DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA
OFFICE OF COMMUNITY LIVING
Wednesday, December 19, 2018
9:00 a.m. – 10:30 a.m.

9:00-9:35 INTRODUCTION & OPENING COMMENTS

Main Presenters:

- Kim Bimestefer, Executive Director
- Bonnie Silvia, Interim Office of Community Living Director
- Josh Block, Budget Director
- Slides 1-10

9:35-9:40 CONFLICT FREE CASE MANAGEMENT

Topics:

- Question 1, Pages 3-6, Slides 11-12

9:40-9:45 COMMUNITY-CENTERED BOARDS PERFORMANCE AUDIT (NOVEMBER 2018)

Topics:

- Question 2, Pages 6-8, Slide 13

9:45-10:00 DEVELOPMENTAL DISABILITIES WAIVER WAITING LIST

Topics:

- Question 3-7, Pages 8-14, Slide 14

10:00-10:15 EMPLOYMENT FIRST AND ADDITIONAL QUESTIONS

Topics:

- Question 8-10, Pages 14-17, Slide 15

10:15-10:30 BREAK

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA
MEDICAID BEHAVIORAL HEALTH PROGRAMS
Wednesday, December 19, 2018
10:30 a.m. – 12:00 p.m.

10:30-10:45 INTRODUCTION & OPENING COMMENTS

Main Presenters:

- Kim Bimestefer, Executive Director
- Laurel Karabatsos, Interim Medicaid Director
- Shane Mofford, Rates Director
- Slides 1-9

10:45-11:45 COMMITTEE QUESTIONS

Main Presenters:

- Kim Bimestefer, Executive Director
- Laurel Karabatsos, Interim Medicaid Director
- Shane Mofford, Rates Director

Topics: Residential and Inpatient Care, Implementation of the Accountable Care Collaborative, Phase II, Implementation of "Suspension" of Medicaid Benefits (S.B. 08-006)

- Questions 1-16, Pages 3-16, Slide 10

11:45-12:00 CLOSING REMARKS & ADDITIONAL QUESTIONS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA
MEDICAID BEHAVIORAL HEALTH PROGRAMS
Wednesday, December 19, 2018
10:30 a.m. – 12:00 p.m.

RESIDENTIAL & INPATIENT CARE

1. **Describe the Department's efforts to ensure Medicaid clients have access to appropriate residential and inpatient psychiatric care within their communities. As part of your response, please include a discussion of the following two topics: The Department's plans to: (a) require hospitals to include an analysis of inpatient psychiatric and substance use disorder beds as part of their community assessment; and (b) tie a portion of supplemental funding to hospitals that make extra beds available for Medicaid clients. The changes recommended by the Governor's Behavioral Health Licensing Task Force to clarify facility licensing and program oversight or approval, and the addition of Acute Treatment Units and Crisis Service Units as part of the treatment continuum for patients in acute crisis.**

RESPONSE

The Department utilizes multiple strategies to ensure Medicaid members have access to appropriate residential and inpatient psychiatric care within their communities. Within the Department's program, inpatient and residential care incorporates Acute Treatment Units (ATUs), Crisis Stabilization Units (CSUs), local residential beds provided by Community Mental Health Centers, and inpatient hospitals.

The guiding principle for the capitated behavioral health benefit is the provision of a full continuum of community-based services for members, including inpatient and residential care. The Community Mental Health Centers have been the cornerstone of this community-based approach to treatment and continue to be so under the Regional Accountable Entities. The Department has established contracts and payment arrangements that balance incentives so the Regional Accountable Entities and their behavioral health provider networks connect members with the most appropriate levels of care.

The Department also monitors the Regional Accountable Entities' activities through contract deliverables and other management activities. The Department has established contracted network access standards to monitor and ensure vendor compliance. Through an annual network adequacy plan and quarterly network reports, the Department is able to monitor compliance with the established standards and the Regional Accountable Entities' activities to address any network deficiencies. In addition, the Regional Accountable Entities must submit a monthly report of Institution for Mental Disease (IMD) stays which can be used to track utilization and compared with historical Behavioral Health Organization (BHO) information.

