they conclude that the more successful initiatives

> were able to either connect financial costs and resultant benefits within a single health care payer or to broaden the range of participating stakeholders beyond health services payers. The latter approach connects services beneficiaries (i.e., clients) with an array of systems funders (i.e., law enforcement, criminal justice, social services, etc.) and allows all stakeholders to realize or anticipate a return on their investment in integrated services (p. 1).

In summary, there is no clear consensus on the whether it is preferable to "carve in" or "carve out" behavioral health from administrative or structural standpoints. However, there is consensus on the importance of the use of formal mechanisms to more closely align, coordinate, and "integrate" the delivery of behavioral and general medical/surgical care. It also appears that financial mechanisms greatly enhance the likelihood and sustainability of successful collaboration and integration.

Role of "Safety Net" Providers

Some authors and interviewees have expressed concern about certain managed care arrangements with respect to potential adverse effects on the traditional public sector

"safety net" providers that historically have been the primary health care resource for high needs individuals without insurance or other funding. Lewin & Altman (2000) have voiced concerns about the potential for such arrangements to shift funding away from "core safety net" providers such that they might find it difficult to remain financially viable, especially in combination with increasing numbers of uninsured individuals, erosion of other funding streams and relative lack of familiarity with a competitive health care environment. The authors warn that

> failure to take into consideration the impact on safety net providers of changes in Medicaid policy could have a significant negative effect on the ability of these providers to continue their mission to serve the uninsured population, particularly those who move back and forth between being eligible for Medicaid and being uninsured (p. 9).

It also is important to consider how stable the Medicaid provider market is generally (regarding the "entry and exit" of health plans) and what effect this "churn" can have on Medicaid beneficiaries, particularly those with complex needs. Similarly, Colorado's Blue Ribbon Commission on Health Care Reform (2008a) has expressed a need for careful consideration of the role of the health care "safety net" providers in any health care reform implementation.

IX. Selected State Program Innovations

Many promising state behavioral health care innovations have been reported in the literature, presented at conferences and were noted by interviewees for this project. The literature review that informed this project resulted in a list of approximately twenty states that various authors presented as having implemented innovative and/or successful programs, or aspects of programs. Interview respondents were asked their views on other states that they thought "really do Medicaid managed behavioral health well". Many of the respondents had prior access to State presentations and/or their own research on this issue, and offered their opinion. However, the opinions of the interviewees varied significantly, and there was no clear consensus on the states selected. Sometimes a state was referenced as a leader by a respondent or author, and then mentioned as a problem state by another.

Understandably, choice of states was influenced by the particular interest of the respondent and their organizational affiliation, for example, whether the interviewee was especially interested in a focus on consumers, preserving "safety net" providers, braided/blended funding, and so on. Respondents did not necessarily discriminate among innovations that related specifically to HCPF's Managed Behavioral Health Services Program as it exists today, versus those that were funded by other or multiple sources, versus those that were "transformational" of an entire state behavioral health care system. Examples were given that illustrated innovations in coordination of care, payment arrangements, uses of multiple funding sources, evidence-based practices, services for specific populations, and interagency initiatives. Consumer advocates tended to emphasize consumer initiatives, BHO leaders tended to emphasize program systemic issues, HJR07-1050 Task Force members tended to emphasize broader state "transformational" efforts, and so on. Consequently, information on other states that was gathered from the literature and interviews for this project was used for its usefulness in strengthening convergent data from other sources.

Perlman and Dougherty conducted a quite comprehensive and methodologically sophisticated review of state behavioral health innovations. While the information gleaned from their study is not specific to Medicaid, many of the findings have convergence with other data sources, including information on trends in managed behavioral health care, and have potential applicability to the Program. The report summarizes 17 behavioral health care innovations being implemented in different states that aim to improve the delivery of behavioral health services. Information was gathered from a number of sources, including an array of "expert informants".

The innovations focus primarily on purchasing and quality improvement initiatives in the areas of:

- Enhancement of consumer-centered care, such as New Jersey's "Consumer Connections" that recruits and trains mental health consumers to be providers of mental health services on a paid or volunteer basis; Georgia's "Certified Peer Specialist" training program that results in Medicaid-reimbursed services; and Florida's Self-Directed Care initiative, administered by a county National Alliance on Mental Illness, that establishes "mental health spending accounts" for consumers;
- Criminal justice/mental health collaboration, such as Ohio's statewide jail diversion projects;
- Systems integration, such as New Jersey's use of a contracted national system administrator and pooled funding to provide single-point access for children needing mental health services; New Mexico's Behavioral Health Purchasing Collaborative (a "virtual" department across agencies providing behavioral health services); and the State of Washington's Medicaid Integration partnership, which blends behavioral health, primary care and long-term care services for Snohomish County in a model that is anticipated to become statewide;
- Use of performance incentives, for example, Delaware's performance-based contracting for substance abuse services; Kentucky's use of state funds to implement provider performance incentives to improve data integrity and collection and establish greater awareness of evidence-based practices; and Oregon's process to implement the use of evidence-based practices after the passage of legislation requiring increased proportions of funding for EBPs;
- Quality improvement, for example, the establishment of the State of Washington's dedicated Research and Data Analysis Division; Iowa's work with the Network for the Improvement of Addiction Treatment to decrease wait time for services (and other improvements); and Oklahoma's use of the "walk-through" technique to trigger systemic improvements in substance abuse treatment;
- Other initiatives, such as Tennessee's collaboration to create permanent housing for individuals with mental illness; Minnesota's establishment of a broad-based coalition of agencies to begin system transformation; California's Proposition 63, which taxed personal incomes above $1 million to provide for more adequate mental health funding; and Wyoming's implementation of a Medicaid "health management" program (Perlman & Dougherty, 2006).

