

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Medicaid Behavioral Health Community Programs)**

FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

**Wednesday, December 16, 2015
9:00 am – 12:00 pm**

**QUESTIONS FOR BOTH THE DEPARTMENT OF HUMAN SERVICES (DHS) AND
THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING (HCPF)**

Presenters:

Reggie Bicha, Executive Director, CDHS

Gretchen Hammer, Medicaid Director, HCPF

10:00-10:20 WICHE STUDY

25. Discuss the findings of the WICHE study and the Department's plans to address the study recommendations, including the following specific recommendations that affect both DHS and HCPF:

- a. Move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department.**

RESPONSE

In response to the implementation of the Affordable Care Act and Medicaid expansion, along with the growing emphasis on integration of behavioral and physical health care, it is timely to consider how the State might best align policy and funding across the health care system. Before a move of state offices is undertaken, the Departments support a thoughtful, strategic analysis, with input from a broad array of stakeholders and subject matter experts to ensure the most effective and efficient structure to support the behavioral health system in the state.

- b. Explore the development of a common management information system for behavioral health data, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards.**

CDHS and HCPF are working closely with several agencies to align both data standards and system interfaces. First, both departments are members on several committees that are looking at the best practices around data sharing and alignment. Two prominent examples of the

departments' participation are: the State Innovation Model (SIM), Health Information Technology (HIT) workgroup that recently mapped out a three-year data exchange and performance measurement strategy and the Colorado Regional Health Information Organization (CORHIO), Behavioral Health Information Exchange work group that has been instrumental in establishing pilots for behavioral health providers to share information with physical health entities such as hospitals and emergency rooms. Second, the CDHS and HCPF are developing shared performance measures to enable behavioral health providers to measure success through defined methodologies agreed upon by both agencies. These shared measures are a key tactic in developing common data definitions that can more easily be shared and conform to standards. Finally, CDHS has recently implemented changes to its primary data collections systems to better align with national data standards and meaningful use requirements.

CDHS and HCPF have recently started defining business requirements and getting cost estimates to modify the new Medicaid Management Information System (MMIS) to process indigent, non-Medicaid behavioral health claims. This project would exchange behavioral health claim information using the latest industry standards.

CDHS also currently exchanges important public safety “Driving under the Influence” data with the Department of Revenue, Division of Motor Vehicles and State Judicial following National Information Exchange Model standards.

c. Determine how behavioral health crisis system services for Medicaid clients will be billed and reimbursed.

Behavioral health crisis response system providers report billable services to Medicaid for Medicaid-eligible clients. These Medicaid billable services are reported to the Department as an offset to the total monthly cost to provide contracted crisis services. The Department reimburses all behavioral health crisis service costs that are not covered by Medicaid and other payer sources.

d. Implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals.

To be eligible to receive Medical Assistance, an eligible person cannot be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. The federal statute that excludes individuals who are patients in an Institute for Mental Disease (IMD) is at 1905(a) of the Social Security Act and is in federal regulation at 42 CFR § 435.1009. Federal Financial participation (FFP) is not available for these individuals.

HCPF continues to work on a “suspend” function for Medicaid eligibility while incarcerated or for clients who are institutionalized. The CBMS change is costly and creates more manual work for an eligibility technician to suspend and unsuspend a Medicaid eligibility span. The

Department is looking to create some functionality for technicians using PeakPro to enroll individuals into an ‘Eligible, but no Benefits’ plan in our new MMIS (referred to as the Colorado interChange) which is scheduled for implementation for November 2016. Currently the Department has the Department of Corrections using PeakPro to enroll individuals into Medicaid upon release. This same functionality could be utilized by workers at the institutes to expedite Medicaid enrollment, if the institutes have personnel who could devote time to process Medicaid eligibility for a client.

26. Please clarify the role of behavioral health organizations (BHOs) related to the provision of inpatient psychiatric care. Which types of Medicaid-eligible clients and which types of diagnoses are excluded from BHO contracts, and what entity (if any) is responsible for providing inpatient psychiatric care to these clients or under such circumstances?

RESPONSE

Most full-benefit Medicaid clients are enrolled in the Community Behavioral Health Services Program and may access inpatient psychiatric services through their Behavioral Health Organization (BHO) if they have a covered mental health diagnosis and inpatient treatment is determined to be medically necessary.¹

The BHO contract specifically excludes several eligibility categories that are not full-benefit Medicaid such as Qualified Medicare Beneficiary only; qualified Disabled and Working Individuals and Special Low-Income Medicare Beneficiaries. Individuals in these eligibility categories have Medicare and would access inpatient psychiatric care through the Medicare system.

Medicaid pays for inpatient psychiatric services on a fee-for-service basis in the following cases:

- Individuals without a covered diagnosis under the age of 21 or over the age of 64; and
- Individuals without a covered diagnosis between the ages of 20 and 65, if they have received their care from a hospital that does not meet the requirement for being an Institute for Mental Disease as defined by the federal Centers for Medicare and Medicaid Services (CMS)

Medicaid does not cover inpatient psychiatric care for individuals with a primary substance use disorder diagnosis, except for children and youth under the age of 21, as required under federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

The Mental Health Institutes accept patients regardless of available benefits. However, due to the Institutions for Mental Diseases (IMD) exclusion, which prohibits Medicaid from making

¹ See <http://tinyurl.com/j3lata9> for the full list of covered diagnoses.

payments to IMDs, for services rendered to Medicaid beneficiaries aged 21 to under age 65, the Institutes cannot bill for services provided to this population. The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health residential treatment facilities larger than 16 beds.

In addition to the eligibility categories mentioned above, individuals in the following programs/placements are also excluded from the BHO contract and may access services in the following manner:

- Clients enrolled in the Program of All-Inclusive Care for the Elderly (PACE); the PACE program is responsible for paying for inpatient psychiatric care for these clients.
- Clients residing in the State Regional Centers for people with Intellectual and Developmental Disabilities (IDD) for more than 90 days; fee-for-service Medicaid is responsible for paying for inpatient psychiatric care for these clients.
- Children or youth in the custody of the Colorado Department of Human Services - Division of Child Welfare or Division of Youth Corrections who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF); fee-for-service Medicaid is responsible for paying for inpatient psychiatric care for these clients.
- Clients under the age of 21 and over the age of 64 who receive inpatient treatment at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan; who are:
 - Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI);
 - Found by a criminal court to be Incompetent to Proceed (ITP); or
 - Ordered by a criminal court to a State Institute for Mental Disease (IMD) for evaluation (for example, competency to proceed, sanity, conditional release revocation, and pre-sentencing).

The Department of Human Services is responsible for the cost of forensic placements in the institutes.

27. Please describe the process for determining how many and which individuals will be admitted to a civil bed at each of the mental health institutes. Are these decisions made by mental health institute staff? What are the respective roles of behavioral health organizations, community mental health centers, county departments of social services, and the Division of Youth Corrections in making these decisions?

RESPONSE

The admission of individuals to a civil bed at the Institutes is occurring principally at the Colorado Mental Health Institute at Fort Logan (CMHIFL), with the Colorado Mental Health Institute at Pueblo (CMHIP) focusing chiefly on forensic admissions in response to pending legal action. The Admissions Department at Fort Logan prioritizes civil admissions based on the acuity

of the clients' clinical presentations and the safety of the setting in which those clients currently reside. Admission information is provided by the referring agencies (e.g. community mental health centers, and the Division for Youth Corrections) and admissions decisions are made by the Institutes in consideration of the information provided and internal operational factors. A sampling of these operational factors include gender of bed availability, staffing availability for high intensity patients requiring 1:1 staffing, overall acuity of the unit/milieu, and ensuring the availability of reserve beds for deaf clients, as the state's designated facility for deaf clients in need of inpatient mental health treatment. Forensic admissions to CMHIP are controlled by court order and fall into the categories of Competency, Sanity, Incompetent to Proceed and Not Guilty by reason of Insanity and represent the vast majority of admissions. CMHIP does admit individuals to civil beds based on bed availability. The Behavioral Health Organizations, the community mental health centers, county departments of social services, and the Division of Youth Corrections are referring agencies that do not have any formal decision making authority for Institute admissions.

28. Discuss the availability of inpatient psychiatric care for individuals requiring medical or other specialized care. Is there a wait list for these types of patients? Are private hospitals legally allowed to discharge such patients without finding another appropriate facility?

RESPONSE

The departments are unaware of any wait list for placement in a facility that accepts individuals requiring medical or other specialized care. The Mental Health Institutes are limited in the ability to provide inpatient care to patients requiring medical or other specialized care.

As part of the FY 2009-10 budget balancing measures, the Department of Human Services (CDHS) submitted a funding reduction to close the 20-bed General Hospital at the Colorado Mental Health Institute at Pueblo (CMHIP). The General Hospital performed a service outside of the mission of CMHIP in that it provided acute medical care, rather than adhering to CMHIP's core mission as a psychiatric hospital. The Mental Health Institutes are still required to provide for the medical care needs of its patients and does so through the use of local acute care hospitals.