<u>Hospital Transformation Program</u>
As directed by statute, the Department and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board are seeking federal approval to implement a Hospital Transformation Program to tie existing supplemental hospital payments to value-based initiatives focusing on high utilizers, vulnerable populations, behavioral health and substance use disorder coordination, clinical and operational efficiencies,

and community development efforts. The program framework, structure, operational components, and program metrics are still under development.

Currently, hospitals are engaging with their community partners including Regional Accountable Entities, community health centers, community mental health centers, consumer advocates, local public health agencies, and others. The goal of the community engagement process before program implementation is to inform selection of initiatives based on a sound understanding of the community's health needs, the resources available to address those needs, and the hospital's role to effectively support the community to address those needs. This includes identifying the delivery system's capacity within the community in a variety of areas, including behavioral health.

A main goal of the Hospital Transformation Program is to increase hospital collaboration with the Regional Accountable Entities and other community partners in care coordination and team-based, patient-centered care. The Hospital Transformation Program will support the Department's commitment to ensuring members have access to the full continuum of behavioral health care, including inpatient psychiatric care. Where there is an identified need in the community and appropriate resources are available, including appropriate staff and clinicians, hospitals may include initiatives to utilize available beds for behavioral health and substance use treatment in the Hospital Transformation Program.

Behavioral Health Facility Licensing Task Force

The Department actively participated in the Behavioral Health Facility Licensing Task Force (Task Force) and the development of recommendations. At this time, the recommendations are focused on streamlining and consolidating licensing by establishing a Behavioral Health Entity License administered by the Colorado Department of Public Health and Environment. The vision is that this new license category would establish core competencies and requirements for the full array of behavioral health entities, including Acute Treatment Units (ATUs) and Crisis Stabilization Units (CSUs).

The Department will continue to participate in operationalization of the Task Force's recommendations to ensure that within the broader licensing framework, distinct licensing criterion are developed for ATUs and CSUs to more accurately capture the level of care being provided by these entities so proper reimbursement arrangements can be developed. Services provided by the ATUs and CSUs are already covered by the Department's capitated behavioral health benefit. Better definition around the levels of care provided in both CSUs and ATUs will assist the Regional Accountable Entities in ensuring that Medicaid members enter treatment at the right level and are stepped down from more intensive levels of care to an appropriate level of care.

2. **How will the expansion of inpatient psychiatric and substance use disorder capacity in each region affect local community-based behavioral health providers?**

RESPONSE

The Department's efforts to expand capacity for inpatient psychiatric and substance use disorder treatment are not intended to shift members from community-based treatment alternatives into higher levels of care. The Department remains committed to ensuring that members have timely access to medically necessary

care in the most appropriate setting and places an emphasis on providing the care in the least restrictive environment.

3. Discuss the Department's implementation of the revised federal managed care rule that limits the use of Medicaid funding to cover inpatient psychiatric care in certain settings.

RESPONSE

The Centers for Medicare and Medicaid Services (CMS) released publicly the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule on April 25, 2016, with compliance effective dates beginning on or after July 5, 2016. The Managed Care Final Rule is a comprehensive overhaul of the regulations pertaining to managed care programs that has impacted rate setting, communications, quality measurement and review, and multiple areas of contracting. The Department requested and received funding from the General Assembly beginning in FY 2016-17 for additional resources to support the Department's implementation of the new rules for all of the Department's managed care plans.

With the additional resources from the General Assembly, the Department established a multi-disciplinary workgroup that developed a comprehensive workplan and began implementation of the new regulations. The workgroup prioritized activities to meet CMS established implementation timelines, particularly the updates to existing contracts required for CMS approval. In June 2017, CMS provided communication acknowledging the complexity of the rule changes and permitting flexibility to states on implementing more challenging regulations. For Colorado, one of the more challenging regulations to implement has been the revised regulations regarding members receiving services in an Institution for Mental Diseases (IMD) services.

The Managed Care Final Rule includes authority for Medicaid agencies to pay for IMD services as an "in lieu-of" service under a capitated managed care program for no more than 15 days a month (42 CFR 438.6(e)). Prior to this change in federal regulation, Colorado Medicaid was one of a few states that was able to allow reimbursement for IMD services under a waiver from the federal government, without a formal limit on the number of days. The change in IMD regulations meant that not only did the Department need to implement new policies to comply with the regulations, but it also had to take away programmatic flexibility that had been an important component of the capitated behavioral health benefit.