Mauer (2006a) has reviewed a number of state program behavioral health/primary care initiatives, including North Carolina's and Massachusetts' pilots involving collaborations between general medical Community Health Centers and Community Mental Health

Centers. Similarly, Edwards et. al. (2007) review various state models of publicly funded coordinated and "integrated" behavioral/general medical health services programs (not solely Medicaid-funded). They review a number of "critical success factors" and conclude that "[t]rue integration of services can occur no sooner than integration of financing for the services" (p.8). Six examples of state program initiatives from the states of Arizona, Massachusetts, New Mexico, Texas, Washington and Wisconsin are profiled in Appendix C.

X. Managed Behavioral Health Care (MBHC) Vendors[6]

A summary of vendors that manage behavioral health is presented below, with relevant Colorado Division of Insurance (DOI), Department of Regulatory Agencies (DORA) status and URAC and/or NCQA status as identified on these, or the MBHC, websites.[7]

Current Local MBHC Vendors

Access Behavioral Care (ABC)/Colorado Access—Nonprofit subsidiary of Colorado Access, a general health plan that provides care for medically underserved populations. Behavioral health care is "carved out" to the ABC subsidiary for the Mental Health Services Program, and in limited cases "integrated" in the general medical plan. Sponsored by The Children's Hospital, Colorado Community Managed Care Network and University of Colorado Hospital/University Physicians, Inc. Listed by DOI/DORA as an authorized insurance company—HMO Medicaid and Health Maintenance Organization. ABC serves Denver County for the Program, primarily through a contract with Mental Health Center of Denver, a CMHC.

Behavioral HealthCare, Inc. (BHI)— Nonprofit "carve out" MBHO that uses Community Reach Center, Aurora Mental Health Center, and Arapahoe/Douglas Mental Health Network as BHI's primary providers. Listed by DOI/DORA as a Limited Service Licensed Provider Network (LSLPN) and "Mental Health Services Medicaid". Serves Adams, Arapahoe and Douglas counties for the Program.

Colorado Health Partnerships LLC dba Colorado Health Networks (CHN)— Nonprofit "carve out" MBHO comprised of eight CMHCs and ValueOptions, and includes three provider owned LLCs: Pikes Peak Medicaid LLC, SyCare LLC and West Slope Casa LLC. Listed by DOI/DORA as an LSLPN; URAC accredited for Health Utilization Management. Serves Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Otero, Park, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit and Teller counties for the Program.

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[6] Information presented relies on what was accessible from the accreditation websites and "front pages" of the MBHO websites in January, 2008. Consequently, it represents a "snapshot" of the various organizations and is not intended to be a comprehensive description of each organization.
[7] URAC is the former Utilization Review and Accreditation Commission (www.urac.org). NCQA is the National Committee for Quality Assurance (www.web.ncqa.org). HIPAA-related NCQA accreditations are not included in this summary.

Foothills Behavioral Health LLC (FBH)— Nonprofit "carve out" MBHO owned by two nonprofit providers of mental health services, The Mental Health Center serving Boulder and Broomfield Counties and Jefferson Center for Mental Health. Listed by DOI/DORA as an LSLPN. Serves Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties for the Program.

Northeast Behavioral Health LLC (NBH)— Nonprofit "carve out" MBHO owned by three nonprofit community mental health centers. Listed by DOI/DORA as an LSLPN. Serves Cheyenne, Elbert, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld and Yuma counties.

Other Vendors

National "Carve Out" MBHC Companies:

American Psych Systems. Inc.—Privately owned, for profit specialty healthcare company with major product lines of behavioral health and disease management services. The Public Programs division delivers specialty healthcare administrative services to support utilization management, disease management, behavioral health, EQRO and other quality improvement endeavors across a diverse set of beneficiary populations. Currently not listed with DOI/DORA.

Magellan Health—National publicly held for profit "carve out" BHO with behavioral health, radiology benefits, and specialty pharmacy management programs. Array of managed behavioral health and employee assistance (EAP) products, with a Public Sector division. Currently not listed with DOI/DORA. Various service sites accredited by URAC for Case Management and NCQA as a Managed Behavioral Health Organization (MBHO).

ValueOptions—Privately owned, for profit MBHO that provides a range of managed behavioral health products. At present, contracts with CHN in Colorado to provide certain administrative services. Currently not listed with DOI/DORA. URAC accredited for Health Utilization Management and NCQA accredited as an MBHO.

Health Plan Companies with "Carved Out" Behavioral Health Subsidiaries:

Cenpatico/Centene—MBHO subsidiary of for profit, publicly traded Centene Corporation that specializes in focused case management for high-risk populations such as Medicaid, SCHIP and SSI. Products include capitated behavioral health programs, and "carved out" administrative services such as utilization management, network development, credentialing, physician reviews & after hours support/crisis services. Holds URAC Health Plan accreditation. Currently not listed with DOI/DORA.

CIGNA Behavioral Health/CIGNA—CIGNA is a publicly traded for profit company listed by DOI/DORA a Health Maintenance Organization. NCQA accredited in Colorado as Commercial/HMO/POS Combined. URAC accredited in some locations. Appears to serve only employer plans. Plans to purchase Great-West Healthcare of Colorado in 2008.