Patients who are highly medically acute, and/or require other specialized medical care require additional staff care, as well as require additional financial resources for the medical costs. The Mental Health Institutes are restricted from billing Medicaid due to the Medicaid Institutions for Mental Diseases (IMD) exclusion. The IMD exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health residential treatment facilities larger than 16 beds. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21. High cost medical patients typically result in the need for CDHS to submit a funding request for additional General Funds. In FY 2013-14, CDHS submitted a supplemental request for

additional on-going General Fund in the amount of \$1,329,390 to provide outside medical care for patients at the Mental Health Institutes. The Mental Health Institutes are funded in FY 2015-16 in the amount of \$3,589,425 at CMHIP and \$1,269,465 at CMHIFL to provide outside medical care to patients.

Under 2 CCR 502-1 Volume 21; 21.190.6 DISCHARGE PLANNING AND SUMMARIES, all Office of Behavioral Health designated facilities must have a discharge plan that is concise, complete and comprehensive in order to facilitate a transition to the next level of appropriate care. The discharge summary must explain in detail the rationale and specifics of the discharge plan. The departments are not familiar with the laws surrounding private hospital discharges.

29. Workforce shortages:

- a. Please discuss the adequacy of the behavioral health workforce in Colorado. Are there shortages of certain types of professionals or in certain regions?**

RESPONSE

The Department of Human Services is aware capacity issues exist and some behavioral health care disciplines are in short supply based on information from providers and other stakeholders. This includes, but is not limited to, psychiatrists, child psychiatrists, nurse practitioners and other disciplines licensed to dispense psychiatric medications, psychologists, and other psychotherapists, especially those trained to treat children.

There are shortages of specific disciplines within varying regions of the state. While the Department does not currently have a systematic analysis of these shortages per capita, it is aware, for example, that there is no psychiatrist available to provide publicly funded treatment for the southeastern region of the state, and that there is a shortage of properly trained and licensed psychotherapists in the Park and Teller county areas of the state.

- b. What role can telemedicine play in addressing shortages of certain types of behavioral health professionals?**

Telemedicine, or telehealth, is used extensively in the State of Colorado. The Department would support expansion of these services. When provided within appropriate quality, compliance parameters, and environment telehealth can be a valuable and effective treatment tool, especially in areas that suffer a significant shortage of qualified and credentialed behavioral health care providers. Telemedicine eases the strain on the delivery of behavioral health services in underserved areas especially in situations such as involuntary mental health civil commitments. Currently a significant barrier for many psychiatric hospitals is discharging consumers who require an outpatient mental health involuntary certification especially in rural areas. Telemedicine would improve access to outpatient services for this population and somewhat

improve the psychiatric bed shortage Colorado is experiencing. With a statewide shortage of child psychiatrists, Colorado faces challenges treating this vulnerable population. Primary care providers – more often than mental health practitioners – are the first to see children or adolescents for behavioral health issues.

The Department of Health Care Policy and Financing (HCPF) is also looking at how to expand the role of telemedicine in addressing behavioral health needs in the Medicaid Program. In March 2015 HCPF implemented the Chronic Pain Disease Management Program (Program) to improve the health of clients with chronic conditions and address rising rates of prescription abuse in Colorado. The Program uses interactive video to connect primary care providers to a team of specialist with expertise in a variety of pain management disciplines. Additionally, Behavioral Health Organizations (BHOs) are supporting the use of the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program. It is an innovative program utilizing the expertise of child psychiatrist as consultants to assist primary care physicians in addressing many of the behavioral health challenges their patients and families.

30. [Rep. Young] How would HCPF's proposal to shift from a capitated to a fee-for-service payment for behavioral health care (ACC 2.0) affect the State's ability to implement the WICHE study recommendations?

RESPONSE

HCPF's proposal to shift from a capitated payment system to a value based payment model built on fee-for-service architecture would facilitate the implementation of many of the recommendations in the WICHE study.

Below are some specific WICHE study recommendations that would be supported by the change in payment model.

- ***Improvement in penetration rates.*** Many clients and other stakeholders have cited the current capitated model as a barrier to accessing services. By removing the capitation and promoting the delivery of behavioral health services in primary care settings, HCPF would be able to increase client access to a broader range of behavioral services in a variety of practice settings. This is expected to improve client experience and significantly increase the number of Medicaid clients who receive behavioral health services.
- ***Develop service delivery systems for individuals with significant co-occurring needs.*** Having separate administrative and payment models for behavioral health and physical health services has hindered the ability of clients with co-occurring needs to receive necessary services. Aligning payment methodologies and administration is expected to eliminate the obstacles, enable clients to receive the care they need, and improve client experience.

- **Reimbursement for crisis services.** The current capitation model was cited as an issue for reimbursing crisis services and one solution presented was to allow providers to submit fee-for-service claims for crisis services.
- **Develop a common management information system.** By paying directly for services, HCPF would have a greater insight into the services clients are receiving. This increased access to data would facilitate the combining of information with DHS and other state agencies, and enable the implementation of more robust value-based payment methods.
- **Support whole-health integration.** The primary purpose for implementing alternative payment models for behavioral health services is to eliminate the current barriers to delivering integrated physical health and behavioral health services. More clients would be able to receive whole-person services in the location of their choice.
- **Increase services for justice-involved individuals.** As part of ACC Phase II, HCPF is committed to exploring options to improve the coordination and delivery of services for individuals involved in the criminal justice system, particularly those individuals being released from prison. Alternative payment models would enable HCPF to more effectively target services for this population, monitor outcomes, and adjust payments based on regular evaluations to ensure HCPF is effectively supporting clients in achieving health and wellness goals.

10:20-10:30 METHADONE TREATMENT AND BEHAVIORAL HEALTH PHARMACEUTICALS

31. HCPF reported that Methadone treatment and detoxification represented 50 percent of substance use disorder-related services provided through behavioral health organizations in FY 2014-15. Please describe how Methadone treatment is provided in Colorado. Specifically:

- a. What are the roles of DHS and HCPF in funding and overseeing Methadone treatment?**

RESPONSE

The Department of Human Services (CDHS) credentials all methadone treatment providers in the state and is responsible for monitoring these providers to ensure they are compliant with state and federal regulations; CDHS also funds methadone treatment for qualifying individuals who are not eligible for Medicaid through the federal Substance Abuse Prevention and Treatment Block Grant, which is administered through a contract with the Managed Service Organizations.

In 2014 the Department of Health Care Policy and Financing (HCPF) added treatment for substance use disorders (SUD), including methadone treatment, to the services covered under the behavioral health organization (BHO) contracts.

The BHOs pay for medically necessary methadone treatment services rendered to their members by a network provider.

The fee-for-service Medicaid program pays for medically necessary methadone treatment services for clients not enrolled with a BHO, when the services are rendered by a provider enrolled in the Medicaid program.

With the expansion of the Medicaid SUD benefit, funds administered by DHS are used to provide services for those indigent clients who are not on Medicaid and do not have another source of funding to pay for methadone.

b. Do the services provided through each department differ?

The service standards for methadone treatment for CDHS and HCPF are the same; Medicaid and the BHOs only contract with methadone treatment providers who are certified and perform services under the regulation of CDHS.

32. It appears that various state agencies have different policies and practices for providing behavioral health-related drugs to clients (e.g., the Department of Corrections' institutions, HCPF's behavioral health organizations, DHS' Division of Child Welfare, DHS' Division of Youth Corrections, DHS' Mental Health Institutes, and the Department of Local Affairs' Fort Lyon Supportive Housing Program). This appears to cause problems as individuals transition from one setting to another. Is it possible to establish a statewide policy related to these drugs to provide more continuity and better health outcomes?

RESPONSE

The departments recognize this issue and believes it is important to have consistency between programs. As the table below shows, the members involved with many of the entities mentioned in the question are under Medicaid coverage and receive the consistent coverage with other Medicaid clients. Where they are not Medicaid clients, the Departments are working on solutions for consistent coverage.

The two departments (CDHS and HCPF) and other agencies are working on projects to promote consistent use of medications. For example, the Psychotropic Medication Steering Committee is a statewide effort involving several agencies and other stakeholders that creates psychotropic medication guidelines for children and adolescents in the child welfare system. The guidelines are designed to provide consistent use of these medications across the state. Although it was targeted to this population, the goal was for these guidelines to be used more broadly as well.