The Department created an interdisciplinary work team of policy and rates staff to operationalize the new IMD limit of 15 days. As it is impossible to know in advance which members will require more than 15 days in an IMD, the Department has had to build a manual process to collect the necessary information from the RAEs and IMDs regarding member length of stay and to adjust capitations as required. The Department shared the proposed process with CMS in February 2018 and determined that it would implement the new policy upon the execution of the new Regional Accountable Entity contracts on July 1, 2018.

In January 2018, the Department also began a series of conversations with the Office of Behavioral Health, the Colorado Behavioral Healthcare Council, and the Regional Accountable Entities to explore potential solutions to address possible gaps in coverage generated by the change in federal regulation. The consensus among participants was that the proposed solutions were not viable.

Initially the Department expected to have a solution to present to the IMDs prior to July 1, 2018. However, as a solution could not be reached among the community partners, the Department reached out to the IMDs in August to convene a group of IMDs and the Regional Accountable Entities to find a resolution. One result of these conversations is that the Department has modified its enrollment policy into the Accountable Care Collaborative to allow retroactive enrollments for Medicaid eligible individuals who were admitted to an IMD prior to receiving their Medicaid eligibility determination and being enrolled into a Regional Accountable Entity.

The Department is utilizing its contract management meetings to create a monthly forum with both the Regional Accountable Entities and IMDs. Together, the organizations are operationalizing the agreed upon strategy and addressing outstanding issues to ensure IMDs are reimbursed for eligible services to Medicaid enrolled individuals.

4. **As indicated in the JBC staff budget briefing document, the Department has operationalized the new 15-day limit for institutions for mental disease (IMDs). The interpretation of the 15-day limit was communicated to IMDs the final week of September 2018, and was retroactively applied to be effective July 1, 2018. These facilities provided care in good faith to Medicaid beneficiaries for almost three months before being informed that related payments would be "clawed back." Why would the State be allowed to conduct business in this manner?**

   The IMD limit states that federal financial participation is not allowed for patients who receive more than 15 days of care in an IMD. Colorado is fairly unique in its interpretation that <u>no</u> payment is made to the IMD when a patient requires more than 15 days of care. Why is Colorado taking such an aggressive interpretation of this limit when other states are not?

   How will the Department avoid inappropriately shifting the cost of care to the State or to private psychiatric hospitals?

   How will the Department ensure that regional accountable entities (RAEs) have appropriate financial incentives to provide cost-effective, clinically appropriate care for clients?

RESPONSE

The Department is fully committed to ensuring reimbursement for all covered services provided to all eligible Medicaid members. That said, all payments made by the Department need to comply with federal and state regulations; otherwise, the Department and the state could be at financial risk for disallowances.

<u>Overview of Federal Regulations on IMDs</u>
Colorado is not taking a unique position in its interpretation of the federal regulations related to IMDs.

Federal regulations at 42 CFR §§ 435.1008 and 441.13 preclude Federal Medicaid funding for any services to residents under the age of 65 who are in an IMD, except for inpatient psychiatric services provided to any individuals under the age of 21.

CMS offered some flexibility regarding the IMD restriction in the recently revised Managed Care Final Rule at 42 CFR § 438.6(e) which states:

> The State may make a monthly capitation payment to an MCO or PIHP for an enrollee aged 21-64 receiving inpatient treatment in an Institution for Mental Diseases, as defined in § 435.1010 of this chapter, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services at § 438.3(e)(2)(i) through (iii).

Additional clarification was provided in the Centers for Medicare & Medicaid Services (CMS) Frequently Asked Questions document specific to 42 CFR § 438.6(e) published in August 2017.

> States are permitted to make a pro-rated capitation payment to the managed care organization or prepaid inpatient health plan to cover only the days within the month when the enrollee is not a patient in the IMD. Federal Financial Participation is not available for payments related to days when the enrollee is in an IMD when the requirements of 438.6(e) are not met.

Therefore, if a member is in an IMD longer than 15 days within the capitation month, the Department cannot claim federal financial participation for any Medicaid services while the member is a resident in the IMD during that month.

