

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

**-AND-**

**DEPARTMENT OF HUMAN SERVICES  
(Mental Health and Alcohol and Drug Abuse Services)**

**FY 2011-12 JOINT BUDGET COMMITTEE HEARING AGENDA**

**Thursday, December 16, 2010**

**3:00 pm – 5:00 pm**

**3:00-3:05 INTRODUCTIONS AND OPENING COMMENTS**

**3:05 – 3:25 GENERAL OVERVIEW OF THE BEHAVIORAL HEALTHCARE SYSTEM**

- 1. How do the Department of Health Care Policy and Financing and the Department of Human Services describe and measure client outcomes for individuals participating in behavioral healthcare programs funded by the State?**

Response (DHS):

The Department of Human Services (DHS) measures client-level outcomes using multiple data sources including the Colorado Client Assessment Record (CCAR), the Drug/Alcohol Coordinated Data Systems (DACODS) and service encounter data. The Colorado Client Assessment Record collects client demographic information, diagnostic data, and client outcome measures consistent with federal national outcome measures (e.g. symptom severity, employment status, education status, housing status, hope, empowerment, criminal justice involvement, and socialization). The Drug/Alcohol Coordinated Data Systems collects admission and discharge client-level demographic information, diagnostic impressions, drug and alcohol use, and client outcome measures consistent with federal national outcome measures (e.g. symptom severity, employment status, education status, housing status, criminal justice involvement, and social connectedness). Consistent with national trends in performance measurement, the Department administers both the Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey for Families (YSSF) consumer surveys to assess perceptions of public behavioral health services provided in Colorado.

DHS and the Department of Healthcare Policy and Financing (HCPF), in collaboration with representatives from the community mental health centers, entered into a joint venture to develop state performance indicators for mental health clients. These performance indicators reflect an agency's progress in the outcomes of: access to care, continuity of care, administration of funds, quality and appropriateness of care, as well as client outcome measures.

DHS, in collaboration with managed service organizations (MSOs) and community substance use providers, is working to identify similar performance indicators for clients

with substance use disorder. The outcome measures include examining the improvement of access to services, client perception of the care received, and increased retention in treatment.

Response (HCPF):

The Department of Health Care Policy and Financing (HCPF) looks at client outcomes in four major ways: access to health services, service utilization, client health outcomes, and client satisfaction. The outcome measures that are specific to the Medicaid Community Mental Health Services Program contract are included in Exhibit I-1, Performance Measures, attached to this response. This exhibit contains 59 performance measures, 22 of which are currently implemented.

HCPF collects data to track performance on these 22 measures in different ways. For example, client satisfaction is measured using two surveys: the Mental Health Statistics Improvement Program and the Youth Services Survey for Families. Both of these survey tools are administered annually by the Division of Behavioral Health and the results are shared with the Department of Health Care Policy and Financing. Progress on some of the remaining performance measures is calculated by HCPF, and progress on others is calculated by the Behavioral Health Organizations (BHOs). Progress on all measures is reviewed at least annually.

In addition to tracking specific performance measures, the BHOs are required to conduct ongoing quality and performance improvement projects required by the Centers for Medicare and Medicaid Services (CMS). These projects focus on factors that impact client outcomes, such as access to services, grievance and appeals processes, penetration rates, and utilization rates. Projects are evaluated by HCPF's External Quality Review Organization (EQRO) annually and monitored throughout the year.

The BHO contract specifies that a sub-set of contract performance measures will be associated with financial performance incentives starting in the second year of the contract. HCPF worked with the BHOs to determine which performance measures would be associated with financial incentives, but funding for the incentive pool was not available in contract year two. The contract was amended to state that HCPF and the BHOs will develop an implementation plan for the selected measures, but implementation of the financial incentives is dependent upon legislative spending authority.

Another way that HCPF monitors client outcomes is through the Medicaid Ombudsman for Managed Care contract. The Ombudsman assists Medicaid members to obtain needed services and to navigate the Medicaid behavioral health system, as well as educates individuals and professionals about Medicaid behavioral health services. The Ombudsman submits quarterly and annual reports to HCPF that summarize client issues and outcomes. Issues that involve quality of care concerns or issues that are more difficult to resolve may be brought to HCPF's attention immediately.

Finally, client outcomes are measured anecdotally through referrals from HCPF's Customer Service staff, community advocates, and stakeholders themselves. Stakeholder input is included in discussions of any major initiative that could impact client outcomes and satisfaction.

**2. Provide a list of the legislation in the past few years that has resulted in increases in behavioral health benefits or expansion of eligible populations for behavioral health services that has not been mandated by the federal government.**

Joint Response (DHS & HCPF):

The following list represents bills that have been passed from 2004 forward. There is substantial evidence that providing behavioral health services early can prevent deeper and more costly involvement in public systems such as child welfare, emergency rooms and corrections. Many of these bills were designed to provide behavioral health care to the most expensive users of public systems (ex: substance abusing mothers) or to reduce recidivism rates through the provision of more effective treatment.

- HB 04 – 1075 extends the Medicaid postpartum substance use disorder benefit (Special Connections) from two months postpartum to 12 months post partum.
- HB 05 – 1015 establishes a fee-for-service outpatient substance abuse benefit for Medicaid members. (Effective July 1, 2006).
- SB 07 – 02 expands Medicaid eligibility to young adults, who are under 21 years of age and who were in the foster care system immediately prior to their 18th birthday or emancipation. Currently, most foster children lose Medicaid eligibility on their 18th birthday or when they graduate from high school.
- SB 07 – 36 adds additional mental disorders to mandatory health insurance coverage for mental illness. Defines mental disorders subject to the provisions of the bill to include post-traumatic stress disorders, alcohol and drug disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. Includes anorexia nervosa and bulimia nervosa to the extent treated on an outpatient, day treatment, and inpatient basis, but excludes residential treatment.
- SB 07 – 146 creates the Mental Health Services Pilot Program for Families of Recently Discharged Veterans. The 3-year pilot program provides mental health treatment and education to families of veterans who would otherwise be unable to receive such services, and is limited to the Colorado Springs area. Participating families pay a monthly fee of up to \$20 to the community mental health center, and the Department of Human Services (DHS) pays for a full range of mental health services. Participating community mental health centers are to provide mental health education services including creating and maintaining a website with information on post-traumatic stress disorder.