Harmony Behavioral Health, Inc. (HBH)/WellCare— Publicly held, for profit group of plans that provide services to government-sponsored healthcare programs, focusing on Medicaid and Medicare. Behavioral health subsidiary, HBH, is URAC accredited, and provides services for the WellCare group of companies serving Medicaid, Medicare, CFC, ABD and SCHIP members. HBH is URAC accredited in Florida for Health Utilization Management.[8]

United Behavioral Health (UBH, now OptumHealth Behavioral Solutions)/United Healthcare (UHC) of Colorado/ PacifiCare— Publicly held for profit "carve out" with a range of managed behavioral health care products including capitated and ASO products, EAP and "integrated" DM. Listed by DOI/DORA as an authorized insurance company—HMO Medicaid (UHC) and Health Maintenance Organization (UHC and PacifiCare). Various UBH/OptumHealth Behavioral Solutions locations have accreditation from NCQA and/or URAC. PacifiCare and United Healthcare are NCQA accredited in Colorado as Commercial/HMO/POS Combined, and PacifiCare is also NCQA accredited as a Medicare/HMO.

Wellpoint Behavioral Health/Anthem BCBS/Wellpoint Health Networks—Anthem BCBS is listed by DOI/DORA a Health Maintenance Organization; URAC accredited in Colorado for Health Utilization Management. Wellpoint Behavioral Health serves BCBS plans.

Health Plans with Other Models, Including "Integrated" and "Carved In":

This list is not comprehensive, as a number of companies are listed as "Multiple Line" types with DOI/DORA. Plans may or may not serve Medicaid beneficiaries. Also, it is not readily apparent from some plans' websites exactly how they handle behavioral health services.

Aetna Health Inc.—Listed by DOI/DORA as an authorized insurance company—HMO Medicaid and Health Maintenance Organization. NCQA accredited in Colorado as Commercial/HMO/POS Combined.

Amerigroup Community Care—Specializes in health plans for persons enrolled in Medicaid, SCHIP or Medicare.   Also developing new products for individuals and/or families who may no longer quality for Medicare or Medicaid and become uninsured. NCQA accredited for Disease Management, and as a Medicaid/HMO in one location.

Colorado Choice Health Plans—Listed by DOI/DORA a Health Maintenance Organization.

Great-West Healthcare of Colorado Inc.—Plan to be purchased by CIGNA in 2008. Listed by DOI/DORA a Health Maintenance Organization. URAC accredited in Colorado for Case Management (provisional) and Health Utilization Management.

Denver Health Medical Plan—Listed by DOI/DORA as an authorized insurance company—HMO Medicaid and Health Maintenance Organization.

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[8] A 1/25/08 company press release announces the that company recently replaced the Chairman & CEO, while the former CEO, CFO and General Counsel have resigned, corresponding with federal and state investigations of the Florida operation.

HMO Colorado, Inc.—Listed by DOI/DORA as an authorized insurance company—HMO Medicaid and Health Maintenance Organization. NCQA accredited in Colorado as Commercial/HMO/POS Combined.

Humana Health Plan—Listed by DOI/DORA as a Health Maintenance Organization.

Kaiser Foundation Health Plan of Colorado—Listed by DOI/DORA as an authorized insurance company—HMO Medicaid and Health Maintenance Organization. NCQA accredited in Colorado as Commercial/HMO/POS Combined and as a Medicare/HMO.

Molina Healthcare, Inc.—Specializes in health plans and primary care clinics for Medicaid, the Healthy Families Program, SCHIP and other government-sponsored health insurance programs. Not listed by DOI/DORA. NCQA accredited for Medicaid/HMO in various states. URAC accredited as a Health Call Center.

Rocky Mountain Health Maintenance Organization, Inc.—Listed by DOI/DORA as an authorized insurance company—HMO Medicaid and Health Maintenance Organization.

XI. Conclusions & Recommendations

Taking information from these various sources, what might one conclude about the next steps for the Mental Health Services Program? Some observers have noted that the Program and the BHOs "have come a long way in three years". However, there are still many basic areas of the Program that can be strengthened, especially in areas related to basic "business" processes and functions, such as more standardized processes and performance across the State, systems to promote accountability of performance, and data and payment systems.

Examination of other states' activities can be useful to identify national trends and examine their experience with certain programs and tactics, such as success or failure in the implementation of evidence-based practices, braiding/blending funding, and so on. But, largely because other states' models have a great degree of variability (largely due to the particular political influences of each state), more immediately practical guidance may come from convergent data from sources that have a closer and more intricate knowledge of Colorado's Program. Audit reports in particular provide information that is immediate and pragmatic. Interviewee and task force reports incorporate Colorado stakeholder views and include the effect of Colorado's particular political exigencies to a great degree.

The following recommendations are drawn from all sources of information gathered during this project, but emphasize national trends, audit findings, and interviewee input. The recommendations vary in terms of the likely amount of resources that are needed to implement them, and the anticipated timeframes in which they can be implemented. It will be important to consider what immediate or intermediate steps taken now can improve the Program, as well as pave the way for longer term initiatives. Conversely, consideration should be given to actions that are important to avoid now, so as not to create obstacles to the accomplishment of desired longer term initiatives.

Recommendations:

1. **Establish clearer, more specific BHO contractual performance requirements and consequences for meeting or not meeting them.**

   The area of "BHO accountability" was the most frequently expressed concern of interviewees and the most commonly noted area for attention in the audit reports. An increased focus on the development of clear and specific standards, meaningful performance measurement and action-oriented oversight is needed. The clearer the specifications that are set ahead of time by the Department, the easier it will be for the vendors to perform well (Savela, Robinson & Crow, 2000). Implementation of measures typical of national standards may help to inform longer term strategies (such as the "1050" recommendation to move to more standardized outcome measures across State programs). BHO representatives typically desire clearer, more specifically defined expectations, such as clarification of service definitions (for example, covered vs. alternative services, peer services) and billing requirements.