<u>Operationalization of the IMD Regulations for IMD stays greater than 15 days</u>

As the Department only has authority from the General Assembly to pay for services that receive federal financial participation, the Department is required to recover all payments made for the days the member was in an IMD when the member is in an IMD longer than 15 days within the capitation month. This means the Department must recover any fee-for-service claims payments, capitation or per-member per-month payments to the Regional Accountable Entities, and per-member per-month fees paid to the Dental Administrative Service Organization for the days when the member was in the IMD during the capitation month.

As referenced in the response to Question #3, the Department has been working with community partners to limit the financial risk for IMDs while providing additional supports to reduce lengths of stay. The Department has asked the Regional Accountable Entities and IMDs to partner in aggressively managing member lengths of stay to reduce the number of members who exceed 15 days during a capitation month, thereby minimizing the instances where the Department would need to recover capitation payments. The Regional Accountable Entities have also been requested to use the flexibility of their payment arrangements, such as the implementation of value-based payment arrangements, to support the continued viability of the IMD business models so that inpatient services remain available in their regions.

The Department has incorporated a variety of checks and balances within the Regional Accountable Entity contracts to hold them accountable for the provision of cost-effective, clinically appropriate care for members. However, partnership between the RAEs, the Department(s), and the IMDs coupled with aggressive management of stays is what will ultimately ensure members are treated in the most appropriate

setting based on their needs, and that the financial burden of treatment is not shifted to private providers or to the state.

[Background Information: On November 13, 2018, the federal Centers for Medicare and Medicaid Services' Department of Health and Human Services Secretary Alex Azar wrote a letter to State Medicaid Directors (SMD #18—011 Re: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance) announcing a new waiver opportunity which allows states to apply for 1115 waivers to allow federal financial participation for inpatient mental health services for adults in IMDs. Secretary Azar is strongly encouraging states to consider applying for these waivers, partially due to results in states with existing waivers. (For example, Virginia obtained a waiver in 2016 and saw a 39 percent decrease in opioid related emergency department visits and a 31 percent decrease in emergency department visits related to substance abuse.) States are expected to achieve a length of stay of no greater than 30 days, thus addressing the issues related to the IMD 15-day rule.]

5. **Given the federal encouragement for states to consider this waiver option, is the Department considering submitting this waiver request as part of the expansion of the Medicaid benefit for substance use disorder services? If not, why?**

RESPONSE

On November 13, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director Letter[1] (SMD #18 – 011) entitled "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." In this letter CMS provides resources on existing strategies states can use to provide services to these populations (support for integration of mental health care into primary care settings which can allow for earlier identification and connection to appropriate treatment, better care coordination and transitions to community-based care, and increased access to supportive services that can help these individuals maintain a job or stay in school). The letter also identifies a new 1115 Waiver Demonstration opportunity for states to receive federal financing to cover inpatient mental health stays for adults in Institutes for Mental Diseases.

As referenced in the question, the Department is in the process of expanding the Medicaid benefit to include residential and inpatient SUD services. This expansion, authorized by HB 18-1136, builds off research funded by the General Assembly during the 2017 session and research conducted this year on the experience of 14 other states, and will require a 1115 Demonstration Waiver. This waiver opportunity was initially introduced via SMD letter in July 2015. Since that time, CMS has issued additional guidance and amended the original requirements regarding implementation and evaluation of the residential and inpatient SUD demonstration.

Given that SMD letter #18 – 011 was issued just over a month ago, the Department is early in the process of reviewing it to determine how it might align with other Department and legislative priorities, including the implementation of HB 18-1136.

The Department is meeting regularly with CMS for technical assistance and support in implementing the inpatient and residential substance use disorder benefit waiver. To the extent possible and practical, the

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

Department will use this forum to obtain additional guidance on the brand-new mental health waiver opportunity. The Department remains committed to timely implementation of the SUD inpatient and residential benefit and wants to ensure that concurrent implementation of a new mental health benefit requiring additional waiver authority would not jeopardize the work that has been underway for several years.