- SB 08 – 06 specifies that persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, Department of Corrections facility, or Department of Human Services facility, shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement. The bill also clarifies that juveniles retain Medicaid eligibility when held in a facility operated by or under contract with the Division of Youth Corrections or Department of Human Services if care within that facility qualifies for federal financial participation.
- SB 08 – 160 requires that mental health services for the Children’s Basic Health Plan Plus (CHP+) program be at least as comprehensive as the mental health services provided to Medicaid recipients in the schedule of health care services. Following passage of that legislation, the Children’s Health Insurance Program Reauthorization Act of 2009 (signed in February 2009) imposed mental health and substance use disorder parity requirements on all Children’s Health Insurance Program state plans under title XXI of the Social Security Act.
- HB 08 – 1072 directs the Department of Healthcare Policy and Financing to submit an amendment to the state medical assistance plan and to request any waivers necessary to expand eligibility under Medicaid to implement a Medicaid buy-in program for individuals with disabilities who would otherwise be eligible for supplemental security income except for their income and for individuals with disabilities whose medical condition improves.
- HB 09 – 1119 creates the rural youth program and detoxification program within the Division of Behavioral Health to assist entities providing programs to address substance abuse problems in rural areas of Colorado.
- HB 09 – 1204 requires health insurance coverage to include certain preventive health care services including alcohol misuse screening, behavioral health counseling interventions, and tobacco use screening and cessation interventions.
- HB 09 – 1293 provides public health insurance benefits, including behavioral health services, to individuals who had previously been ineligible for Medicaid. With this Medicaid expansion the Department hopes to reduce the unmet need for many health care services, including behavioral health services. The expansion populations and the timelines included in HB 09-1293 are as follows:
  - Medicaid parents up to 100% of the Federal Poverty Limit (FPL) – implemented in spring 2010
  - CHP+ children up to 250% FPL – implemented in spring 2010
  - CHP+ prenatal up to 250% FPL – implemented in spring 2010
  - Buy-in programs for people with disabilities – phased in beginning summer 2011
  - Adults without dependent children up to 100% FPL – early 2012
  - Continuous eligibility for Medicaid children – spring 2012
- HB 10 – 1033 – institutes the Screening, Brief Intervention and Referral for Treatment program to provides those services to all Colorado Medical Assistance clients aged 12 and

over who are at risk of substance abuse. Clients must be referred to the appropriate level of intervention and treatment.

- HB 10 – 1284 allocates the first two million dollars of sales tax associated with medical marijuana sales. The first million dollars are allocated to be used to provide integrated behavioral health services for juveniles and adults with substance use disorders and mental health treatment needs who are involved with, or at risk of involvement with, the criminal justice system.

**3. Did HB 05-1015 specify that the Medicaid substance abuse benefit be administered in a fee-for-service model? If not, why does the Department of Health Care Policy and Financing opt to use the fee-for-service model rather than the existing managed care model in place for Department of Human Services' funded substance abuse programs through Managed Service Organizations (MSOs)? Are there barriers to transitioning the Medicaid substance abuse benefit to managed care? Would a managed care model provide better cost containment for the Medicaid substance abuse benefit?**

Response (HCPF):

House Bill 05-1015 required that the Medicaid outpatient substance abuse benefit be delivered via a fee-for-service model. The Department of Health Care Policy and Financing (HCPF) agrees that managing care is preferable to a fee-for-service delivery model. However, the HCPF does not believe that creating a separate managed care plan for substance abuse alone (in addition to physical health behavioral health), is the appropriate solution. Health care is moving away from such “carve-outs” and towards more integrated care and services. In recognition of this trend, an option to integrate the substance abuse benefit into managed care was included in the 2008 Request for Proposals for the Community Mental Health Services Program. This option has not yet been exercised by HCPF. We believe that the current fee-for-service benefit may not cover the existing need for services; therefore, proper implementation of the benefit would almost certainly result in increased cost to the State.

HCPF will consider including the substance abuse benefit in its Request for Proposals when the Behavioral Health Organization (BHO) contracts are re-procured for Fiscal Year 2014-15. Any managed care organizations that meet the qualifications in the Request for Proposals may bid on the contract at that time.

- 4. Please provide an update on the impacts of the FY 2009-10 treatment division closures at the Colorado Mental Health Institute at Fort Logan. Are there future plans to change the services delivered at the Fort Logan facility? Is there a long-term strategic plan for the institutes as a whole?**

Response (DHS):

When the Department was asked to propose reductions to balance the budget, the Department established criteria such as eliminating whole programs and selecting programs in which alternatives might be available in the community for the clients served. The application of these criteria resulted in the decision to close the units at Fort Logan Mental Health Institute. Patients on each of these units had some form of insurance and the community provider systems were poised to expand services to these populations. For example, Children's Hospital and Denver Health have expanded inpatient services to children and adolescents since the Fort Logan unit closures. In addition, the state has struggled to find resources for basic capital improvements in its facilities (e.g. some units do not have air conditioning), which are sorely needed on these units and in this facility overall.

Fort Logan stopped admissions to each of the units slated for closure and appropriately discharged the patients prior to the January 1, 2010 closure date. The Department of Human Services (DHS) is tracking the outpatient status of the 22 patients treated on the Geriatrics unit and the seven patients on the Adolescent unit for one year after discharge from these units. As of September 30, 2010, all former Geriatrics patients were receiving mental health services in facilities that met their identified mental health needs such as nursing home facilities, alternative care facilities (ACF), the Stout Street Clinic and supportive housing placements with adjunctive case management services. Three of the former Geriatrics patients remain hospitalized at Fort Logan in alternative units. Similarly, all former Adolescent patients were referred to community-based mental health services in their home communities. While one former adolescent patient's family has not responded to Departmental inquiries, all other former adolescent patients continue to respond successfully to community-based mental health services. DHS is working with providers and other stakeholders to strengthen the community capacity to serve the elderly, adolescents, and children formerly served by the units that closed at Fort Logan.

There are currently no plans to change the type of services delivered by Fort Logan. The Department has included a comprehensive strategic plan for both institutes in its capital request in recent years, but these requests have not moved forward. The Department has discussed the creation of new programs on existing units to serve populations with co-occurring issues (such as a developmental disability and a psychiatric illness) as well as considered the consolidation of civil psychiatric beds at Fort Logan and forensic beds at the Pueblo facility.

Both institutes serve as a ‘safety net’ for Medicaid eligible and indigent individuals with very complex psychiatric needs. For example, the institutes are increasingly caring for individuals with severe co-occurring issues such as a developmental disability, autism, traumatic brain injury, or sex offense behavior history in addition to a mental illness. Services for these types of individuals are currently difficult to find in the community.

**5. Were Fort Logan patients in the children’s and adolescents treatment units transferred to Children’s Hospital? If so is Children's Hospital compensated for this increase in responsibility? If so, how are they compensated? If so, at what level are they compensated?**

Response (DHS):

There were no Fort Logan patients transferred to Children’s Hospital as a result of the child and adolescent unit closures. Fort Logan stopped admissions to the units prior to the January 1, 2010 unit closure date. Fort Logan appropriately discharged all existing child and adolescent patients prior to the closure date. Children’s Hospital is compensated for the care they provide based on the inpatient psychiatric benefits available to each patient they admit.