Agency/Organization	Status	Notes
Department of Corrections	Working with other agencies to establish a consistent	The Departments have been engaged in a multi-agency Medication Consistency Workgroup, through which the Department of Corrections and other correctional institutions are working to establish a consistent formulary between those

	formulary	institutions, Medicaid, the mental health institutes, and the Veterans Administration. Additionally, the Department and other work group members are working to enhance information sharing and to develop a purchasing pool to assist correctional entities in purchasing medications in a cost-effective manner.
HCPF's Behavioral Health Organizations	Covered under Medicaid benefits	BHOs do not pay for medications; all medications are billed by pharmacies through the fee-for-service Medicaid program
DHS' Division of Child Welfare	Covered under Medicaid benefits	Children in the child welfare program are covered under Medicaid and receive the same benefits as other Medicaid recipients
DHS' Division of Youth Corrections	Working with other agencies to establish a consistent formulary	Also a part of the Medication Consistency Workgroup (see above)
DHS' Mental Health Institutes	Covered with General Fund and, when applicable, Medicaid, Medicare or third party payers.	Patients receive behavioral health medications based on a clinical determination by the patient's prescriber, in collaboration with the patient. There are no formulary restrictions for behavioral health medications.
Department of Local Affairs' Fort Lyon Supportive Housing Program	If Eligible, Covered Under Medicaid benefits	Behavioral health drugs are not provided by Fort Lyon; instead participants who need behavioral health services are sent to local facilities in the area; behavioral health services for Medicaid clients who reside at Fort Lyon are covered by Medicaid

With all of these efforts, it is important to remember that there can be impediments to establishing consistent medication coverage. Various agencies are subject to differing rules regarding medication purchasing and drug reimbursement. In addition, Medicaid does not purchase medications; rather Medicaid pays claims for the medications, which are purchased by the providers. Agencies such as the Department of Corrections purchase the medications to dispense to inmates under their custody and care. These differences become important as agencies are each working toward providing quality health care in a cost-effective manner. One agency may receive better prices on a particular medication than another agency and so providing the same medications with the same medication coverage rules ultimately may be more expensive to the state. For example, the rules regarding the federal rebates afforded to Medicaid are specific to Medicaid. Thus, the rebates only apply to medications reimbursed by Medicaid. In addition, Medicaid must cover all medications that are rebatable under the federal CMS program whereas other agencies are not restricted in such a way and can make other coverage determinations on rebatable medications. Thus what is most cost-effective medication coverage policy may vary among agencies. Despite these difficulties, the departments remain committed to finding ways to

provide quality care that includes the recognition of the need for continuity between programs.

10:30-10:45 BREAK

QUESTIONS FOR THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

10:45-10:55 INTRODUCTIONS AND OPENING COMMENTS

Presenters:

Gretchen Hammer, Medicaid Director, Health Programs Office Director
Laurel Karabatsos, Deputy Health Programs Office Director

10:55-11:50 INTEGRATED CARE AND ACCOUNTABLE CARE COLLABORATIVE (ACC) PHASE II

ACC 2.0

33. Please discuss the Department's plans for "ACC 2.0". Please highlight the benefits and drawbacks of the two existing payment methods (*i.e.*, fee-for-service versus capitation). In addition, please provide information indicating how the proposed regional accountable entity regions would compare to existing regions for behavioral health organizations (BHOs) and regional collaborative care organizations (RCCOs).

RESPONSE

The goal of Phase II of the ACC is to optimize health for those served by Medicaid through accountability for value and client experience at every level of the health system and at every life stage. In order to achieve this goal, the ACC Phase II is based on three key principles:

- Person- and family-centeredness
- Outcomes-focused and value-based
- Accountability at every level

ACC Phase II will focus on integrating and aligning efforts and systems. That means integration within the health care system, integration between medical and non-medical programs, and alignment between efforts to achieve that integration. A primary means to achieve this integration is that HCPF will combine administrative organizations for physical and behavioral health to form new Regional Accountable Entities (RAEs). The RAEs will be responsible for the health and cost outcomes for clients in their region, as well as:

- Overseeing behavioral and physical health regional networks,
- Onboarding and activating clients,
- Developing and supporting Health Teams (clients and the providers who provide the majority of their well and sick care)
- Making value-based payments to Health Teams, and
- Convening Health Neighborhoods (the broader health system).

Payment Methods

Currently, the Department pays for most Medicaid enrollees under two primary systems - the Community Behavioral Health Services Program and the Accountable Care Collaborative. Both have fee-for-service underpinnings. In the Community Behavioral Health Services Program, the state sets a capitated rate that is predominantly based on utilization. The Community Mental Health Centers then receive a sub-capitation from the BHOs that is a percentage of that rate. The majority of payment for the Behavioral Health System is primarily driven by utilization similar to fee-for-service. The ACC program is a managed fee-for-service system where all clinical services are paid fee-for-service but the Regional Care Collaborative Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs) receive an additional per member per month payments to support coordination of services and incentive payments that are tied to quality metrics.

All payment methodologies have their strengths and weaknesses; therefore, the choice of payment must be aligned with the specific goals a system is trying to achieve. Comprehensive capitated payments are most effective at reducing the number of unnecessary episodes of care for a particular condition or group of people. The current Community Behavioral Health System has been effective at helping individuals with serious and persistent mental illness manage their conditions utilizing community-based services and thereby reducing hospital admissions. This approach was most effective when the Medicaid population was significantly smaller and a greater percentage of Medicaid clients required intensive behavioral health services. Under the current Medicaid program where most of the 1.2 million Medicaid clients do not have serious and persistent mental illness or a covered behavioral health diagnosis, but may have other behavioral health needs, this payment approach has lesser value.

Simple fee-for-service payments can be effective at addressing the underuse of high-value services such as preventative and early intervention services, supporting episodes of care where the total cost of services needed is low and there is little opportunity for savings, and paying for conditions that are rare or difficult to diagnose and are therefore difficult to plan for in capitated or other payment models. However, simple fee-for-service payments reward volume, focus on short-term gain rather than long-term value, and do not control for poor quality of services.

Having two different payment methodologies and different administrative agencies has created barriers to integration and the delivery of whole person care. The current program structures have created challenges between physical health and behavioral health, particularly when it comes to

deciding which system is responsible for paying for services for individuals with physical and behavioral health needs. This has sometimes resulted in individuals with co-occurring complex health needs not getting appropriate care or having to wait to get medically necessary services. Furthermore, continuing two payment systems continues the misperception that behavioral health needs are distinct from physical health needs.

In order to best support the integration of services, the Department is working with stakeholders to evaluate different alternative payment methodologies across the Medicaid service array. Alternative payment methodologies are neither fee-for-service nor fully capitated payments, but lie between the two options with greater proportions of payments tied to quality and value. Specifically, the Department is working with CBHC and other stakeholders to explore a cost-based reimbursement model for Community Mental Health Centers (CMHCs), similar to what Federally Qualified Health Centers (FQHCs) use today. This model would allow the same flexibility it has offered FQHCs in terms of ensuring compensation for innovation, integration, maintaining critical system capacity, and offering cost effective services.

In Phase II of the ACC program, the state will move toward value based payment strategies aimed at ensuring clients get the right care in the right setting and directly incenting providers. For the Regional Accountable Entities, the state will implement a number of quality based payments on top of the fee-for-service system including paying for improved performance on key performance metrics related to utilization and health outcomes; sharing in the savings generated by the program; and creating an incentive pool to reward improvement in areas where opportunity exists, such as follow-up care within 30 days of discharge from the hospital or quality measures for the State Innovation Model (SIM). For hospitals, the state agency will explore changes in rates to better align payments with value and will explore options for a Delivery System Reform Incentive Program, a federal waiver program that allows the Department to create hospital incentive payments tied to achieving improved health outcomes in local communities.² For specialists and fee-for-service primary care, HCPF will explore implementing a multiplier for some services that takes into account client socioeconomic status and provider performance so that base fee-for-service rates reflect value. For Federally Qualified Health Centers and Community Mental Health Centers, the Department will explore a payment methodology that incorporates quality into the payment.

By paying directly for services delivered, using this multi-pronged alternative payment methodology, the state will achieve the following:

- **Greater flexibility to drive payment models** that will change the fabric of the delivery system.
- Removal of the covered diagnosis model under the BHO capitation will present options for **providing a continuum of lower acuity behavioral health interventions**.

² Upper payment limit financing is the mechanism by which the Department maximizes reimbursements to hospitals pursuant to section 25.5-4-402.3, C.R.S.

- Cost efficiencies by **leveraging the state’s newly acquired, state of the art claims system** rather than paying seven vendors for building or maintaining a claims payment system. By directly paying for clinical services, the state will have **more information about services rendered**.
- Will **reduce administrative burden for providers** providing both behavioral and physical health services; providers will not have to submit different claims/encounters to two different processing systems.

This model is **one step in an iterative process** to bring Colorado closer to a value-based payment model.