   Priority areas that have been identified for more specific performance standards include:
   --provider credentialing and delegation,
   --adequacy of provider access and timeliness of service delivery,
   --utilization and care management processes,
   --telephone access standards,
   --complaint, grievance and appeal processes,
   --peer service delivery,
   --accountability for the "BHO portion of HCBS services" and for appropriate case management when another provider system is involved,
   --service documentation, and
   --implementation of a more standardized set of evidence-based practices that are determined to be highest priority for cost-effective care.

   In addition, expectations of how savings, margins or profits are to be used need to be clear. For example, what is an acceptable balance between administrative and direct service costs? If there are savings from a specific program, how are the savings to be used? Such questions will become more important as HCPF returns to Medicaid managed care for general health care, and as there are better mechanisms to track general medical and surgical cost savings that accrue from the delivery of behavioral health services.

   Specific performance requirements should be aligned with those from other State systems as much as possible, especially Behavioral Health Services, DHS.

2. **Related to recommendation # 1, establish a process to achieve greater statewide consistency of Program standards and processes, and a method for systematic monitoring of performance.**

   In order to be meaningful, the Benefits Division must have a consistent statewide oversight process and structure to apply well understood and timely consequences if BHOs meet, do not meet or, ideally, exceed, the standards. The Division should select the priority areas for immediate improvement and

assess how resources can be allocated to enforce the standards. This assessment might include a reevaluation of the type and volume of tasks now being performed by current staff, the potential need for additional personnel and the probability of obtaining them, and the pros and cons of contracting with a statewide or national managed care organization that has these types of structures and processes already established. Enforcement mechanisms need to be clear to the BHOs and CMHCs, for example, how incentives and penalties would be calculated and applied.

3. **Make meaningful data collection and analysis a priority.**

All project information sources emphasized the intense need for valid data collection and analysis with regard to the amount and type of services delivered, program planning, trend projection and valid rate setting. A method to collect all relevant service data is needed. As long as encounter data comprise the basic method, the accuracy and completeness of these data are critical. For services that do not lend themselves well to encounter data (for example certain prevention services, services to homeless individuals and certain wraparound programs), explore other possible methods of collecting information on services delivered in order to capture these aspects of the Program.

It has been recommended that a benefits and billing manual be written to provide clear and specific guidance for providers about what & how to bill. This tool could help with data completeness, accuracy and standardization (Mercer, 2006).

In collaboration with Behavioral Health Services, DHS, determine the essential, core elements of performance information, and reduce the number on which providers are required report to these key elements. If nothing significant is done with a data element, eliminate it.

Make formal quarterly data analysis an explicit and critical component of Program management. Data should include key performance indicators such as cost and utilization data, as well as quality indicators such as access benchmarks. The number of key indicators should be limited to a manageable array of variables that illustrate the functioning of the primary, most important aspects of Program functioning. Consistent analysis would result in identification of trends, problem points with actions to address them, and overall Program planning.

4. **Establish a consistent, structural way to work collaboratively with Behavioral Health Services, DHS, on areas of similar accountability and where synergies and efficiencies might be created.**

This need is described consistently in the literature, audit reports and by interviewees. Interviewees typically noted that the "tone" of the Department has become more open and collaborative. Yet they still mentioned a need for more action in this regard. Colorado has been identified nationally for being a "lower collaboration" state with regard to links between Medicaid and mental health agencies, defined by the relative absence of regular meetings between agency directors, weekly meetings between agency staff, the number of "very influential" work groups in which each agency participates, and links between data sets

(Verdier, Barrett & Davis, 2007). Given limited resources and the sheer volume of State initiatives and common interests, Division management will need to carefully determine which such meetings are truly "value added."

Attempt to align contracting, performance standards, rate setting & audits as much as possible with other behavioral health care systems, beginning with Behavioral Health Services, DHS, due to the shared provider system. This task will be challenging, given that BHS has similar issues with its "nonintegrated" divisions and provider networks, as well as variability in contracts, standards and processes for mental health and substance abuse services.

5. **Continue efforts to improve Medicaid funding for substance abuse services and incorporate managed care methodologies in its administration. Develop a work group to make recommendations with regard to the administrative and programmatic "integration" of substance abuse services.**

Recently HCPF has submitted a budget request to increase provider payment rates for the recently established substance abuse benefit. A work group could explore how to best "integrate" these benefits with the mental health benefits in order to facilitate more appropriate treatment for the large group of individuals with co-occurring disorders. In addition to others, the work group should include representatives from both the BHOs and the managed service organizations (MSOs, which manage the provision of alcohol and drug abuse services for BHS). Correspondingly, it would be prudent to establish performance measures related to the success of such an integration.

Similar to the "safety net" issue for mental health providers, certain providers in the substance abuse treatment community might appropriately be termed "safety net" providers. Consequently, they may need similar consideration as has been granted to the mental health center providers. Finally, the Benefits Division should watch closely the outcomes of the Behavioral Health Services' (DHS) recent Federal grant to implement a voucher system for substance abuse treatment.

6. **Establish more substantial and consistent mechanisms for increased consumer and family input into Program development and evaluation, particularly at the service delivery (CMHC/BHO) level.**

Set clear expectations with the BHOs that they have effective mechanisms for consumer and family input. With the BHOs, evaluate the potential for establishment of consumer and family advisory boards or councils, separate from the "professional" advisory boards at all CMHCs and high volume clinics. Members could be nominated from neutral groups such as Mental Health Colorado and go through an application process to help with selection. With consumers and families, evaluate the effectiveness of the current Program consumer advisory boards and other mechanisms for involvement in Program development and evaluation at the Division level. Determine whether there is effective distribution of information to the community about such mechanisms that already exist.

Identify peer services with good potential to improve care and cost-effectiveness of care, and determine how these services can be made more accessible across the provider networks. With DMH/BHS, establish peer service credentialing standards.