HCPF:

The Department of Health Care Policy and Financing (HCPF) analyzed the mental and physical health services provided by Children’s Hospital and received by those clients who were affected by the closure of Fort Logan. Two of the clients received emergency department services at Children’s Hospital for mental health reasons; neither of these claims resulted in inpatient stays. There were also two outpatient claims incurred by these clients for physical health reasons. Thus far, these claims are the extent of the impact to Children’s Hospital from the Fort Logan closure.

Children’s Hospital is compensated on a fee-for-service basis for the physical health claims. Mental health claims are paid for by the clients’ Behavioral Health Organizations (BHOs). The Department increased the capitation rates paid to the BHOs in order to cover the additional responsibility to serve the clients formerly at Fort Logan.

**6. Has the Department of Human Services looked at changing the delivery service at the two institutions to a public-private/non-profit based community model?**

Response (DHS):

The Department of Human Services (DHS) has explored public/private partnerships with Children’s Hospital, Denver Health and Mental Health Management. To date, capital, financial and legal constraints have limited the ability for these partnerships to be implemented.

- 7. Over the past 15 years, the Department of Human Services has decreased the number of public psychiatric beds considerably. Have resources been provided to community providers to replicate the services in the community?**

Response (DHS):

The Department of Human Services (DHS) provides funding to the community mental health centers for alternatives to inpatient hospitalization. The FY 2010-11 appropriated funding for these services totals just over \$3.1 million. These funds are generally used by the community mental health centers to provide an array of intensive services to support clients to remain in the community and avert hospitalization. Examples of services provided include outreach, case management, emergency services, outpatient, individual and group therapies, medication services, vocational services, and residential treatment. Alternative to inpatient hospitalization funding originally began in FY 2002-03 in conjunction with bed closures at Fort Logan and the Colorado Mental Health Institute at Pueblo (CMHIP).

Additionally, DHS funds two community mental health center inpatient facilities through the 8(B)(1) "Services for Indigent mentally Ill Clients" budget line. The FY 2010-11 appropriations for these two facilities are \$1,227,158. Of this amount, \$527,829 funds a portion of the Southwest Colorado Mental Health Acute Treatment Unit and \$699,329 funds a portion of the Colorado.

- 8. Does a service difference exist between the Therapeutic Residential Childcare Facility (TRCCF) at Fort Logan and similar TRCCFs managed by community providers?**

Response (DHS):

The Fort Logan Therapeutic Residential Childcare Facility (TRCCF) serves as a safety net for hard-to-serve children and often serves patients that are at a higher level of acuity than patients in other TRCCFs. Referring agencies, including the Division of Youth Corrections (DYC), indicate the Fort Logan TRCCF has successfully and consistently admitted and treated youth who meet a profile that few other TRCCF providers can serve as well. DYC views the Fort Logan TRCCF as the placement of choice for younger DYC boys and girls who demonstrate significant mental health needs.

**9. Is the Department of Human Services going to request more funding in a supplemental or a budget amendment as a result of the report that reviewed the three recent deaths at the Colorado Mental Health Institute at Pueblo? Is there going to be any action taken as a result of the report? Do we need a change in law to deal with the hiring process challenges outlined by the report?**

Response (DHS):

The Department of Human Services (DHS) is currently examining whether additional funding and FTE are needed to implement the recommendations included in the Colorado Mental Health Institute at Pueblo (CMHIP) November 1, 2010, Consultant Report. DHS has developed an action plan to implement, as appropriate, the recommendations included in the report. In addition, several actions have already been taken by DHS to strengthen the operation of CMHIP, including:

- a. Implementing aggressive recruiting efforts to hire temporary nursing staff;
- b. Contracting with an independent consultant to assist the hospital with implementation of survey findings and the consultant recommendations;
- c. Reorganizing and strengthening the hospital's Governing Body;
- d. Retaining an independent consultant to mentor and train the Superintendent;
- e. Implementing several physical plant modifications to increase patient and staff safety;
- f. Increasing staff training activities; and,
- g. Contracting with an independent person or group to conduct ongoing risk and compliance evaluations on a quarterly basis for the next year.

No changes are needed to deal with the hiring process challenges outlined in the report. While the CMHIP Consultant Report states that CMHIP is not able to recruit to fill vacant positions until positions are vacant, CMHIP Institute works with the Department's human resources staff to proactively recruit for the majority of direct care positions, including nursing positions, prior to vacancies occurring.

**10. Why are administrative costs continuing to rise at the State mental health institutes when the bed count is decreasing?**

Response (DHS):

Total costs to operate the institutes have declined as the institutes have closed beds. Institute costs are composed of both fixed costs and variable costs. Fixed costs (e.g. equipment, laboratory, radiology, pharmacy, dietary, buildings and grounds) do not decrease as bed capacity decreases. Variable costs (i.e. food, pharmaceuticals) do decrease as bed capacity decreases. When beds are reduced, only the variable costs decrease. The fixed costs remain and are spread over fewer beds, thereby increasing the cost per bed. Other reasons the institute cost per bed has not decreased as the number of beds has decreased include increases in costs due to salary survey, nursing compression pay, physician salaries, and pharmaceuticals.

**3:55 – 4:10 BEHAVIORAL HEALTHCARE NEED IN COLORADO**

- 11. According to the Colorado Population in Need 2009 report, there is an unmet need for behavioral health services. Are individuals in the unmet need category getting no services or do they receive services from other providers outside of the Department of Human Services and the Department of Health Care Policy and Financing? If so, how do behavioral healthcare service providers interact outside of the State-funded system interact with the Department of Human Services and the Department of Health Care Policy and Financing?**

Joint Response (DHS & HCPF):

The 2009 Population in Need Study, completed by the Department of Human Services, estimates the number of ‘persons receiving services’, which includes a variety of data sources on services provided outside of the traditional behavioral health system funded by the Departments of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF). The 2009 Population in Need Study included information on service provision from child welfare, youth corrections, Medicaid, vocational rehabilitation, corrections and judicial (probation). The ‘receiving services’ category does not include services provided through funding sources such as self-pay, private insurance, and services provided in primary care settings.

Private behavioral health service providers and insurance networks may interact with DHS providers and HCPF on committees/councils and through case consultations. HCPF expects its Behavioral Health Organizations (BHOs), Medical home practices and accountable care organizations to interact with and coordinate care with any non-State funded providers of whom they are aware.

- 12. Is there any information on how the Colorado Population in Need 2009 report numbers of prevalence, service utilization, and unmet need have changed since 2006? If not, is there any indication of how the numbers are changing?**

Response (DHS):

No, the 2009 Population in Need Study (using 2006-2007 data) is the first time that the Department of Human Services (DHS) was able to calculate the unmet need for behavioral health services. The 2002 Population in Need Study did not include the full variety of data sources used in the 2009 Population in Need Study. Therefore an accurate comparison cannot be made to the 2002 Population in Need Study. DHS would prefer to update this study every two years to better track the unmet need in the future depending on available resources. DHS has received anecdotal evidence from Community Mental Health Centers and Managed Service Organizations regarding an increase in need for services.