ACC Phase II Regions

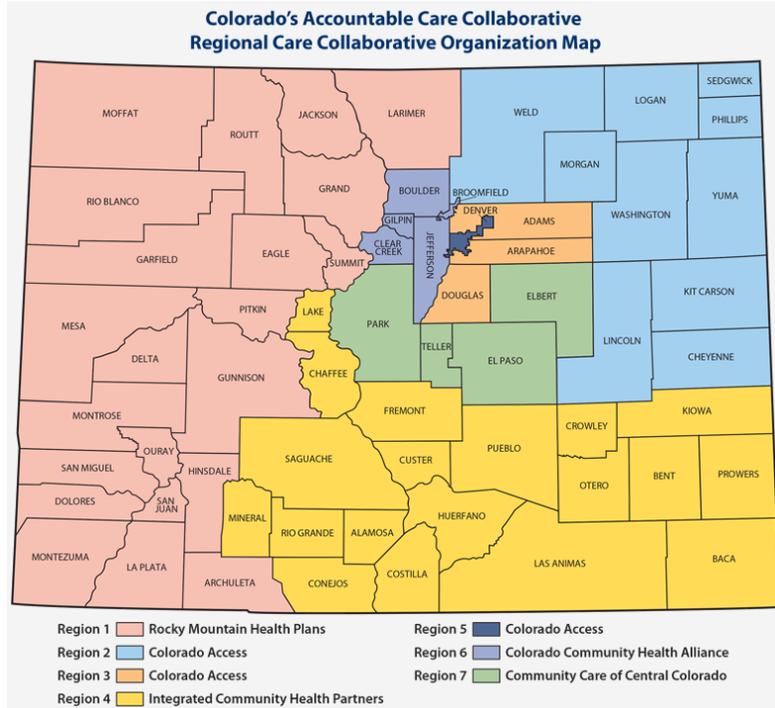
In Phase II of the ACC there will be a single regional map for both physical and behavioral health service administration. Regional Care Collaborative Organization (RCCO) and Behavioral Health Organization (BHO) regions are being aligned to support combining the administrative functions within a single Regional Accountable Entity.

The map for ACC Phase II will largely align with the current seven regions of the RCCOs. Stakeholder feedback was that the seven regions more accurately capture the cultural and geographic differences in the state. In addition, smaller regions will allow contractors to better understand and address local needs, capitalize on local strengths, and tailor interventions accordingly.

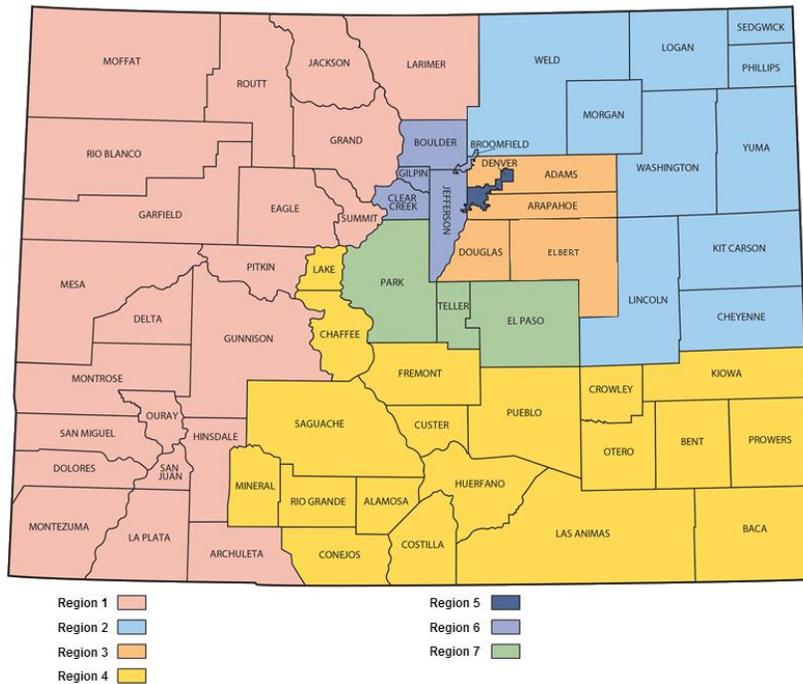
The major change from the BHO map is that the one BHO region currently covering the western and southern counties will be divided into two regions. In addition, the Department conducted stakeholder meetings to determine the best regional assignments for Larimer and Elbert counties which do not align with the current seven regions in the RCCO map. Larimer County will remain with Region 1. Elbert County will be a part of Region 3. The regional map was informed by current and projected utilization analysis, stakeholder input, and guiding principles developed by the ACC Advisory Committee.

Maps are included below for reference:

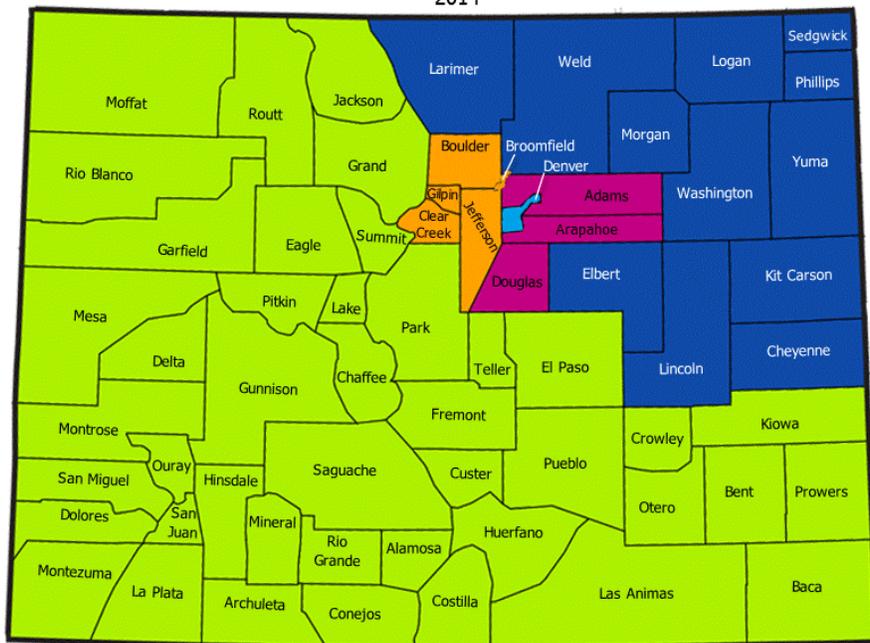
ACC Phase I: Current RCCO Map



ACC Phase II: Regional Accountable Entity Map



Colorado Medicaid
Community Behavioral Health Services Program
Geographic Service Areas
2014



Current BHO Map

34. Please describe HCPF's long-term vision for the Medicaid program. What will "ACC 3.0" look like? Will it include services currently provided through managed service organizations?

RESPONSE

The vision of the Department of Health Care Policy and Financing is that the Coloradans we serve have integrated health care and enjoy physical, mental and social well-being. The Accountable Care Collaborative is fundamental to achieving this vision. Since its inception the program has been flexible and regional in its design allowing the program to adapt to the needs of clients, providers and local communities. It has also been a testing ground for new ideas for care delivery and payment.

The contracts for the Regional Accountable Entities currently proposed in the ACC Phase II concept paper will be a minimum of five year contracts from July 1, 2017 – June 30, 2022. As with the current Accountable Care Collaborative and our contracts with Behavioral Health Organizations (BHOs) and Regional Care Coordination Organizations (RCCOs), there will be opportunities to continue innovation in care delivery and payment through program maturation and contract modifications.

Department staff recently met with leadership of the managed services organizations to explore how services currently provided through the managed services organizations can be incorporated into Accountable Care Collaborative. Currently, some services provided by the managed services organizations are included in the BHO scope of services and some are paid through State Plan benefits. The proposed payment methods in phase II of the Accountable Care Collaborative will bring some alignment to the payment for services currently provided through managed services organizations. Additionally, Department staff are exploring options with the Centers for Medicare and Medicaid services about how other services currently provided by the managed services organizations, but are not covered by Medicaid, may be included in the Accountable Care Collaborative.

35. In addition, please address the following questions and concerns raised by behavioral health providers:

- a. In the 1990s, after careful study by stakeholders and the Executive Branch, it was declared by the General Assembly that capitated managed care was a preferred payment mechanism by which to contain costs and deliver locally responsive services. Given this history, how does HCPF justify reverting the capitated mental health program to a fee-for-service model?**

RESPONSE

Medicaid in 2015 is not the same as Medicaid in the 1990s. In the mid-1990s, Medicaid had fewer than 200,000 enrollees and eligibility was available only to certain populations such as pregnant women and those with disabilities. The managed care structure was developed to support a dramatically different population than the approximately 1.26 million Medicaid enrollees served today. Now that Medicaid covers over 20 percent of the state's population and is nearly 50 percent adults, the Department needs to explore different models of paying for services that meet the needs of the entire Medicaid population while preserving the quality and diversity of services currently available for the population with higher acuity behavioral health diagnoses.