6. **For patients in need of court-ordered treatment, the Court is allowed 10 days to schedule a court hearing to order involuntary medication. Given this circumstance, the 15-day IMD limit is an unreasonable time period for severely mentally ill citizens in Colorado. Would the Department consider a state-only funding solution for these high acuity patients in need of longer lengths of stay until the 1115 IMD waiver is secured for improved access to mental health treatment for those citizens most in need of care?**

RESPONSE

The Department lacks the statutory authority to run a state-only program as described in the question above. The General Assembly would need to authorize the program, provide an appropriation, and determine which state department would be most appropriate to administer the program. Regardless of whether such legislation is pursued, the Department recommends consideration of a cross-agency collaboration to shorten and streamline the process for securing involuntary medication for persons admitted to an inpatient facility.

7. **Discuss the recently passed federal *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*, and the potential implications for the Medicaid Capitation Program and the expansion of the Medicaid benefit for substance use disorder services.**

RESPONSE

The federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was signed by President Trump on October 24, 2018. The legislation is more than 600 pages long and broad in nature, with changes to Medicaid, Medicare and law enforcement. As it relates to Medicaid, there are required activities in the areas of benefits, prescription drug monitoring, and eligibility for youth who are incarcerated. The legislation provides new options such as those for special populations and the use of telehealth services. Additionally, the SUPPORT for Patients and Communities Act provides new federal financing opportunities like the new State Plan option allowing states to receive federal funds for substance use disorder services provided to individuals in an Institution for Mental Disease (IMD) and grants to support provider capacity building. Finally, the legislation directs multiple levels of government including the Centers for Medicare and Medicaid Services (CMS), the Health and Human Services Secretary, and the Government Accountability Office, to research and report on topics such as gaps in Medicaid coverage for pregnant and postpartum women, medication assistance treatment utilization control policies, substance use disorder payment rates, and methods to improve non-opioid pain management.

In light of the very recent passage, the Department is early in the process of reviewing the legislation and summary reports prepared by health policy organizations. As more guidance, regulations and research findings are released, staff will review to assess the impacts to the behavioral health capitation benefit and the expansion of the Medicaid substance use disorder benefit. The Department is exploring, with CMS,

whether the State Plan option for coverage of SUD services provided in an IMD will meet programmatic goals for the expansion of the SUD benefit to include inpatient and residential services. Upon initial review, the limit of 30 days within a 12-month period may be too restrictive and an 1115 Demonstration Waiver may still be needed.

In all of this, the Department will work closely with the Office of Behavioral Health and other partners.

IMPLEMENTATION OF THE ACCOUNTABLE CARE COLLABORATIVE (ACC), PHASE II

[Background Information: As part of the Department's plans to implement phase II of the ACC, it proposed taking a portion of the savings that resulted from decreases in per-member-per-month rates paid to behavioral health organizations (BHOs) to finance new performance incentive payments. With respect to the first set of incentive payments that are being paid out in FY 2018-19 (for services provided in FY 2017-18), we understand that none of the BHOs earned incentive payments for two performance measures:
#6 Emergency Department Utilization for mental health condition
#7 Emergency Department Utilization for substance use disorder condition]

The BHOs assert that these measures are flawed for several reasons:

- **All BHOs experienced a negative change compared to the prior year, which is unusual.**
- **The BHOs do not have the data to validate these measures, and with respect to measure #7, did not receive any Department feedback until five months after the close of the fiscal year.**
- **Both of these measures were changed for FY 2018-19, which indicates that Department recognized inherent problems with these measures.]**

8. **The BHOs asked the Department to toss out performance measures #6 and #7 for FY 2017-18, and to distribute the associated funding (15 percent of the total available for BHO incentive payments) based on BHOs' performance on the other five performance measures. Explain why the Department did not accommodate this request. Further, describe how the Department will use these funds if it does not allocate them to BHOs (which would reinvest the funds in community-based services).**

RESPONSE

In 2017, the Centers for Medicare and Medicaid Services (CMS) approved contracts and a 1915(b) waiver authorizing the Department to implement the Behavioral Health Incentive Program. The intent of the Behavioral Health Incentive Program was to encourage meaningful changes within the behavioral health system that improve health outcomes for members while containing program costs. This program was developed in collaboration with the Office of Behavioral Health (OBH) and the Behavioral Health Organizations (BHOs) for the performance period of July 2017 - June 2018.

The Behavioral Health Incentive Program provided the opportunity for the BHOs to earn additional payments of up to five percent of their actuarially sound capitation rate for achieving performance goals on ten measures. The measures selected as part of this Incentive Program were, in part, based on previously existing performance measures that had been monitored by the Department and its External Quality Review

Organization. The BHOs collaborated with the Department on the development of the methodology for the measures.