**13. Is there any prioritization on how people are provided mental health services? For example, are State funds prioritized by acuity of illness?**

Response (DHS):

The Department of Human Services (DHS) prioritizes how people are provided mental health services based upon financial eligibility and mental health need (acuity of illness). This prioritization is pursuant to requirements of the Community Mental Health Services Block Grant and Colorado law, 27-66-104 (2)(a)(III)(b), C.R.S. (2010). Factors for this prioritization are as follows:

In order for a person to be eligible, they must:

1. Have a Serious Mental Illness (SMI) (Adults) or a Severe Emotional Disturbance (SED) (Children) and;
2. Not have insurance coverage, have Medicare only coverage (dual eligibility not allowed), or have insurance coverage that does not include mental health benefits and;
3. Have an income that is at or below 300% of the United States Department of Health and Human Services (HHS) Poverty Guidelines for the 48 Contiguous States.

Response (HCPF):

Medicaid is an entitlement program; therefore, Medicaid members are not prioritized for services. Requirements for receiving Medicaid mental health services are medical necessity and having a covered diagnosis. Access to care standards in the Behavioral Health Organization contract apply equally to all Medicaid members, including those members for whom it is not known if a covered diagnosis exists.

**14. Does the proportion of individuals by age with prevalence of behavioral health disorders, as reflected in the chart on page 32 of the JBC staff briefing document, stay constant or vary from year to year?**

Response (DHS):

The Joint Budget Committee (JBC) staff briefing contains an abbreviated version of the table from the Colorado 2009 Population in Need (PIN) study. Below is the full table. Historically, the Department of Human Services (DHS) has found age, gender and race/ethnicity distributions to be stable. Given that the data used for the PIN study is the most recent comprehensive data available for these populations, DHS assumes that the percent of total distribution of these variables to be stable.

Adult Prevalence Estimates by Demographic Group

Variable	Serious Mental Health (MH) Illness Only	Co-occurring Disorder (MH/SUD)	Substance Use Disorder Only (SUD)	Total Serious Behavioral Health Disorders	% Total
Age Group					
18-20	2,200	1,173	10,401	13,774	8%
21-24	8,858	2,669	16,976	28,503	17%
25-34	24,451	4,765	23,208	52,424	31%
35-44	24,005	3,216	10,675	37,896	22%
45-54	15,600	1,419	3,499	20,518	12%
55-64	7,760	453	898	9,111	5%
65+	6,929	263	333	7,525	4%
Adult Total	89,803	13,958	65,990	169,751	100%
Gender					
Female	54,285	6,289	17,056	77,630	46%
Male	35,518	7,669	48,934	92,121	54%
Adult Total	89,803	13,958	65,990	169,751	100%
Race/Ethnicity					
White-NH	59,390	8,871	39,123	107,384	63%
African American	5,377	498	1,843	7,718	5%
Other-NH	3,845	773	3,014	7,632	4%
Hispanic	21,191	3,816	22,010	47,017	28%
Adult Total	89,803	13,958	65,990	169,751	100%

**15. Are there variances between the type of disorders based on age or do they all follow the same pattern as shown in the chart on page 32 of the JBC staff briefing document?**

Response (DHS):

There is some variation across age groups. For example, ADHD is very prevalent in the 0-9 year age group, but not in the adult age group. Depression is pronounced in the adult population and less so for those under age 12. According to Division of Behavioral Health FY 09-10 Colorado Client Assessment Record (CCAR) data, the following relationship exists between age and most recent diagnosis:

Primary Diagnostic and Statistical Manual of Mental Disorders Diagnosis – IV-TR	Child -0-11.9 yrs	Adolescent 12-17.9 yrs	Adult 18-59.9 yrs	Older Adult 60+ yrs
ADHD	17.79%	10.46%	1.10%	0.19%
Adjustment Disorder	34.60%	19.55%	6.72%	4.31%
Anxiety Disorder	15.98%	13.55%	12.77%	7.03%
Bipolar Disorders	7.56%	17.95%	26.81%	21.94%
Dementia / Other Cognitive Disorder	0.02%	0.02%	0.09%	1.20%
Depression	4.25%	19.05%	29.46%	36.10%
Diagnosis Deferred/No Diagnosis	3.27%	1.91%	1.37%	0.79%
Disruptive Behavior Disorders	13.62%	13.97%	0.30%	0.06%
Other	0.55%	0.81%	1.18%	0.79%
Other Childhood Disorder	1.12%	0.19%	0.07%	0.04%
Personality Disorder	0.01%	0.00%	0.20%	0.04%
Pervasive Developmental Disorders / Mental Retardation	0.70%	0.61%	0.25%	0.09%
Schizophrenia other Psychotic Disorders	0.44%	1.30%	17.36%	26.55%
Substance Related Disorders	0.08%	0.63%	2.32%	0.86%
Total	100.00%	100.00%	100.00%	100.00%

**16. Why is the State experiencing a treatment spike for marijuana use disorders? Is marijuana an addictive drug? Is there a process in place for rescinding the doctor's recommendation for a medical marijuana card if they determine the person is addicted to marijuana? If no process exists, does the Department feel a process should exist?**

Response (DHS):

Statewide, marijuana treatment admissions have been gradually on the rise since 2006, with the largest increase from 2007 to 2008. For 2008 to 2009 the total statewide substance use disorder admissions for marijuana (excluding alcohol) rose from 36.6 percent to 37.4 percent. According to National Survey on Drug Use Health (NSDUH, 2008), marijuana use has increased. There is a lower perception of risk associated with marijuana use, and with a lower perception of risk comes the higher probability of use. Colorado was among five states with

the lowest proportions of people who perceived that smoking marijuana was a great risk (NSDUH, 2008). This, along with greater accessibility, may account for an increase in marijuana use. In addition, Denver area substance use treatment providers have reported an overall climate where marijuana is much more accessible and less stigmatized. The influx of medical marijuana dispensaries may be contributing to the quality, availability, and an increased use of marijuana.

The Colorado Department of Public Health and Environment (CDPHE) is the state health agency responsible for the administration of the medical marijuana registry. CDPHE has two processes for rescinding a card. First, the issuing doctor can rescind the order at any time. Second, if the cardholder has been convicted of a crime related to the Medical Marijuana law, the card will be rescinded.

**17. Why do inmates with mental illnesses inmates have longer jail stays at the county level? Is it because of lack of treatment? Is it because they are committing more serious crimes? Is it because meds are not available? Who pays for these behavioral health services at the county level?**

Response (DHS):

There are a number of variables impacting the length of stay for county jail inmates with mental illnesses, including:

- Prevalence of in-jail treatment services,
- Ability to access psychiatric medications (restricted medication formularies),
- Extended evaluation and court proceedings due to questions of competency (a minimum of 30 days to conduct a competency evaluation and if found incompetent, additional 90 day reviews until competency is restored),
- In-jail disruptive behavior leading to additional charges, and
- Complicated jail release planning due to extensive community housing, employment, and health care needs which can delay community re-entry/release.