The current Community Behavioral Health Services Program that is predicated on a list of covered diagnosis does not support the broad spectrum of behavioral services essential for bending the long-term trajectory of health care costs in Colorado. In response to feedback from multiple stakeholder groups, the Department has proposed moving away from the covered diagnosis model in order to expand behavioral services for prevention, early intervention, and integrated primary care and behavioral health models. The current Community Behavioral Health Services Program requires that a person have a behavioral health diagnosis that is covered by the program to receive a medically necessary covered service. In order to move away from the covered diagnosis payment model and align payments to support integrated care, the Department is working with stakeholders to explore a cost-based reimbursement model for Community

Mental Health Centers (CMHCs), similar to what Federally Qualified Health Centers (FQHCs) use today. This model would retain some of the flexibility of the current capitated system by ensuring compensation for innovation, integration, maintaining critical system capacity, and offering cost-effective services.

It is important to note that the alternative payment methodology the Department is currently exploring in partnership with, and at the request of, the Colorado Behavioral Health Council is not a traditional fee-for-service model. The proposed alternative payment methodology would fully compensate Community Mental Health Centers (CMHCs) for costs associated with service provision (including “(B)(3)” and alternative services), innovation, integration, and maintaining capacity necessary for emergency response in a way that fee-for-service cannot. While there is a volume-based component to this model that is similar to fee-for-service, this is also true under capitation as capitation rates are built on volume assumptions informed by prior year utilization. The Department recognizes these concerns and agrees that the APM is insufficient as a standalone payment mechanism. The Department intends to coordinate funding streams and payment mechanisms to support the work of Community Mental Health Centers and the program.

Providing integrated behavioral health services within the physical health system is expected to increase the opportunity for early assessment and intervention and decrease the need for more costly services (both physical health and behavioral health services) in the future. At this time, the Department recognizes that there are areas where investing more in behavioral health could result in decreases in physical health expenditures. There are behavioral health interventions that have been proven effective in assisting clients in the behavior change necessary to prevent or manage physical health conditions, for example, smoking cessation, weight management services and co-occurring depression.

b. If the research shows, and decades of experience in Colorado and around the country prove, that integrated care requires a different funding model than fee-for-service, why is the State moving in this direction?

The Department proposes moving to an alternative payment model, not fee-for-service. There is broad consensus among our stakeholder community, including behavioral health providers, that the current carve-out for behavioral health is a barrier to true integration. Using an alternative payment model will ensure that the Department is able to build on the progress that has been made in our physical and behavioral health delivery systems.

c. Colorado moved away from fee-for-service for behavioral health 20 years ago to move more people out of hospitals and support them in their own communities. How can HCPF guarantee that the full spectrum of critical community-based services will

not be eliminated under this new model? How can HCPF ensure that a managed fee-for-service model will realize similar cost-containment as the mental health managed care program has demonstrated?

Keeping the full spectrum of critical community-based services is not optional; they must be preserved. The Department will not be successful in managing costs and achieving health outcomes without these services. The Department has begun conversations with CMS on the authority options for providing these services under a different payment structure and has been working with its BHO partners to ensure the model preserves the services afforded under the current behavioral health capitation.

Providing a capitation payment to administrative entities is only one of many ways to contain costs. In a non-capitated system, costs can be controlled through:

- Supporting prevention and health management for clients
- Setting service limits or prior authorization criteria;
- Building payment structures that hold providers accountable for total cost (i.e. shared savings);
- Establishing rate models that promote efficient and high value expenditures (i.e. regular outpatient check-ups); and
- Instituting contract requirements that set clear enforceable standards.

The Department will facilitate a robust stakeholder process to determine the right incentives across the continuum of care to ensure that the program contains costs.

d. Is there a different approach that can be considered that won't dismantle the foundation for comprehensive, integrated community-based care for the sake of aligning behavioral health with a fee-for-service model (e.g., Can we accelerate payment reform for the rest of healthcare)?

The Department proposes moving to an alternative payment model, not fee-for-service and would not pursue an approach that undermines the value that has been created under the current model. As stated above, there is broad consensus that the current behavioral health carve-out is a barrier to health care integration and better outcomes for clients. The Department is committed to pursuing opportunities that improve on the current system and will continue to do so as this is the Department's statutorily-defined mission.

e. Is there a risk of shifting funding away from behavioral health to cover primary health care costs?

No. The Department anticipates an increase in behavioral health spending as access to preventative care is increased and existing services are preserved for higher acuity populations. The Department is committed to short term budget neutrality and long-term savings in the overall

Medicaid budget, but fully anticipates an increase in some types of behavioral health services; for example, therapy and counseling. Despite increases in behavioral health utilization, budget neutrality is expected due to savings on physical health services as is indicated in the body of evidence on physical and behavioral health integration.^{3 4 5 6 7}

f. Will the State lose the flexibility provided by the existing federal waiver to use Medicaid funds to pay for inpatient psychiatric services (despite the federal institutions for mental disease (IMD) exclusion)?

The Department will seek federal authority to continue to pay for inpatient psychiatric services in Institutes for Mental Disease. The Department understands that this is a vital component to the program and is a requisite component in delivering the continuum of behavioral health care.

g. Will the State lose the flexibility that has allowed behavioral health organizations and community mental health centers to financially support local integrated care initiatives?

The Department plans to increase the flexibility to provide these services by moving towards an alternative payment model that builds in community mental health centers' cost into their payment and also ties payments to quality. However, even the current capitation model requires billable codes in order to develop rates for the BHOs.

h. Is it premature to implement a new funding and service delivery model in FY 2017-18 without the full benefit of data and information gathered through: H.B. 12-1281 payment reform pilot program (RMHP Prime); four-year SIM grant initiatives; and recently "turned on" Medicaid billing codes related to integrated care?

The Department is ready to implement reforms and improvements to the current system because of its extensive stakeholder efforts and because the ACC Program is designed to be iterative and continually evolving.

³ State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment. 2014. Deborah Bachrach, Stephanie Anthony, and Andrew Detty. The Commonwealth Fund.

⁴ Integrating Physical and Behavioral Health Care: Promising Medicaid Models. 2014. Mike Nardone, Sherry Snyder, and Julia Paradise. Kaiser Family Foundation. <http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/>

⁵ Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. 2014. Martha Gerrity, MD, MPH, PhD. Milbank Memorial Fund. <http://www.integration.samhsa.gov/integrated-care-models/Integrating-Primary-Care-Report.pdf>

⁶ The Business Case for Bidirectional Integrated Care. 2010. Barbara J. Mauer and Dale Jarvis. MCPP Healthcare Consulting. <http://www.cbhc.org/wp-content/uploads/2015/11/CiMH-Business-Case-for-Integration-6-30-2010-Final.pdf>

⁷ CBHC Position on Healthcare Reform and Integration. 2010. Colorado Behavioral Healthcare Council. <http://www.cbhc.org/news/wp-content/uploads/2010/05/cbhc-position-on-healthcare-reform-final.pdf>

The Department has been engaging with stakeholders on the design of ACC Phase II since April 2014. The Department has conducted over 40 stakeholder meetings related to the new system and has conducted an extensive Request for Information (RFI) process which brought in over 120 formal responses and nearly 4,000 pages of written suggestions and analysis from the behavioral and physical health providers, advocates, counties, clients, and others. These meetings, materials, and suggestions have helped the Department to understand the current landscape, as well as to develop a proposal that addresses many of the shortcomings of the current systems. As noted in question 31, the Department fully anticipates that continued and continuous evolution of the program will be necessary to keep pace with the rapidly expanding knowledge and readiness of the health care delivery system in Colorado. The Department will continue to incorporate lessons learned from both ACC: RMHP Prime and SIM. The Department seeks to create a program that is flexible and iterative so that it can evolve and adapt over time to changes in the system.

36. The legislation that established a statewide prepaid mental health managed care program (S.B. 95-078) acknowledged the unique and historical role the community mental health centers have assumed in meeting the mental health needs of communities throughout the state (e.g., providing mental health services following a natural disaster). How would ACC 2.0 impact the business model of community mental health centers and their ability to meet the needs of their communities?

RESPONSE

The payment model for Community Mental Health Centers (CMHCs) under ACC 2.0 will enable them to meet a broader range of needs of Medicaid clients in their communities by reimbursing for a more comprehensive array of services. Under the current Community Behavioral Health Services Program, CMHCs are limited primarily to providing Medicaid services to clients who have a covered diagnosis and receive a medically necessary covered service. By removing the covered diagnosis requirement and expanding the types of services provided, CMHCs will be able to collect reimbursement for providing appropriate behavioral health services to any Medicaid client, regardless of their behavioral health diagnosis. CMHCs have an established expertise in treating individuals with severe mental illness and the payment model will certify mental health centers meet minimum standards for access and quality and allow centers to receive additional payments for meeting key performance indicators intended to ensure a robust continuum of behavioral health services for individuals in a catchment area, while also allowing flexibility for expanding their existing services. This payment model also allows the CMHCs to be reimbursed for services they have indicated are not currently compensated by Medicaid since they are not submitted on an encounter and built into annual rates. Additionally, the Department has the opportunity to establish an alternative payment model that incorporates costs required to meet the mental health needs of Medicaid clients in a community following a crisis or natural disaster. That being said, the Department only has the legal authority to reimburse for services rendered to Medicaid enrollees. Services such as responding to mental health needs following a natural disaster are reimbursable by the Department so long as they are rendered for the benefit of Medicaid enrollees.