7. **Allow suspension rather than termination of benefits while inmates are incarcerated and support the "Quick Start" initiative being pursued by the Subcommittee on Medication, Housing and Public Benefits/TFMICJS in order to promote the timely re-establishment of Medicaid benefits after release.**

   This change can help prevent predictable relapses and downstream higher costs due to interrupted behavioral health care.

8. **Until the feasibility of a plan for more comprehensive "integration" of behavioral health and general medical/surgical health is assessed, increase the focus on meaningful collaboration among mental health, substance abuse and general medical/surgical service administrators and providers.**

   a. **Establish clear requirements of MCO, BHO and substance abuse treatment providers regarding care management and collaboration across service settings. Include performance measures specifically related to the effectiveness of general medical/surgical and behavioral health coordination for both general medical MCOs and BHOs.**

   b. **Investigate the potential impact of implementation of the CPT "Health and Behavior Assessment and Intervention" billing codes.**

      Federal reimbursement for health and behavior assessment and intervention services is drawn from monies for medical and not behavioral health services. Yet there may be cost-effective ways to use these codes for BHOs that have established good collaborative working relationships with their medical/surgical provider counterparts, and that can identify properly trained and oriented staff to provide these services.[9]

   c. **Establish clearer Shared Services Protocols for the effective delivery of services for autism, traumatic brain injury and fetal alcohol syndrome.**

      Continue to refine the "BHO practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD)" put into effect by HCPF June 7, 2007. Have a formal mechanism to evaluate the effectiveness of these protocols that includes direct involvement of consumers and families.

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[9] In the event that BHOs do not have this capability or relationship with the MCOs, the Program potentially could benefit from the MCOs incorporating these health care professionals into their own staff.

      d. **Provide incentives for BHOs and MCOs to co-locate their providers in high volume service settings.**

      e. **Investigate what capabilities the current IT system has to track medical cost offsets from specific behavioral medicine programming, with consideration of how identified savings should be used.**

      The Division needs a way to determine the effectiveness of these services, the financial efficiencies produced, and where the savings are applied.

9. **Consider alternative BHO structures for addressing complaints and grievances, with greater arm's length from the CMHCs. Evaluate the feasibility of other potential mechanisms to address the conflict of interest perception of CMHC controlling interests in BHOs.**

10. **Evaluate how the Department might become a stronger advocate with CMS for rational Medicaid programming.**

CMS still bases many of its requirements on the fee-for-service model, and has not kept pace with the flexibility needed to implement EBPs. Determine the resources that would be needed to pursue elimination of obstacles to care continuity and collaboration, such as the IMD exclusion (since there is a precedent for this change in the action taken by the Commonwealth of Massachusetts) and critical evaluation of rules such as "Patients who require both psychiatric service codes (i.e., 90801–90899) and the new health and behavior codes cannot receive both types of service on the same day" (Noll & Fischer, 2004).

11. **Begin a standardization process among BHOs, MCOs and BHS, DHS with regard to paperwork such as consent forms, prior authorizations, and other common paperwork and processes.**

This effort could be a longer term one, since in most cases, the forms are automated and, to varying degrees, interactive with the business functions of each of the five BHO organizations.

12. **Explore whether there are CMS-allowable ways for Medicaid Program services to be used to bolster housing supports for Medicaid recipients who are, or who are at risk of becoming, homeless—a situation that interrupts the most effective use of Medicaid (and other) resources. Research how Medicaid services might be used to bolster more comprehensive "wraparound services."**

Solicit input from selected BHS/DHS and BHO representatives about the potential use of "alternative" services.

13. **Establish an implementation plan for an integrated information technology system that can share data across behavioral health—both mental health**

and substance abuse—and general medical/surgical care organizations that serve Medicaid recipients.

True "integration" (case finding, coordinated care, disease management, assessment of cost-effectiveness, etc.) is greatly enhanced by a common data system. Begin by assessing the capabilities of the current HCPF IT system that supports Medicaid general medical, surgical, behavioral and pharmacy services, for example whether data from these various Medicaid health care components can be consolidated in management reports, such that important data relationships can be identified (such as correlative precursors to emergency room visits).

14. **Work toward a Statewide "integrated" model for general medical/surgical and behavioral health care.**

At the highest level, evaluate whether it is necessary for general medical and surgical care funding always to be separated from behavioral health funding in the State budget. Combining the funding could provide greater flexibility for HCPF to manage health care costs for the "whole person" and simplify the issue of medical cost offsets in general medical and surgical care that accrue from behavioral health interventions. Keep apprised of other states' successes and failures in similar efforts, beginning with the State of Washington initiative (summarized in Appendix C).

A broader service-based initiative would need to be staged, guided by strategic and implementation plans, to:
-- provide incentives both for BHOs and MCOs to collaborate on care (as in Recommendation # 8)
-- develop enhanced mechanisms for information sharing on common cases that are likely to benefit from collaborative care, with information technology support (as in Recommendation # 13)
-- determine what administrative entity or entities are responsible for population-based management, such as case finding and trend determination and management
-- evaluate a move to integrated health plans that have features of: a single or shared general medical/behavioral health capitation, a common IT system or database capability, and shared financial incentives across overall health outcomes
-- achieve a fully integrated electronic medical record across Medicaid and non-Medicaid health systems, envisioned by the HJR07-1050 Task Force

Components of the strategy would:
-- include health care for general medical/surgical, mental, and substance-use conditions
-- protect the portion of overall funding that is devoted to behavioral health, in order to avoid reversion to the problem of erosion of funding that historically has occurred in general medical health maintenance organizations (and was a primary reason for the development of "carve outs" in the first place)