Jail inmates have significantly greater education, employment, housing, social support, and health care needs, and these needs strain county jail resources and influence community re-entry efforts. The costs associated with longer jail stays impact the budget for county jails, the court system, and the state (factoring the costs for competency evaluation and restoration procedures, where applicable).

County jails are required to provide health care to inmates housed in the jail (U.S. Supreme Court case *Estelle v. Gamble*, 1976), including psychiatric medications. County revenues support the health care services delivered in county jails. Public health insurance, such as Medicaid and Medicare, does not pay for individuals who are housed in jails. Upon release from jail, public health insurance (Medicaid) can pay for community behavioral health services.

**18. Are there strategies to identify mental health issues before individuals are arrested and placed in county jails that have been successful in counties in Colorado? If so, what are these strategies and in what counties have they been established?**

Response (DHS):

There are a number of successful strategies employed in Colorado to identify mental health issues before individuals are arrested and incarcerated in county jails, including: Crisis Intervention Teams (CIT), Crisis Services, and Mental Health First Aid.

- CIT is an evidence-based jail diversion strategy whereby law enforcement officers are trained to identify, engage, and de-escalate a person in a mental health crisis and collaborate with community-based emergency and treatment agencies to ensure community and individual safety. CIT decreases arrest and injury rates for people with mental illness, increases officer and citizen safety, and enhances public involvement in law enforcement efforts. The Colorado CIT effort is a multi-jurisdictional initiative including community behavioral provider agencies. The Division of Criminal Justice is the lead State agency for CIT; however, these funds have been reduced in recent years. To date, over 1,700 law enforcement professionals representing 63 police and sheriff's departments are CIT certified. The Department of Human Services (DHS) has supported these activities, which are occurring in Summit, Mesa and Pueblo counties, through SB 07-097 (Tobacco Settlement money).
- Crisis services delivered through emergency rooms are a key early intervention strategy. Hospital emergency departments are front-line triage centers, and unfortunately, individuals in behavioral health crisis can quickly overload these systems. Metro Crisis Services, Inc. (MCS) was created out of a partnership between Mental Health America - Colorado and other private and public community partners, including law enforcement, to develop a behavioral health crisis triage system located throughout metropolitan Denver to provide emergency behavioral health services in lieu of a hospital emergency room or incarceration. The program is designed to provide emergency psychiatric intervention, assessment, stabilization and community/social support. MCS is developing a crisis line (24 hours, 7 days-a-week telephonic crisis intervention, assessment, support, and service referral), an information exchange system (on-line information system to assist first responders, law enforcement, consumers, families, and communities with resources, tools, education, and real-time data dashboards to report service encounters), and three planned crisis clinics (urgent care facilities to provide behavioral health crisis intervention, assessment, and rapid stabilization). DHS has invested federal Substance Use Prevention and Treatment Block Grant and Community Mental Health Services Block Grant funds to support the critical behavioral health crisis services.
- Mental Health First Aid (MHFA) is an evidence-based, public education and prevention program designed to advance the mental health literacy of the general public and to train citizens in how to identify, provide initial help, and guide individuals displaying mental health and substance use problems to professional treatment. DHS is working with the

Colorado Behavioral Healthcare Council (CBHC) who is the statewide leader in MHFA to develop instructors and expand training and education programs to the public. To date, there are approximately 106 people trained as MHFA Instructors and close to 148 trainings have been provided to public schools, county housing departments, workforce centers, local religious/faith-based communities, local employers, county social service departments, local police, probation, and parole. Funding for MHFA has been limited, yet the Colorado Behavioral Healthcare Council, individual community mental health centers, Division of Criminal Justice (through an American Recovery and Reinvestment Act funded Justice Assistance Grant) and DHS (through federal Community Mental Health Services Block Grant funds) have supported MHFA.

#### **4:10 – 4:40 BEHAVIORAL HEALTH ORGANIZATIONS**

**19. Northeast Behavioral Health Partnership is concerned that the current rate-setting methodology penalizes them for being more efficient than other Behavioral Health Organizations (BHOs). Please indicate if the Department believes that the current rate-setting methodology is equitable across the five BHOs. Additionally, what steps, if any, are being to make the final rate-setting product more equitable from BHO to BHO.**

##### Response (HCPF):

The Department of Health Care Policy and Financing (HCPF) is moving towards a more equitable set of rates across the five Behavioral Health Organizations (BHOs). HCPF believes that the rates across the five BHOs will be equitable even if they vary, as long as the variance is the result of differing client needs. As those needs are not uniform statewide, rates will ultimately also vary statewide. HCPF is currently taking several steps to ensure an equitable set of rates. First, HCPF is working collaboratively with the BHOs to improve the data quality and the pricing system used in rate-setting. Potential miscodings, incomplete data, inconsistent coding, and inconsistent reporting of costs all create a rate that is not directly tied to client need. Last year, HCPF hired contractors to assist in implementing corrections to these data reporting problems. This current year marks the first year of operating under the revised guidelines, and data quality should improve in future cost reports. HCPF and the BHOs will continually monitor and update the reporting requirements, if needed, in order to move towards a more equitable rate-setting product.

Additionally, HCPF and BHOs have worked to reform the current rate-setting methodology by incenting improvements in efficiency through the incorporation of a state-wide average cost comparison into the rate setting process, i.e. the 'case rate.' For further information about the case rate and future rate reforms, please see Legislative Request for Information #15, submitted in December of this year.

**20. What methods are Northeast Behavioral Health Partnership implementing that allow them to deliver services for a lower rate than other BHOs?**

Response (HCPF):

The existing rates for each of the five Behavioral Health Organizations (BHOs) are set based on an analysis of historical funding and service provision across all BHOs, as well as current service provision within the particular BHO. Because of the current methodology for determining BHO rates, it is not accurate to say that efficiency is the only factor that would lower the rates. Prior to the consolidation of the Medicaid Mental Health program into the Department of Health Care Policy and Financing (HCPF), community support for mental health practitioners and organizations varied widely across regions. Those varying levels of support have impacted the ability of those practitioners and organizations to develop the infrastructure necessary to deliver services. In the latest re-procurement of Behavioral Health Organizations (BHOs), Northeast Behavioral Health Partnership, while meeting the requirements for service provisions, bid to provide fewer optional services as compared to other BHOs. The service package bid, as well as historical funding, dictates their current rate.