In order to be eligible for Behavioral Health Incentive Program funds, the BHOs first had to meet the following three participation measures:

1. All corrective action plan submissions and activities shall be in accordance with the provisions of the Contract, for the duration of the Contract term.
2. Encounter data shall be submitted monthly in accordance with the provisions of the Contract, for the duration of the Contract term.
3. The Contractor shall demonstrate documentation accuracy in the 2018 Contractor reported 411 audit.

All BHOs met the above minimum requirements and therefore qualified to earn potential incentive payments on the measures listed below.

Incentive Performance Measure		**Percentage of Funding Allocated for Measure**
#1 Mental Health Engagement (all members excluding Foster Care)		15%
#2 Mental Health Engagement (Foster Care)		5%
#3 Engagement of SUD Treatment		10%
#4 Follow-up Appointment within 7 days after a hospital discharge for a mental health condition		5%
#5 Follow-up Appointment within 30 days after a hospital discharge for a mental health condition		5%
#6 Emergency Department Utilization for mental health condition		7.5%
#7 Emergency Department Utilization for substance use disorder condition		7.5%
Incentive Process Measure	**Percentage of Compliance**	**Percentage of Funding Allocated for Measure**
#8 Suicide Risk Assessment	80%	10%
#9 Documented Care Coordination Agreements	100%	15%
#10 Denials: Dual Diagnosis	80%	20%

Each of the BHOs made progress and earned incentives on at least five (5) of the measures, with two BHOs meeting performance targets on eight (8) of the measures.

The individual incentive performance measures and their values relative to the overall incentive funds available are delineated in both the 1915(b) Waiver and associated BHO contracts approved by CMS. In a pay-for-performance program there is no guarantee that all available funds will be distributed. As an example, the Regional Care Collaborative Organizations have participated in a performance program for seven years and it was only within the last year that one of the seven organizations earned any payments for meeting performance targets for well child visits.

The Department is committed to pursuing value-based payment arrangements with its vendors to reward improved health outcomes and efforts to contain costs. To date the Department has not retroactively removed performance measures based on vendors not achieving agreed upon performance targets. To do so seems to be a violation of the core principles of an incentive program. Based on the principles inherent to an incentive program and the logistical challenges related to CMS authority, the Department is retaining incentive measures number 6 and 7 as part of the Behavioral Health Incentive Program. The unearned incentive funds will revert to the General Fund and Healthcare Affordability and Sustainability Fee Cash Fund.

The Department revised its incentive measures for the Regional Accountable Entity contracts. This was done to reflect the broader scope of accountability of the Regional Accountable Entities; it does not reflect any concern on behalf of the Department on the validity of the original measures.

9. The JBC staff budget briefing document, page 19, references Performance Incentive Payments to the BHOs for services provided in FY 2017-18, and lists seven performance measures and three process measures. Please describe the third process measure, "Denials: dual diagnosis."

- Were the BHO's incentivized to deny care to Medicaid members with a mental health disorder who also struggle with substance abuse?
- If so, has this incentive continued under the Regional Accountable Entity (RAE) contracts?
- Is there an equivalent incentive to deny physical health care for individuals who struggle with substance abuse?

RESPONSE

The description of the Dual Diagnosis Denials process measure in the BHO-HCPF Incentive Performance Measures Scope Document states:

Documented care plans, either by the BHO or other entity, are executed for members with service denials for non-covered diagnoses (TBI, DD, autism, etc.) when the member also presents with a co-occurring mental health or substance use disorder diagnosis.

The Department created the Dual Diagnosis Denials process measures to incentivize greater care coordination when service requests were denied for members based on the need for treatment related to a diagnosis not covered by the BHO. For instance, a provider may have requested respite services for a member and upon review of the request, the BHO determined the need for respite was because the member was experiencing behaviors related to autism. As the treatment of autism was not covered under the BHO capitation, the BHO would deny a request for respite services for the treatment of autism.

This process measure required the BHOs to document how care coordination plans were developed and tracked for members for whom services were denied for a diagnosis not covered by the BHO. The BHOs had to demonstrate that 80 percent of members denied services for a non-covered behavioral health diagnosis and co-occurring mental health/substance use disorder diagnosis (for inpatient services) had a documented care coordination plan to assist the member to access services not covered by the BHO. All 5 BHOs met this measure.