37. Please describe how the key principle of "person- and family-centeredness" relates to the proposed mandatory enrollment of Medicaid clients into the Accountable Care Collaborative.

RESPONSE

Mandatory enrollment into the ACC Phase II will support person- and family-centered care by automatically connecting new clients with a Primary Care Medical Provider (PCMP) and a regional entity that can support clients with accessing needed services. Clients will continue to have the same benefits and be able to choose any PCMP participating in the ACC. Mandatory enrollment is currently used for the BHOs, and HCPF has received broad stakeholder support for the inclusion of mandatory enrollment in ACC Phase II.

38. HCPF recently "turned on" many Medicaid billing codes related to integrated care. Are providers required to use these codes in FY 2015-16 even though they are not being reimbursed for such services? If not, does HCPF expect to gather meaningful data to inform a decision about whether to begin reimbursing providers for such services?

RESPONSE

The Department has not turned on any new billing codes in the MMIS related to integrated care. However, the Department did incorporate new integrated care billing codes in the BHO service code manual to allow the BHOs to track the provision of integrated care services. The BHOs are not currently required to use these codes, but they may voluntarily do so in order to provide the Department with more information on the provision of integrated care. This information may help the Department make decisions about ways to more effectively reimburse for integrated care services in the future. While the Department is not specifically paying for these codes, all BHOs receive payment for administrative costs as part of the capitation rate; the rate development specifically incorporates compensation for integrated care activities.

H.B. 12-1281 Payment Reform Pilot

39. Please summarize the lessons learned from the H.B. 12-1281 payment reform pilot.

RESPONSE

ACC: Rocky Mountain Health Plans Prime (ACC: RMHP Prime) is the payment reform pilot the Department has implemented under H.B. 12-1281. Program enrollment began in September 2014 using a phased approach. Because the program has only been fully operational for one year, there are only preliminary findings and lessons learned. Early program experience indicates that the potential for success with different program and payment models is dependent upon existing infrastructure and community and regional strengths and limitations.

In addition, the Department has learned that providers are interested in engaging clients in new ways and in tailoring interventions and practice processes to meet clients where they are. This was demonstrated through the greater than expected uptake of the Patient Activation Measure (PAM) within the program. The PAM is a practice tool used to assess a patient's level of engagement in their health care. The results of the PAM are then used by providers to match interventions and health care strategies to clients based on their level of health knowledge and readiness to change. During the first year, RMHP was able to implement the measure in twice as many practice sites as expected. The Department believes this is an encouraging sign.

The Department has also learned that value based payments to providers, including behavioral health providers, can support enhanced integration of physical and behavioral health care services. As an example, RMHP is providing additional payments to primary care medical providers (PCMPs) in advanced practices for the employment of behavioral health providers on comprehensive care teams. Clients using these advanced PCMPs have direct access to behavioral health services in the course of routine visits.

Finally, using payment tools, such as a Medical Loss Ratio (MLR) tied to carefully selected quality metrics can contribute to an enhanced focus on quality and value in a program. The quality measures were chosen for the program to align with the ACC program at large and with other statewide initiatives, like the Comprehensive Primary Care program. This alignment allows providers to narrow their focus on a few key measures for their entire patient population. RMHP has achieved all of the MLR quality targets in year one of the program.

a. What happens to the pilot program with the expiration of funding in FY 2016-17?

Based on existing statute, the pilot program will sunset on June 30, 2016. However, to meet the evaluation requirements of the statute, the Department has annualized the resources needed to submit a detailed final program report. The Department requested partial continuation funding of \$527,504 in its FY 2016-17 base budget for the program, which includes \$227,504 to keep the 4.0 FTE appropriated in the bill until March 31, 2017, and \$300,000 for consultant costs to assist with the completion of final program report. A final report will be available on April 1, 2017.

b. Should funding for H.B. 12-1281 be continued and what could the Department accomplish with a continuation of funding?

The Department is currently working with Colorado Access and Kaiser Permanente Colorado to implement another HB 12-1281 payment reform proposal and continued funding would allow the Department to implement that pilot, evaluate the effectiveness of both ACC: RMHP Prime and the pilot with Colorado Access, and implement additional payment reform pilots.

c. How are the lessons learned from H.B. 12-1281 informing the Department's payment policies, including the rebid of the Accountable Care Collaborative?

Due to the inherent lag in billing and claims processing, the Department is waiting for a full year of claims data. However, the lessons learned as described in the first part of the response are informing future payment reform policies and programs, such as the effort underway with Colorado Access and Kaiser Permanente Colorado. Additionally, the design of ACC Phase II is building on learnings related to the use of value-based payments to providers, enhanced alignment between quality and payment, and the importance of community and regional infrastructure that can support program design features.

40. Will the RMHP Prime pilot program be able to operate for a full two years as anticipated in H.B. 12-1281? Should the General Assembly consider any statutory changes to maximize the information gained from this pilot program?

RESPONSE

The ACC: RMHP Prime program would not be able to operate for the full two years as anticipated in H.B. 12-1281 since enrollment did not begin until September 2014 and current statute expires June 30, 2016. Statutory changes to extend or remove the current repeal date would allow for adequate time for claims run-out and collection of information on the ACC: RMHP Prime program. An extension would also provide continued authority under which to implement additional payment reforms. Pending final review by OSPB and the Governor's Office, the Department is currently working with Rocky Mountain Health Plans to determine the necessary statutory changes to achieve the above stated goals.

41. Please describe the goals of the RMHP Prime pilot program and how HCPF plans to evaluate the program. Will HCPF evaluate the overall cost effectiveness of this payment method, or will it only evaluate specific types of costs such as emergency room visits?

RESPONSE

The goals of the ACC: RMHP Prime program are to: provide support for interventions that take place outside of traditional health care settings; support broad-based practice transformation, collaborative learning and measurement; increase the use of technology and data aggregation at the point of care; drive collaboration between physical and behavioral health providers; and reduce costs to the Department while delivering high quality care.

According to statute, the Department is required to report yearly on the program's payment methodology, quality measures, and the impact of the program's design on health outcomes, cost, provider satisfaction, and client satisfaction. This report, the *Department of Health Care Policy and Financing's report on the Medicaid Payment Reform and Innovation Pilot Program required by Section 25.5-5-415 (4)(a)(III), C.R.S.* is available on the Colorado General Assembly's [website](http://www.leg.state.co.us/library/reports.nsf/reports.xsp). (<http://www.leg.state.co.us/library/reports.nsf/reports.xsp>)

The program has already demonstrated some success developing a medical neighborhood that includes primary and behavioral health providers and other community partners, such as

Community Health Workers. However, because there is an inherent lag in billing and claims processing, the evaluation report did not include a robust overall cost and utilization analysis. The Department will provide an update to this report in the spring of 2016.

In addition to the Department's annual evaluation of the program provided in the legislative report, a comprehensive evaluation of the program will be conducted at the conclusion of the program. This final program report will build upon the key data points in the legislative report, including the required analysis of the cost effectiveness of the program. The program's effect on specific costs like ER visits will also be examined, in order to determine the most impactful elements of the program and main drivers of any cost savings. Additionally, the Department will evaluate program areas such as performance on quality measures like body mass index assessment and use of the Patient Activation Measure.

42. Has HCPF considered whether any of the other proposals submitted by RCCOs can be implemented to achieve the goals of H.B. 12-1281?

RESPONSE

Yes, the Department has considered other HB 12-1281 proposals submitted by the Regional Care Collaborative Organizations and is currently working with Colorado Access and Kaiser Permanente Colorado to implement another HB 12-1281 proposal. The Department will continue to learn from payment reform initiatives and implement new programs if the General Assembly decides to continue the program and its resources.

43. It is the Committee's understanding that health care premiums tend to be significantly higher in the Western Slope region. Please explain how HCPF's capitated payments to Rocky Mountain Health Plans for the RMHP Prime pilot program were calculated, and how these rates compare to other health care costs in the Western Slope region.

RESPONSE

During the first year of the ACC: RMHP Prime, the Department's fee schedule rates were used, with the exception of Pharmacy rates, to develop capitation rates for the program. During the second year of the program, the Department used RMHP's fee schedule rates for Primary Care, Physician Specialty Care, and Pharmacy to develop capitation rates for the program. For reference, RMHP's fee schedule reimburses at approximately 125% of the Department's fee schedule for primary care and 130% of the Department's fee schedule for physician specialty care (Physician – ER, Physician – Inpatient Hospital, Physician – Outpatient Hospital, and Physician – Office). Even with the higher primary care reimbursement, the program remains budget neutral overall due to expected reductions in higher cost services such as hospitalizations and ER.