**21. Why is the contracted capitation rate for foster care decreasing more than other aid categories?**

Response (HCPF):

Historical capitation rates were built on Fee For Service (FFS) costs. The FFS costs for foster care clients were historically high since treatment at the time was often provided through more costly inpatient hospital services. More recently, the Behavioral Health Organizations (BHOs) have provided mental health services to foster care children with more emphasis on community-based mental health services, which tend to yield improved client outcomes at lower costs. In recent years, under Center for Medicare and Medicaid Services' (CMS) direction and in alignment with actuarial best practices, the Department of Health Care Policy and Financing (HCPF) has been putting progressively more weight on the recent encounter data as opposed to historical FFS data when developing mental health rates. This progression in weighting captures the decreasing cost of foster care services that are being driven by the shift to community focused care.

**22. Is there an auditing schedule that the BHOs follow? How do these audits work? Who performs these audits? Do these audits review the rate-setting methodologies?**

Response (HCPF):

The Behavioral Health Organizations (BHOs) are expected to fulfill the requirements identified in the Mental Health Accounting and Auditing Guidelines, which are maintained by the Department of Health Care Policy and Financing (HCPF) and the Division of Behavioral Health (DBH), when filing their annual statements. The current Accounting and Auditing Guidelines can be found at [http://www.colorado.gov/cs/Satellite?c=Document\\_C&childpagename=HCPF%2FDocument](http://www.colorado.gov/cs/Satellite?c=Document_C&childpagename=HCPF%2FDocument)

[C%2FHCPFAddLink&cid=1251569226877&pagename=HCPFWrapper](#). HCPF and DBH require that the BHOs hire an independent auditor to audit their financial statements and provide an attestation report on the Fiscal and Supplementary Schedule. HCPF uses both the financial statements and the supplementary schedules when calculating the BHO rates. The rate-setting methodology is not reviewed by the independent auditor. Instead, HCPF and the BHOs separately hire members of the American Academy of Actuaries to annually review the rate-setting methodology.

HCPF monitors the BHO program performance via numerous vehicles, including performance measures validation, annual site reviews, encounter data validations, reporting deliverables, and referrals from contractors and stakeholders. The BHO contract contains a deliverables schedule for all required documentation and reports that is monitored by HCPF staff. HCPF's External Quality Review Organization (EQRO) works with HCPF's Health Outcomes and Quality Management section to monitor and review quality deliverables and projects throughout the contract year. Corrective action plans are required of plans that fall short of compliance standards on any of these contractual requirements.

### **23. Why do penetration rates vary between BHOs?**

#### Response (HCPF):

Demographics vary across Behavioral Health Organizations (BHOs). For example, the proportion of clients within a BHO that are disabled or foster care clients can be different from one BHO to another. Disabled and foster care clients typically have higher penetration rates as, historically, disabled and foster care clients utilize more mental health services than other types of Medicaid clients. Even among these client groups, mental health need varies. As such, Behavioral Health Organizations (BHOs) with a higher proportion of disabled clients and foster care clients also typically see higher penetration rates, but even then, penetration rates are affected by the proportion of clients that need mental health services. Additionally, while the Department sets requirements for community outreach, establishment of provider networks, and client penetration, variances in community support and resources can allow certain BHOs to exceed these standards.

### **24. How do penetration rates for behavioral health services for the Medicaid-eligible population compare to penetration rates for the non-Medicaid eligible population? If the rates differ, why is this so?**

#### Response (DHS):

At this time, it is not possible to determine exact penetration rates for non-Medicaid versus Medicaid individuals, but the 2009 Colorado Population in Need study estimates the penetration rate in FY 2006-07 was 52% for youth, 33% for adults, and 39% statewide. This is a combination of Medicaid and non-Medicaid individuals.

Response (HCPF):

Penetration rates are higher for Medicaid-eligible populations than national averages. Severe mental illness can qualify a person for Supplemental Security Income (SSI). Qualification for SSI leads to automatic eligibility for Medicaid. Therefore, Medicaid serves a disproportionate number of disabled clients including clients that are disabled due to mental illness.

**4:40 – 5:00 FEDERAL HEALTHCARE REFORM AND WHAT IT MEANS FOR BEHAVIORAL HEALTHCARE IN COLORADO**

**25. How much has the current governance structure of publically funded behavioral health services contributed to the decentralization of the service delivery of mental health services substance use disorders services? Is a different governance structure required to increase the delivery of behavioral health services in a more integrated fashion?**

Joint Response (DHS & HCPF):

The current governance structure of publicly funded behavioral health services has contributed to the decentralization of the service delivery of mental health and substance use disorder services. In the past few years, the public has come to understand and expect the provision of behavioral health services in equal measure to physical health care. Prior to this change, federal and state governments established separate funding systems and provider networks for the provision of behavioral health care.

A different governance structure may be required for the integration of behavioral health care with physical health. Senate Bill 10-153 created the Behavioral Health Cabinet and Behavioral Health Transformation Council, which is charged with streamlining funding systems and administrative structures and processes for the integration of behavioral health and physical health systems.

**26. When will Accountable Care Collaborative (ACC) pilot program release a report of findings? What activities are occurring at the national level in terms of ACCs?**

Response (HCPF):

The Department's Statewide Data and Analytics Contractor (SDAC) with oversight from the Department will be tasked with analysis and evaluation of all activities of the Accountable Care Collaborative (ACC). The SDAC contract award is scheduled to occur in March 2011. The SDAC contractor will prepare and submit a preliminary cost savings and analysis report including a detailed narrative for the initial phase of the ACC program (the period of July 2011 through June 2012) by June 15, 2012. The final cost savings and analysis report for the period July 2011 through June 2012 will be submitted by November 30, 2012. Public release of this information is expected to be available shortly thereafter.

The Department is interested in fostering collaboration and cooperation of care across the BHOs and other providers including the ACC providers and organizations. The Department

is committed to advancing integrated care service delivery models and will measure and potentially incent these efforts. The Department will address the ACC in more detail at its hearing on the 21<sup>st</sup> of December.

**27. Can the departments learn anything from studying the consolidation of medical delivery that occurred several years ago in the military as it applies to the integration of healthcare services at the state level?**

Response (DHS):

The Department has not investigated the consolidation of medical service delivery for the military for application to the integration of behavioral health. This may be a model for consideration in the implementation of health care reform.

Response (HCPF):

The success of the military's integrated health care system is well aligned with the Department's objectives and is useful to inform future decisions pertaining to Colorado Medicaid health care reform. The extensive use of health information technology by the VA has led to superior health outcomes relative to the private sector, according to a report from Brown University, the University of California, Los Angeles and RAND Corporation. The military's integrated care delivery systems' success is significant in determining best practices for the future of public health reform in Colorado, and is aligned with the Department's strategy of improving health information technology, measuring performance to improve quality of care, and organizational restructuring to ensure effective and efficient decision making.