-- consciously attend to issues of the relevant[10] "safety net" (mental health, substance abuse and general medical/surgical) providers. However, these providers must be required to meet the same performance requirements as other providers

--include a movement toward a broader network that allows better overall access to non-CMHC providers with expertise and interest, and that provides a more "level playing field" in which to compete

-- establish greater statewide standardization of processes and paperwork for consumers and providers

-- determine what data are crucial for management and development, and create a sub-strategy to produce these data with accuracy and consistency

-- establish case mix payment adjustments to recognize different levels of needs and complexity of cases

-- establish a data collection mechanism that captures all services and does not rely solely on encounters and collection of traditional CCAR data for programs and services that are not suited to these approaches

-- recognize the need for a plan for provider training, which may be significant

-- enlist the current BHOs (and others, such as the MSOs) as working partners in this effort

-- determine a mechanism to measure and manage medical/surgical savings that occur due to the effective implementation of behavioral medicine interventions

15. **Be a proactive partner in the HJR07-1050 implementation plan. Include a contractual requirement that the behavioral health managed care organization(s) work with HCPF and other groups identified by HCPF (such as a possible HJR07-1050 Task Force successor) to work toward the Task Force goals.**

    There are a number of actions that can be taken within the purview of this initiative that can be of great help to the development of the Medicaid Mental Health Services Program, including increasing the flexibility of funding for behavioral health services, establishment of an integrated electronic medical record, and greater standardization of forms and processes.

Some Issues for Further Consideration:

Certainly the following issues are not the only ones that present complexity and challenge to effective Program development. However, some additional considerations that will need to be addressed include:

1. **"Build or Buy": Does HCPF have sufficient resources to implement recommendations that might be adopted?** Most require not only personnel, but certain types of expertise, in order to be implemented effectively. Enhancements in information technology are necessary—does HCPF have the resources to research what is necessary, and then test and implement? Where will these types of initiatives fall in the listing of priorities for the Department and

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[10] Just as Lewin & Altman (2000) discriminate "core" safety net providers from other providers that have served the same populations, it is important to discriminate those that are critical to *systemic* support for these populations from those that merely serve these populations in addition to multiple others.

other decision making bodies? An objective assessment will need to be made of what the Benefits Division can actually accomplish with expected resources. Consider whether any aspects of the initiatives might be "outsourced" to an organization with already existing infrastructure (for example a national managed care firm) for statewide administrative or other services. Or, if any of the current BHOs can extricate themselves from the "conflict of interest" problem with CMHCs, do any have the capabilities, existing infrastructure and demonstrated track record to develop and manage a statewide presence? The "bottom line": If resources are not available to implement an initiative effectively, it should not be undertaken.

2. **If behavioral health administrative and delivery services eventually are incorporated with general medical/surgical services, how will the strong emphasis on consumer and family-driven care in behavioral health fare with the "medical model"?** How will the issues of data privacy versus holistic care be bridged?

3. **Will there be enough qualified providers?** For example, most traditional behavioral care therapists are not trained in behavioral medicine, and not all have the disposition to practice this subspecialty.

4. **With regard to longer term planning, should the Division (and partners) embark on a carefully thought out, staged and implemented broader plan, or start first with one or more "pilot(s)"?** It should not be assumed that one or more well done pilot(s) would be much simpler or less resource intensive than a multi-year, carefully staged, broader plan. Also, unless multiple pilots are done with the goal of selection of the most successful one for Statewide implementation, there is the risk of further entrenchment of inefficient variation across the State.

5. **To what extent might it be effective to establish greater "integration" of behavioral health and general medical/surgical administration within HCPF, that is, co-locate staff, modify selected meetings to have joint presence, and so on?**

The increased interest in behavioral health in Colorado provides exciting opportunities to improve the cost-effectiveness and outcomes for Medicaid members. For Colorado's Medicaid Mental Health Services Program, there are a number of actions that can be taken in the shorter term that do not have to wait for longer term, broader initiatives. The results of interviews performed for this project do not suggest that respondents wished to wait for such improvements. However, some of the recommendations clearly are complex and surely would be implemented more slowly—over many years and in conjunction with other broad State initiatives. Whatever specific actions are taken by the Benefits Division with regard to the next steps in Program improvement, they will need to be taken with the longer term vision in mind. Regular objective assessments must be made of progress and mid-course corrections determined. All states have needed such flexibility.

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Appendix A1

"External" Interviewee Questions—CO Version

1. **What are the most important immediate strengths, as well as gaps in or problems with, the CO Medicaid Mental Health program?**

2. **What do you think needs to be done about them?**

3. **What other, longer term changes do you think are needed?**

4. **What's your perception of the division of responsibilities and relationship between DMH in DHS and HCPF's behavioral health care responsibilities?**

5. **If you have an opinion on this—what state or states do you think really do Medicaid managed BH well?**

6. **Anything else you'd like to tell me that can help HCPF evaluate where they should take this program in the future?**

Thank you. Please feel free to call or e-mail me if you have any additional thoughts.

Appendix A2

"External" Interviewee Questions—National Version

1. **What are the most important trends you see in private managed BHC programs today?**

2. **State Medicaid programs?**

3. **What do you think are the major challenges in implementing them?**

4. **What other, longer term changes do you think are needed?**

5. **What state or states do you think really do Medicaid managed BH well?**

6. **Anything else you'd like to tell me that can help Colorado Medicaid evaluate where we should take this program in the future?**

Thank you. Please feel free to call or e-mail me if you have any additional thoughts.