The Department cannot determine how the program's capitation rates compare to other, non-Medicaid health care costs in the Western Slope for the same time period. Western Slope plans on the Connect for Health Colorado, Colorado's health plan marketplace, are not directly comparable to ACC: RMHP Prime due to significant differences in case mix, cost sharing, and benefit

package.

44. **HCPF initially established a medical loss ratio of 93.5 percent for the RMHP Prime pilot program; this percentage will decrease if the program meets certain quality performance measures. Please provide any available data about the medical loss ratio for each behavioral health organization (BHO). Further, please indicate whether HCPF's contracts with BHOs include any performance measures related to administrative costs.**

RESPONSE

The Medical Loss Ratio (MLR) in the current BHO contracts is set at 77 percent. However, the Centers for Medicare & Medicaid Services (CMS) recently proposed regulations that would require the MLR for Managed Care Organizations be set at 85 percent, effective January 1, 2017. The Department will likely be required to update the BHO MLRs to 85 percent to comply with the new regulations.

Review of the most recent available contractor MLRs, using the BHO's FY 2013-14 audited financial reports, showed MLRs of 82 percent to 89percent. It is important to note that the BHOs heavily utilize subcapitation agreements with community mental health centers. This makes the BHO MLRs less meaningful because all costs under the subcapitation agreement are considered health care costs even if a portion of the subcapitation funds are actually being utilized for administration. In other words, there is a loss of transparency when managed care entities heavily utilize subcontracting; specifically, the MLR no longer indicates what portion of the capitation went toward services and what portion went toward administration and profit margin.

The Department's contracts with the BHOs do not include any performance measures related to administrative costs.

SIM Grant

Please note that the SIM Grant is administered through the Governor's Office and collaborates with multiple state agencies. The responses below are from the SIM Office.

45. **Please provide an update on the \$65 million federal State Innovation Model (SIM) grant that was awarded to the State last year.**

RESPONSE

In December 2014, Colorado received a State Innovation Models (SIM) Round Two Testing award of up to \$65 million from the Center of Medicare and Medicaid Innovation (CMMI) to implement and test its State Health Care Innovation Plan. The 48-month project period for the award – which runs from February 1, 2015 to January 31, 2019 – is broken into four budget periods: a pre-implementation period (February 2015-January 2016), followed by three testing

phase periods, each of which lasts for one year. Funds for the pre-implementation period were released on February 1, 2015. Since that time, the Colorado SIM Office, established by Executive Order in March 2015, has been engaged in planning activities and is currently transitioning to begin the first year of model testing.

Over the course of the last 10 months, the SIM Office has worked with stakeholders to develop and operationalize strategies to achieve the initiative’s overarching goal of improving the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment structures, for 80 percent of Colorado residents by 2019. Key accomplishments have included:

- Establishing a SIM governance structure, consisting of an Advisory Board, a Steering Committee, and eight Workgroups;
- Seating members of the Advisory Board (appointed by the Governor);
- Conducting a competitive application process to select over 134 thought leaders from across the state and health care spectrum to participate in SIM Workgroups;
- Convening over 70 stakeholder meetings;
- Garnering commitments from public and private payers regarding participation in SIM;
- Releasing seven Requests for Proposals (RFP), Requests for Applications (RFA) and Requests for Information (RFI), and executing 10 contracts with vendors for key project deliverables;
- Working with state agencies and other partner organizations to ensure SIM’s alignment with other state and federal initiatives; and
- Conducting a state-wide outreach tour.

On December 1, 2015, the SIM Office submitted a draft “Colorado SIM Operational Plan for Year 1” to CMMI, which provides a blueprint of projected activities, objectives, and goals across four core program components: practice transformation, payment reform, population health, and health information technology (HIT). The plan also details how Colorado SIM will engage consumers, develop workforce capacity, implement a comprehensive and dynamic evaluation plan, and utilize a range of policy and regulatory levers to address current systemic barriers and pave the way for future innovation and transformation. The SIM Office will work with CMMI over the next month to finalize the Operational Plan. Upon CMMI approval, the funds for budget period two will be released, and implementation activities for the Test Year 1 will commence on February 1, 2016.

46. How do the planned SIM grant expenditures for health information technology relate to other HCPF and DHS technology projects? Will these SIM grant expenditures assist HCPF and DHS in addressing the WICHE study recommendation to explore the development of a common management information system for behavioral health data (or the modification of existing systems to share physical and behavioral health data)?

RESPONSE

Colorado SIM is committed to aligning HIT efforts throughout the state and working with partners to build upon existing infrastructure in order to provide practices, providers, and other stakeholders with actionable data. Colorado SIM's HIT strategy focuses on the following areas:

- Creating a Shared Practice Learning Integration Tool (SPLIT) to assess practice readiness for transformation;
- Establishing data acquisition and aggregation processes that include aggregation of clinical and behavioral health data at the patient level;
- Creating reporting tools that will provide practices and other relevant stakeholders with actionable data;
- Laying the foundation for integration of clinical and claims data; and
- Developing a statewide telehealth strategy that supports expansion of broadband access and establishes Telehealth Resource Centers to engage patients and providers.

Colorado SIM's planned development of both short- and long-term data acquisition and aggregation tools, processes, and procedures that will have direct relevance to HCPF and DHS technology projects, as outlined below.

Shared Practice Learning and Improvement Tool (SPLIT)

One of SIM's key short-term objectives is the development of a common tool, called the Shared Practice Learning and Improvement Tool (SPLIT), which can be used by SIM, HCPF, DHS, and other statewide projects. Specifically, the SPLIT will offer web-based access to data entry and reporting related to:

- 1) Collecting information to evaluate practice eligibility and readiness for transformation, advancement, quality improvement, or alignment with other programs;
- 2) Collecting assessment and transformation information for baselines, which can be used to plan next steps for transformation work;
- 3) Collecting information on practice improvements over time, which can be used by practices and state agencies for evaluation and planning purposes; and
- 4) Collecting information on data quality, systems usage, etc.

Quality Measurement Reporting Tool (QMRT)

Another short-term SIM HIT objective is the development of a Quality Measurement and Reporting Tool (QMRT), which will serve as a portal through which SIM-participating practices will enter clinical quality measure (CQM) and receive feedback on their performance in relation to this data. The tool will include the following features and capabilities:

- An electronic interface for manual reporting and data entry;
- An electronic interface to support defined format electronic submission of practice measures;
- Data storage and normalization capabilities;
- Ability to provide user performance reports;
- Reports that provide a baseline status related to CQMs and tracks changes in relation to this baseline over time; and
- Other reports related to practice-level measure collection.

The CQMs in the SIM minimum dataset, which will be used in the development of the QMRT,

were specifically selected to align with the measures currently used by other state and federal initiatives, including the Comprehensive Primary Care Initiative (CPC). This alignment will allow the SIM dataset and the QMRT to be utilized by other state agencies and organizations engaged in integrated care delivery and payment reform efforts. HCPF and DHS will specifically be collecting these measures and using the QMRT tool as part of the recently awarded Certified Community Behavioral Health Clinics (CCBHC) Planning Grant from the Substance Abuse and Mental Health Services Administration.

Data Acquisition and Aggregation with QMRT+ Central Data Hub

While the QMRT will be an important first step in “standardizing” data collection and reporting, SIM’s long-term HIT objective involves the development a Central Data Hub, called the QMRT+, which will allow the acquisition and aggregation of not only CQMs, but other data sources, including claims and public health data. The QMRT+ will retain the capabilities developed in the initial QMRT but will greatly expand upon its data reporting and sharing capabilities, to ultimately perform the following functions:

- Accept clinical quality measurement data and aggregate clinical and behavioral health data from measure sets;
- Providing the ability for end users to interface with the QMRT+ to access data such as provider, payer, patient, and condition data;
- Support Public Health usages;
- Allow for linkage to claims data and APCD to provide centralized clinical and cost data support;
- Securely transport patient level data from data acquisition organizations using standard content and transport based protocols (including CCDA and QRDA), which will leverage existing HIE infrastructure networks and others;
- Provide data storage and normalization capabilities including a Master Patient Index, which will allow patients to be tracked across different care delivery systems, and provider identity, terminology and matching services; and
- Include the ability to provide data for multiple reporting user needs.

SIM’s HIT expenditures – including the development of the SPLIT, QMRT, and QMRT+ – will address several of the current systemic or structural issues that gave rise to the WICHE study’s recommendation to develop a common management information system. When fully implemented, the QMRT+ will have the capacity to track a unique individual’s utilization of behavioral health services across different agencies and care settings, a deficiency in the current system noted by the WICHE study. The QMRT+ will also allow for the integration and sharing of different data sets, including clinical quality and behavioral health information, across providers and systems, a key need identified by the WICHE study. The SIM Office has and will continue to pursue the WICHE study’s suggestion to identify and incorporate best practices from other states, regarding both data integration and the utilization and sharing of substance use data in compliance with state and federal regulations.