Exhibit I-1  
Performance Measures

#	Priority	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
<b>Core Measures (implement 9/1/09)</b>						
1	C	OE	Hospital readmissions within 7, 30 and 90 days post-discharge	Number of Member discharges with an inpatient admission within 7, 30, and 90 days of the discharge, reported cumulatively	Total number of Member inpatient discharges during the reporting period	Yes* (if funding available)
2	C	OE	Percent of Members prescribed redundant or duplicated antipsychotic medication	Number of Members with two concurrent pharmacy claims for an atypical antipsychotic medication for 120 days or more during the study period.	Number of unduplicated Members with one or more pharmacy claims for an atypical antipsychotic medication during the study period.	
3	C	OE	Percent of Members diagnosed with a new episode of major depression, treated with antidepressant medication and maintained on antidepressants for at least 84 days (12 weeks)	The number of Members age 18 and older with an 84-day treatment with antidepressant medication	Number of Members age 18 and older diagnosed with a new episode of major depressive disorder and prescribed an antidepressant medication	
4	C	OE	Improvement in Symptom Severity: Child	Calculated by HCPF (CCAR)	Calculated by HCPF (CCAR)	
5	C	OE	Improvement in Symptom Severity: Adult	Calculated by HCPF (CCAR)	Calculated by HCPF (CCAR)	
6	C	OE	Maintaining Independent Living Status for Members with Severe Mental Illness (SMI)	Calculated by HCPF (CCAR)	Calculated by HCPF (CCAR)	

Exhibit I-1  
Performance Measures

#	Priority	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
<b>Core Measures (implement 9/1/09)</b>						
7	C	OE	Progress toward Independent Living for Members with Severe Mental Illness (SMI)	Calculated by HCPF (CCAR)	Calculated by HCPF (CCAR)	
8	C	AC	Penetration Rates by HEDIS Age Groups	Calculated by HCPF	Calculated by HCPF	Yes*
9	C	AC	Overall Penetration Rates by Medicaid eligibility category	Calculated by HCPF	Calculated by HCPF	Yes*
10	C	AC	Overall Penetration Rates by Race category	Calculated by HCPF	Calculated by HCPF	
11	C	AC	Penetration Rates by Service Category	Calculated by HCPF	Calculated by HCPF	
12	C	AC	Utilization rates by Inpatient, Intensive Outpatient or Partial Hospitalization, and ED	Number of Members with (a) at least one discharge from a hospital episode for treatment of a covered mental health diagnosis, (b) at least one Intensive Outpatient or Partial Hospitalization, (c) at least one outpatient claim, or (d) at least one ED claim for treatment of a covered mental health diagnosis during the measurement period	Total number of Members with at least one contact during the specified fiscal year (12-month period)	

Exhibit I-1  
Performance Measures

#	Priority	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
<b>Core Measures (implement 9/1/09)</b>						
13	C	AC	Follow-up appointments within seven (7) and thirty (30) days after hospital discharge	Total number of discharges with an outpatient service within 7 and 30 days (the 30 days includes the 7 day number).	Total number of discharges during the specified fiscal year (July 1 - June 30) including multiple discharges for the same individual	
14	C	AC	Percent of Members with SMI with a focal point of behavioral health care	Total number of Members that meet at least one of the identified track criteria with the same billing provider during the measurement period (SFY). Tracks are: a) Treatment/Recovery Track; b) Med Management Track.	Total number of unduplicated Members meeting identified criteria for age, enrollment, and contact	
15	C	CC	Improving physical healthcare access	Total number of Members with at least one identified preventive or ambulatory medical visit during the measurement period	Total number of unduplicated Members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be enrolled at least ten months with the same BHO during the 12-month measurement period.	
16	C	AC	Inpatient Utilization (per 1000 Members)	All discharges from a hospital episode for treatment of a covered mental health diagnosis: a) non-State hospitals, b) all hospitals	Total number of Members during the specified fiscal year (12-month period).	Yes*

Exhibit I-1  
Performance Measures

#	Priority	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
<b>Core Measures (implement 9/1/09)</b>						
17	C	AC	Hospital Length of Stay (LOS)	Total days for all hospital episodes resulting in a discharge, excluding day of discharge. Discharge day must occur within the specified fiscal year (July 1 - June 30): (a) non-State hospitals, (b) all hospitals. If date of admission and discharge are the same, number of days for the episode equals one.	Number of Members discharged from a hospital episode. The discharge day must occur within the specified fiscal year (July 1 - June 30): (a) non-State hospitals, (b) all hospitals.	Yes*
18	C	OE	Emergency Dept. Utilization (per 1000 Members)	ED visits that do not result in an inpatient admission within 24 hrs of the day of the ED visit	Total number of Members during the specified fiscal year (12 month period)	Yes*
19	C	OE	MHSIP & YSSF Satisfaction Surveys	Calculated by HCPF	Calculated by HCPF	
20	C	OE	Antidepressant Medication Management - Optimal Practitioner Contacts	Number of Members age 18 and older who had at least 3 follow-up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks) of a major depressive disorder	Number of Members age 18 and older diagnosed with a new episode of major depressive disorder and treated with antidepressant medication	

Exhibit I-1  
Performance Measures

#	Priority	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
<b>Core Measures (implement 9/1/09)</b>						
21	C	OE	Increasing post-partum depression (PPD) screening in primary care	All live birth Medicaid providers who use an approved PPD screening tool	A sample of 20 high volume live birth Medicaid providers per BHO who had a patient diagnosed with depression/ PPD	
22	C	OE	Change in Recovery and Resilience	Calculated by HCPF (CCAR)	Calculated by HCPF (CCAR)	