Appendix B

Interviewee List

Internal HCPF Stakeholders:

Katie Brookler
Manager
Quality Improvement Section

Sue Carrizales, LCSW, MPA
Behavioral Health Policy Specialist
Managed Care/Behavioral Health Benefits Section

Nicole Carter-Maddox, MS
Behavioral Health Specialist
Managed Care/Behavioral Health Benefits Section

Marceil Case, BA, BS
Behavioral Health Contracts Specialist
Managed Care/Behavioral Health Benefits Section

Laurel Karabatsos
Director
Benefits Division

Jerry Smallwood
Manager
Managed Care/Behavioral Health Benefits Section

Deborah Van Houten, RN
Caring Solutions
Health Care Consultant to the Benefits Division

Connie Young
Quality Specialist
Quality Improvement Section

Jed Ziegenhagen, M.P.A.
Manager
Rates Section

External Stakeholders:

Lacey Berumen
Executive Director
Colorado Chapter
National Alliance on Mental Illness

Carl Clark, M.D.
CEO
Mental Health Center of Denver

Elizabeth Cookston MD
Medical Director
Colorado Coalition for the Homeless

Jose Esquibel
Director
Interagency Prevention System
Prevention Services Division
Colorado Department of Public Health and Environment

Andrew Keller Ph.D.
TriWest Group

Sharon Lane
Operations Manager
Wellpoint Behavioral Health

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Appendix C

Additional Examples of State Program Initiatives

Available literature as well as interviews with experts in the managed behavioral health care industry suggest that progressive approaches to the delivery of mental health services are occurring in nearly half of the states.   There is wide variety among approaches that is sensitive to the political realities of each state (Gold & Mittler, 2000). Some states have program features that may be of particular interest to the Colorado Medicaid Mental Health Services Program, because they have been referenced by multiple authors, interviewees, or both, and are illustrative of the application of forward-looking managed behavioral health care principles. Six such state initiatives are profiled below, from Arizona, Massachusetts, New Mexico, Texas, Washington and Wisconsin.

Arizona Maricopa County: Specificity of Vendor Performance Requirements

Arizona's last issued RFP for managed behavioral health care vendors is notable for the sheer comprehensiveness of its array of vendor performance requirements. The state's Medicaid agency, the Arizona Health Care Cost Containment System Administration (AHCCCSA), contracts with the Arizona Department of Health Services (ADHS), Behavioral Health Services Division, to administer the Medicaid behavioral health benefits for the state. The ADHS also administers behavioral health services funded through the two Substance Abuse and Mental Health Services Administration (SAMHSA) Federal block grants. The state uses different vendors in different geographic areas of the state and recently issued an extremely ambitious RFP to select a managed behavioral healthcare vendor to manage the behavioral health services for Maricopa County.

Contract expectations are significant in the usual areas of general program management; provider credentialing; network management; claims payment; information and referral services; utilization and care management; quality management; resolution of complaints, grievances and appeals; education and training for provider staff and the community; and possession of viable business continuity, disaster recovery and emergency preparedness plans. In addition, the vendor must "manage" the following programs (although it may subcontract for services): Correctional Officer/Offender Liaison Program; housing; employment development and management; Jail Diversion Program; mental health drug court activities; pharmacy benefits management; Pre-Admission Screening and Resident Review (PASRR) evaluations; laboratory and radiology services; sign language, translation and interpretation services; and the Substance Abuse Prevention and Treatment Performance Partnership and Center for Mental Health Services block grants (State of Arizona, 2007b).

Clear expectations are spelled out with regard to the vendor's collaboration with multiple other systems and organizations, including the county health department, the general medical plans, primary care providers, the judicial and corrections systems, Native American tribes, housing programs, consumers and families, the state mental hospitals, parole and "court-involved" programs, county jails, elder programs, school districts, a

wide range of other state agencies and programs specified by name, and "any other entity that regularly interacts with persons served" by the vendor. In addition, the vendor is expected to administer vocational, employment and "business development"; prevention; provider training; and primary medical care liaison programs. Specific performance measures are identified, with designated thresholds in multiple areas, including coordination of care; sufficiency of assessments; consumer/family involvement; cultural competency; appropriateness of services; informed consent for psychotropic medications; quality clinical outcomes; and Average Speed of Answer and Abandonment Rates for customer service and crisis telephone lines. The contract prohibits the vendor from provision of direct service delivery, in order to avoid "the inherent conflict of the RBHA [Regional Behavioral Health Authority] as a managed care company having to monitor itself as a provider (State of Arizona, 2007a)."

Massachusetts: "Integration" Pilots—CMHCs and FQHPs

The Commonwealth of Massachusetts has established six pilot sites under the supervision of the Massachusetts Behavioral Health Partnership (MBHP), which manages Medicaid behavioral health services for the Primary Care Clinician (PCC) Plan. The pilots focus on various collaboration, "integration", and EBP approaches between community mental health centers (CMHCs) and federally qualified health plans (FQHCs). The initiative is funded through a combination of private grants, Medicaid reimbursement, and other sources.

The various approaches include the use of behavioral health "Navigators" to provide consumers with referrals, coordinate care and provide follow up; co-location of behavioral and general medical health care providers; "systems" integration in a specific opioid treatment program; screening for depression in primary care; and implementation of the National Council for Behavioral Healthcare's "Four Quadrant" Model of behavioral health/primary care integration (Mauer, 2006). In some cases, technology enhancements, such as a common electronic medical record, are a key component of the initiatives.

Results from these projects will be used to promote greater adoption of the successful initiatives across the state, distribute information on "lessons learned," and inform the state for future contracting with the managed care organizations and MBHP. In addition, the state will use information gathered to help identify and address state agency policies and regulations that present barriers to integration (Edwards, Garcia & Smith, 2007).