For Phase II of the Accountable Care Collaborative (ACC), the Department has reduced the number of incentive measures – based on feedback that having too many dilutes the focus - and has moved away from process measures and toward measuring actual health outcomes. As a result, this measure was not continued under the new Regional Accountable Entity (RAE) contracts.

The BHOs were not incentivized to deny care to Medicaid members. The Department also does not incentivize the denial of physical health care.

[Background Information: The Department's contracts with the new RAEs went into effect on July 1, 2018. We have heard that there are community providers who either are not being paid correctly or do not have fully executed contracts. We have been informed of one instance in which the amount a RAE owes a single provider exceeds $1.0 million.]

10. **What is the Department doing to hold RAEs accountable and ensure that the community providers remain viable to provide these critical services?**

RESPONSE

The Department has been actively monitoring and engaged in ensuring that all Regional Accountable Entities (RAEs) have contracts with their local community mental health centers (CMHCs), have the systems in place to pay behavioral health claims, that claims are being paid on a regular basis and that rates are reasonable.

While the Department cannot dictate payment rates or who the RAE must contract with within a capitated managed care model, Department staff have been actively involved in any complaints regarding contracting and rates or payment issues. When outreached by a CMHC or RAE with difficulties, staff facilitate sharing of information about how the rates are set and what costs and assumptions comprise the rates, including assumptions on base-unit costs for CMHC. In a similar fashion, staff are actively tracking the status of RAE contracting with CMHCs statewide and intervene when concerns about correct payment surface. The Department has ensured that RAEs make interim payments as they work to improve payment accuracy with their CMHC partners.

11. **We understand that under the transition from BHOs to RAEs, there are hundreds of Medicaid clients ("members") who have not been properly enrolled by Medicaid into a RAE and who, as a result, have not been able to properly access coverage for inpatient mental health emergencies. When will the Department ensure these members are enrolled and properly assigned to a RAE?**

RESPONSE

During the implementation of Phase II of the Accountable Care Collaborative, 1.3 million members were transitioned from a Behavioral Health Organization (BHO) to a Regional Accountable Entity (RAE). Any time an organization takes on such large-scale changes, there are likely to be errors. The Department was proactive and identified a process for RAEs, providers, members, and other interested stakeholders to ask questions and alert the Department to any member-specific or systemic issues during the transition. The Department staffed a team to review and resolve issues on a daily basis. The Department is not aware of any instance where a member has been unable to access mental health emergency services. Additionally,

provisions of the federal Emergency Medical Treatment and Labor Act (EMTALA) prevent hospitals from denying individuals with an emergency condition with access to care. Instances of Medicaid members being denied access to emergency inpatient mental health treatment should be reported to the Department and to the Colorado Department of Public Health Environment to investigate for an EMTALA violation.

All members have been assigned to a RAE. There are fewer than 3 percent of Medicaid members who are being reassigned for various reasons (i.e.: primary care medical provider preferred fewer members or was too far from the member's home).

12. How does the Department's method of establishing per-member-per-month rates for the Capitation Program account for inflationary pressures and the behavioral health workforce shortage?

RESPONSE

The managed care rate setting process is subject to a rigorous state and federal regulatory framework. Rates are required to be actuarially certified as sufficient for the plans to procure the services covered under the scope of their contract and to satisfy all administrative requirements and expenses such as utilization review, claims processing, reporting, taxes, etc. The certified rates are reviewed by the Centers for Medicare and Medicaid Services and the Federal Office of the Actuary prior to federal approval. Adjustments for inflation and network adequacy/workforce shortage issues are accounted for in the rate setting process and are highly scrutinized at the plan, state department, and federal agency level.

Managed care capitations for the behavioral health program are developed using historical utilization, cost and price information, and assumptions about trend and future policies. Inflationary pressures are accounted for through unit cost trend, which is an adjustment applied by the Department's actuary to ensure reimbursement levels reflect the anticipated cost the managed care entity will have for procuring services during the contract period. Additionally, the Department and contracted actuary use Community Mental Health Center annual cost reports to update assumptions about the cost of providing services and adjusts the capitation rates accordingly.