Exhibit I-1  
Performance Measures

#	Development (investigate for later in contract)	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
23	D	OE	Member use of crisis intervention services > 4 times in a 30-day period	Total number of Members who use crisis intervention services > 4 times in a 30-day period	Total number of Members (all crisis services).	
24	D	OE	Percent of Members screened annually for depression in primary care setting (PHQ-2)	Number of Medicaid PCPs in service area using PHQ-2	Number of Medicaid PCPs in service area	
25	D	AC	Network Adequacy and Provider Availability	a. number of single case agreements b. open panel providers	a. total number of network providers b. total number of providers	
26	D	OE	Percent of Members who fail to fill or refill prescriptions for high risk medications	TBD	TBD	
27	D	OE	Evidence-based and promising practices: measurement of two key elements of (4) adult practices and (4) child practices annually	TBD	TBD	
28	D	OE	Number of children with mental health problems who receive screening and services. (Health People 2010)	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Development (investigate for later in contract)	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
29	D	OE	Use of psychotherapy for Members with diagnosis of borderline personality disorder	Those patients in the denominator who have received psychotherapy during the specified year.	The number of Members with a DSM-IV diagnosis of BPD (DSM-IV code 301.83) in a specified year.	
30	D	OE	Evidence of use of a standardized, validated ADHD screening tool to aid in diagnosis	TBD	TBD	
31	D	OE	Depression management for adolescents: for those started on medication, length of treatment and percent that were referred to a mental health provider	TBD	TBD	
32	D	AC	Penetration Rates by Diagnosis: (a) adults 18-54 years with serious mental illness, (b) adults age 18+ with recognized depression, (c) adults age 18+ with schizophrenia, (d) adults age 18+ with generalized anxiety disorder	TBD	TBD	
33	D	AC	Penetration Rates for Members with co-occurring mental health and substance abuse diagnoses	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Development (investigate for later in contract)	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
34	D	AC	Penetration Rates for Members with substance abuse diagnosis only	TBD	TBD	
35	D	CM	Measure of community health reported by results of the BASIS 24 Health Survey received from a statistically valid sample of Members	TBD	TBD	
36	D	AC	Percent of Members with SPMI with a review recorded in the preceding 15 months	Number of Members from the denominator with a review recorded in the preceding 15 months.	Members with schizophrenia, bipolar affective disorder and other psychoses.	
37	D	AC	Focal point of behavioral care can produce a register of people with schizophrenia, bipolar disorder and other psychoses	The practice can produce a register of Members with schizophrenia, bipolar disorder and other psychoses.	This measure applies to practices whose Member population includes individuals with a diagnosis of schizophrenia, bipolar disorder and other psychoses (one practice at a time).	
38	D	CC	Members referred for follow-up care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these conditions in a hospital emergency department	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Observation	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
39	O	CM	Suicides per 1000 Members	TBD	TBD	
40	O	CM	Suicide attempt and completion rates by adolescent Members (grades 9-12)	Enrollees age >=13 with suicide attempts or completions ascertained using emergency room, hospital and clinic claims data (attempts: ICD-9 codes E950-E959; completions: state suicide registry-CDPHE)	All enrollees age >=13 years	
41	O	CM	Incidence of maltreatment and maltreatment fatalities of child Members	TBD	TBD	
42	O	CM	Percent of adolescent Members who disapprove of substance abuse	TBD	TBD	
43	O	CM	Percent of adolescent Members who perceive great risk associated with substance abuse	TBD	TBD	
44	O	CM	Number of Members reporting use of illicit substances in past 30 days	TBD	TBD	
45	O	CM	Number of Members reporting binge drinking of alcoholic beverages	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Observation	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
46	O	CM	Percent of adult Members who exceed guidelines for low-risk drinking	TBD	TBD	
47	O	CM	Number of Member hospital emergency department visits caused by injuries	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Test for feasibility	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
48	T	OE	Relapse rates following treatment for Members with anorexia nervosa or bulimia nervosa	TBD	TBD	
49	T	OE	Percent of Members with improvement in anxiety frequency	Patients from the denominator whose frequency of anxiety (reported or observed) improved compared to a prior assessment	Patients with a completed episode of care who were eligible to improve in anxiety frequency	
50	T	OE	Frequency of care for identified diagnosis groups (based on current ICD-9 codes): Psychoses (295-299); Neurotic, Personality and Non-psychotic mental disorders (300-302.9, 306-309.9, 311-313.9, 314-316)	TBD	TBD	
51	T	OE	Percent of Members whose results on two Patient Health Questionnaires (PHQ-9s) score less than 5 or similar testing (Hamilton Rating Scale for Depression score of 7 or less) within three to seven months after diagnosis	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Test for feasibility	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
52	T	CM	Percent of adolescents who report that in the past 30 days they rode with a driver who had been drinking alcohol	TBD	TBD	
53	T	OE	Percent of children (age 6-12) with an BHO ambulatory prescription dispensed for an ADHD medication that had one follow-up visit with a BHO prescribing practitioner during the 30-day initiation phase	TBD	TBD	
54	T	OE	Percent of children who remained on an ambulatory prescribed ADHD medication for at least 210 days, percent of children (age 6-12) that, in addition to the visit in the initiation phase, had a least two additional follow-up visits with a practitioner within 270 days after the initiation phase ends	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Test for feasibility	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
55	T	OE	Percent of children with a diagnosed mental health condition based on the DSM-IV or the ICD-9 that received mental/behavioral health services in the past six months	TBD	TBD	
56	T	CC	Members with a preventive or ambulatory medical office visit during the measurement period.	Individuals from the denominator whose medical record documents receipt of a physical examination within the specified 12 month period.	The total number of individuals receiving services for a primary psychiatric disorder during a specified 12 month reporting period.	
57	T	CC	Documentation in the behavioral health record that the primary care physician was notified of changes in Member's medications, living situation, or significant change in Member's health condition within 30 days of change and evidence of documentation in the physical health record of receipt	TBD	TBD	
58	T	CM	Incidence of physical assault by current or former intimate partners	TBD	TBD	

Exhibit I-1  
Performance Measures

#	Test for feasibility	Type	Performance Measure	Numerator (general description only)	Denominator (general description only)	Perf. Incentive (year 3)
59	T	CM	Age and proportion of adolescents who remain drug and alcohol-free	TBD	TBD	

Exhibit I-1  
Performance Measures

<b>BHO RFP Performance Measures Key</b>	
<b><u>Measure Priority Type</u></b>	<b><u>Number</u></b>
Core Measures- C	22
Developmental Measures- D	16
Observational Measures- O	9
Test Measures- T	<u>12</u>
<b>Total # of Measures</b>	59
<b><u>Priority Definitions</u></b>	<b><u>Definition</u></b>
C- Core	Core measures are measures that will be in place from the time the contract begins. Data submission will be either quarterly, semi-annually or annually, depending on the measure.
D- Developmental	Developmental measures will be investigated for the feasibility of implementation as soon as possible.
O- Observational	Observational measures are measures that apply to a broad population; in this case, as they apply to the general behavioral health of the population.
T- Test	Test measures are measures that require testing before implementation.
<b><u>Type</u></b>	<b><u>Definition</u></b>
AC	Access
CC	Coordination of Care
CM	Community Health Measures
OE	Outcomes and Effectiveness

Exhibit I-1  
Performance Measures

<b>Core Measure Number</b>	<b>Source</b>
1	HCPF/BHO Scope Document/HEDIS
2	CNS Pharmacy
3	NCQA
4	CCAR
5	CCAR
6	CCAR
7	CCAR
8	HCPF
9	HCPF
10	HCPF
11	HCPF/BHO Scope Document
12	HEDIS p. 305 (2010)
13	HCPF/BHO Scope Document
14	No Reference
15	BHO Coordination of Care PIP
16	HCPF/BHO Scope Document
17	HCPF/BHO Scope Document
18	HCPF/BHO Scope Document
19	HCPF/DBH
20	AHRQ
21	No Reference
22	CCAR
Definition of Member/s	Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of Member months during a 12-month period divided by 12, which gives equivalent Members or the average health plan enrollment during the 12-month reporting period.