The SIM initiative will serve as an important catalyst in the development of a common management information system, as envisioned in the WICHE report, that can be used to promote

the secure and efficient use of technology to support and advance integrated care delivery and alternative, value-based payment models. The SIM Office will continue to collaborate with HCPF, DHS, and other key stakeholders, to ensure the SIM's HIT efforts align with and complement other state and federal HIT projects.

11:50-12:00 OTHER

47. Data provided by HCPF indicates that the average expenditure per member in FY 2014-15 for Foothills Behavioral Health Partners was \$655.26, while the average for the other four BHOs ranged from \$449.48 to \$500.35. Please explain why Foothills' expenditures were significantly higher than those of other BHOs.

RESPONSE

Foothills Behavioral Health Partners (FBHP) expenditure per member in FY 2014-15 is higher than the average of the other four behavioral health organizations (BHOs) primarily because they have the highest capitation rates for several rate cohorts compared to the other four BHOs. Those cohorts include: low-income adults/parents, children, disabled individuals, and MAGI Adults (formerly adults without dependent children). Rates for FBHP were higher relative to the other BHOs primarily due to two factors; higher costs and higher utilization. For low-income adults/parents, children, and disabled individuals, FBHP had a higher utilization per 1,000 members months than the statewide average, shown in the table below. Additionally, in the data used for setting FBHP's FY 2014-15 capitation rates, 93 percent of FBHP's utilization is from Community Mental Health Centers (CMHCs), specifically Jefferson Center for Mental Health and Mental Health Partners of Boulder. Those particular CMHCs have a higher unit cost, \$97.26, than the state average, \$84.72. Therefore, due to a higher unit cost and higher utilization per 1,000 member months FBHP received the highest rates for these populations. The MAGI Adults rate is derived through a combination of the disabled individual's rate and the low-income adults/parents rate and because FBHP had the highest rate for those two cohorts, its MAGI Adult rate was also the highest.

Utilization per 1,000 Member Months

Rate Cohort	Foothills Behavioral Health Partners	Statewide Average
Disabled Individuals	23,895	18,432
Adults/Parents	2,235	1,696
Children	2,135	1,422

48. HCPF indicates that the per-member-per-month rates paid to BHOs have decreased for many eligibility categories in aggregate based on lower than anticipated BHO expenditures. Are these lower rates related to lower utilization or a different mix of service utilization, or are they due to provider capacity issues?

RESPONSE

The per-member-per-month rates paid to the BHOs decreased for many eligibility categories in aggregate because of a required methodology change in setting the BHO rate ranges. Under the revised methodology, which essentially required greater reliance on actual utilization data, service utilization levels were insufficient to justify the historical rate levels, which lowered the rates.

In previous rate-setting cycles, the Department's actuaries developed the BHO rate ranges using a combination of audited financial and encounter (utilization) data. The audited financials were used due to concerns about potential underreporting and inaccuracies in the encounter data. As a result of these data concerns, CMS (who must approve the program's payment rates) issued a Corrective Action Plan (CAP) that required steps to address the data integrity issues and eliminate the use of financial statements to supplement the encounter data. Working with the BHOs, the Department complied with the requirements of the CAP. The per-member-per-month rate decreased in many eligibility categories because the encounter data was significantly lower than the subcapitated premiums reported on the audited financials, as the subcapitated premiums include the service costs, admin load, and potential margin. Utilization in the encounter data simply did not support the historical rate levels.

49. Please describe how behavioral health services for "dual eligible" clients (i.e., individuals who are eligible for both Medicaid and Medicare) are provided and funded.

RESPONSE

Individuals who are dually eligible have access to and are able to receive the same behavioral health services as other full-benefit Medicaid clients. This means that individuals who are dually eligible are enrolled in the Medicaid Community Behavioral Health Services Program (Program) and belong to a Behavioral Health Organization (BHO). As a member of the Program they must have a covered diagnosis in order to access the full range of medically necessary behavioral health services provided by the BHOs.

Individuals who are dually eligible also have access to behavioral health services covered by Medicare. However, Medicare only covers a limited range of mental health services that does not include alternative services (i.e. vocational, intensive case management, clubhouse and drop-in centers, residential, and respite care) that are available under the state's Medicaid 1915(b)(3) waiver. As a result, individuals who are dually eligible with a covered diagnosis likely access most mental health services through the Medicaid program rather than Medicare.

50. How will the proposed 1.0 percent provider rate reduction affect behavioral health services provided through the fee-for-service program?

RESPONSE

From July 2009 to July 2010, the Department implemented a series of rate reductions that together, added up to a 5.39 percent rate reduction.⁸ These reductions affected nearly all providers. After implementing the reductions, the Department continued to see consistent increases in the number of enrolled Medicaid providers. Between November 2008 and November 2010, provider enrollment increased 14 percent. The table below shows the number of participating providers submitting claims by fiscal year for FY 2008-09, FY 2009-10, and FY 2010-11, which shows an increase in participation despite the reductions. There was also no increase in client complaints during that time period regarding access to care. Based on this historical experience with rate reductions, the Department anticipates that any impact of the 1 percent rate reduction requested for FY 2016-17 on provider enrollment or client access to care will likely be minimal.

Fee-for-service is a relatively small percentage of total behavioral health services expenditure, making up about 1.3 percent of the Department's behavioral health budget. The Department expects the impact of the 1.0 percent provider rate reduction to be \$87,332 total funds for FY 2016-17.

Average Number of Distinct Rendering Providers with Claims Paid Per Month by Fiscal Year

Fiscal Year	All Practitioner Providers	Physician/Osteopath	Mid-Level Practitioner
FY 2008-09	10,652	7,808	1,109
FY 2009-10	11,698	8,375	1,298
Percentage Change	9.81%	7.25%	17.04%
FY 2010-11	12,552	8,790	1,460
Percentage Change	7.30%	4.96%	12.47%

51. Currently, the Medicaid Program covers antipsychotic long-term injectable drugs through the medical benefit rather than the pharmacy benefit. As a result, the reimbursement paid to BHO pharmacies for these drugs does not cover actual costs. Would HCPF consider moving these types of drugs to the pharmacy benefit so that the reimbursement is adjusted more frequently and is more likely to cover actual costs?

RESPONSE

⁸ This was not the total rate reduction applied to Medicaid providers during the recession; reductions in subsequent fiscal years further increased the total rate reductions.

The fee schedule for physician administered drugs is based on the Average Sales Price for a drug when coverage begins. The Average Sales Prices are calculated by manufacturers and reported to the Centers for Medicare and Medicaid Services on a quarterly basis. Medicare uses Average Sales Price in its reimbursement methodology for drugs covered under Part B. The Department's rates include amounts that are above and below the most current Average Sales Prices. Due to budget constraints, the Department has not been able to update all rates as regularly as desired. The Department previously identified rates that were lower than Average Sales Price and sought additional spending authority of \$700,000 to increase the amount for physician antipsychotics and cancer infusion drugs but that request was not approved by the Joint Budget Committee.

Drugs covered under the pharmacy benefit are mostly reimbursed based on Average Acquisition Cost or Wholesale Acquisition Cost rates. The Average Acquisition Cost rates are determined by a vendor when it has received sufficient acquisition cost data from surveying pharmacy providers. The Department does not currently collect acquisition cost data on physician administered drugs and it is unknown whether physician offices or clinics would voluntarily submit such data. In addition, determining rates for physician administered drugs is not included in the current scope of work.

Wholesale Acquisition Cost is a national pricing benchmark and represents a drug's published catalog or list price for wholesalers as reported to First Databank by the manufacturer. Wholesale Acquisition Cost does not truly represent actual transaction costs and First Databank determines when the prices are updated. Since the Department does not have data on actual acquisition costs for physician administered drugs, it is unknown to what extent Wholesale Acquisition Cost-based rates would cover providers' costs for these drugs.

Reimbursing physician administered drugs following the methodologies for outpatient drugs would not necessarily result in more frequent rate updates or rates which cover acquisition costs. The Department recommends that the reimbursement methodology for physician administered drugs continue to be based on Average Sales Price since it is a pricing benchmark specifically developed for physician administered drugs and it is used by Medicare. In order to more regularly update the rates to reflect the most current Average Sales Prices, the Department would require additional funding.

The Department recognizes there are ways to improve the management of Physician Administered Drugs and strongly encouraged that this benefit be one of the first reviewed by the Rate Review process outlined in SB 15-228. The codes are included in year one of the Rate Review process and benefit and codes were discussed at that Medicaid Provider Rate Review Committee in early December. The review of these codes will continue through May 2016 and the Department looks forward to the discussion of the findings and recommendations for improving access, service utilization and quality of this benefit.