New Mexico: One Statewide Vendor and "Purchasing Collaborative"

Up until mid-2005, up to 17 different New Mexico agencies funded and provided for behavioral health services to Medicaid recipients, including the Department of Health, Department of Human Services, and Department of Children, Youth and Families. The state Behavioral Health Services Division of the Department of Health provided mental health services for the indigent population, through three Regional Care Coordination organizations which managed the delivery of services in five regions. The Medical Assistance Division provided services to Medicaid recipients. Due to growing concern about their fragmented behavioral health care system and ongoing problems with access, the state contracted with one managed behavioral health care organization.

An Interagency Behavioral Health Purchasing Collaborative was established to design a statewide system of care. State statutes also required that the Collaborative work with 15 local Collaboratives and the Behavioral Health Planning Council. Contract requirements include an array of specific expectations regarding access (geographic, cultural competency and telecommunications), communication, transportation, care coordination, and collaboration, including with primary medical care and the criminal justice system. The extent to which the vendor is compliant with state statutes also is measured.

A key aspect of the New Mexico project is the technical work that is occurring with regard to data definition and collection. The initiative requires various entities to have common, HIPAA compliant service definitions and codes. If done successfully, there is the potential to greatly improve the state's ability to obtain valid data on the needs, services and gaps in, as well as cost-effectiveness of, services. It also can offer significant relief to providers with regard to their data reporting requirements.

The transition began in July, 2005 and has three primary phases through 2009. Assessment to date indicates that as of March, 2007, this single oversight arrangement has improved access, consumer satisfaction and performance on certain quality measures compared to the prior model of service oversight and delivery. There is strong consumer and other stakeholder involvement in decision-making and an emphasis on EBPs. Reaction from providers so far is mixed. ("New Mexico's Interagency Behavioral Health Purchasing Collaborative", 2005; Menges & Shah, 2007).

Texas: Blended Funding for Mental Health and Substance Abuse Services

Through the Texas Department of State Health Services, the Texas NorthSTAR Program blends Medicaid and other mental health and substance abuse funding through a 1915(b) waiver for seven counties. Traditionally, the public behavioral health services were funded by the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Commission on Alcohol and Drug Abuse (TCADA). The NorthSTAR Program's intention was to improve access, accountability and the cost-effectiveness of funding for these services. Within a managed care framework, the initiative blends the funding from the Texas Health and Human Services Commission (HHSC), TDMHMR, TCADA and local governments to provide "a single system of public behavioral health." Blended funding promotes integrated care for individuals with co-occurring disorders, care management and technological enhancements to promote integration of care. Private organizations assume full financial risk. Provider subcontract arrangements replaced state block funding to traditional public providers, "introducing competition into a system that historically lacked both private sector incentives and service level accountability."

> NorthSTAR challenged the notion that consumers of public behavioral health services should be limited to traditional providers. Additionally, for mental health consumers the traditional system (and current system in all other service delivery areas in Texas) limits specialty mental health service providers to the local community mental health centers thereby restricting consumer access to centers in their county of residence, regardless of preference, complaints or proximity to programs. NorthSTAR eliminated the county of residence requirement and has encouraged and allowed new providers to emerge to offer these crucial specialty services regionally.

In order to achieve its goals, NorthSTAR staff, composed of representatives from three state agencies that have not always taken advantage of collaborative opportunities, have worked to competently manager[sic] state level coordination and oversight (Innovations, 2001, p. 2).

Washington: Behavioral and General Medical/Surgical Integration Pilot

The Washington Medicaid Integration Partnership (WMIP) (2007) is a pilot managed care plan in Snohomish County that combines medical, mental health, substance abuse and long-term care services. An integrated medical managed care organization is the contracted vendor. The initiative began in 2005, and its goal was to use preventive care, coordinate care across services, improve consumer health outcomes and decrease expenditures. At present and by design, it has a limited number of enrollees. However, if the initiative is successful, the plan is to expand the model across the state, and other counties already are expressing interest in doing so.

There is variability in consumers' responses to the plan. However, many (40 percent) report that their care is better coordinated. So far the plan appears to be producing savings when compared to the more traditional approaches. This effect seems to be especially true with regard to the integration of mental health and general medical services, and the inclusion of psychotropic medications. Medical and psychiatric inpatient utilization has been lower than for matched consumers served in a more traditional approach. However, consumers with high medical costs and those using long term care "have tended to disenroll from the project." The Research and Data Analysis Division continues to collect outcome data in order to assess the success of the program and make mid-course adjustments as needed (Silow-Carroll & Alteras, 2007; State of Washington, 2007).

Wisconsin: Statewide implementation of a Cost-Effective EBP

Wraparound Milwaukee began with a federal grant in 1995, and was "designed to provide comprehensive, individualized and cost effective care to children with complex mental health and emotional needs." Additional goals were to reduce institutional care and provide more cost-effective care in the community, improve collaboration among child welfare, juvenile justice and mental health systems in the provision of services, and improve family involvement in care. It is highly family focused and extremely flexible with regard to use of funds and services to improve functioning of families and reduce the need for high-end services. Because of its improved clinical outcomes, reductions in delinquency, and cost-effectiveness, the New Freedom Commission on Mental Health identified Wraparound Milwaukee as a model EBP program (New Freedom Commission, 2003).

Primary components of the service design include:
▪ an at-risk administrative structure that manages care,
▪ a single internet based information technology system,
▪ family teams that determine medical necessity according to the Medicaid contract,
▪ one care manager who coordinates services across multiple systems,
▪ an open provider network (any provider who can provide the necessary services is able to provide care), and
▪ a mobile crisis team.

The program is funded through blended (pooled) monies across multiple child serving systems. Reimbursement is provided through case rates, fixed funding, and Medicaid capitation ("Wraparound," 2007).

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