To the extent an area is experiencing a workforce shortage, this is reflected in utilization rates; members can only use services they have access to. In the event that a managed care entity is unable to satisfy the network adequacy standards in their contract and the only identifiable solution is to increase reimbursement to the contractor and subsequently to downstream providers, capitation rates are adjusted accordingly. This is a relatively rare situation because increasing reimbursement above and beyond the unit trend assumption does not necessarily translate to an increase in available providers. In fact, it may just cause a change in where services are rendered without increasing access at all. For example, if psychologists were paid 15 percent more at a Federally Qualified Health Center than at a Community Mental Health Center and rates/wages were increased by 30 percent for the Community Mental Health Center, the limited behavioral health staff may move from the Federally Qualified Health Center to the Community Mental Health Center, but there would be no net gain in capacity to the overall system.

Due to the rigorous regulatory framework and because the Department sets rates at the regional level, policies that impact workforce must be closely evaluated prior to making rate adjustments. Rate adjustments in isolation are unlikely to address workforce shortages as many factors impact network capacity for any given region. With a workforce shortage, substitution effects may eliminate the benefit of increasing provider reimbursement.

13. How is the Department ensuring that its implementation of the new RAE contracts and the expansion of the Medicaid benefit for substance use disorder services are aligned?

RESPONSE

The Department will ensure alignment of the expansion of substance use disorder services with the implementation of the new Regional Accountable Entities contracts by building the responsibility for managing the expanded substance use disorder services into the RAE contract. The new services and associated costs will be built into the existing behavioral health capitation benefit. In this way, the RAEs will be responsible for the full continuum of substance use disorder services. The Department will work with the RAEs and other interested parties through the required stakeholder process to ensure the RAE contract reflects the development of an evidence-based benefit for persons that meet nationally recognized level of care criteria and that the RAEs possess the necessary infrastructure to implement and manage the services effectively.

IMPLEMENTATION OF "SUSPENSION" OF MEDICAID BENEFITS (S.B. 08-006)

14. Discuss the Department's recent implementation of a "suspension" functionality within the Medicaid claims and eligibility systems. How will the suspension of clients' Medicaid eligibility while they are incarcerated, committed, or admitted to a psychiatric hospital affect Department expenditures?

RESPONSE

In March 2017, the Department fully implemented the suspend function in both the MMIS (claims) and CBMS (eligibility) systems.[2] This function means Medicaid eligibility is not terminated upon incarceration; prior to implementation, incarceration meant Medicaid eligibility was terminated and a new eligibility determination was required. Operationally, county eligibility technicians change the Medicaid enrolled inmate's status to "incarcerated" in CBMS (the incarceration is considered a change in the living location). This change to status triggers an indicator to the MMIS and the individual is placed in the "Incarcerated Benefits Package." This benefit package limits the member to only inpatient hospital services and those services related to the inpatient stay (this was also an allowable expenditure prior to the implementation of the suspend function). Upon release, the eligibility technician changes the status in CBMS to a different living location status. This change triggers an indicator for the MMIS and the status is changed to make the member eligible for the full benefit package. Additional information about the Department's outreach, training, and communications in support of implementation of this functionality is provided in Question 16.

[2] MMIS: Medicaid Management Information System. CBMS: Colorado Benefits Managements System

The fiscal impact of the implementation of the suspend function cannot be determined with certainty. Expenditures could increase because it will be easier for hospitals to bill Medicaid for services provided to someone who is an inpatient for 24 hours or more. Expenditures could also increase because individuals will receive full Medicaid benefits upon release rather than having to wait for a Medicaid determination. This can play an important role in ensuring more timely access to primary care, behavioral health services, and necessary medications. Additionally, with mandatory and immediate enrollment into a Regional Accountable Entity, the newly released member will have access to care coordinators who can help identify needed medical care and make appointments. This additional utilization could increase costs. However, this greater coordination and easier access to lower-acuity, less expensive services could reduce emergency department use and hospital admissions – more expensive services – and have an overall effect of decreasing costs.

15. **How will the suspension function affect a Medicaid client's access to primary and behavioral healthcare when he or she transitions from one of these settings back to the community?**

RESPONSE

As addressed in the response to Question 14, implementation of the suspension function allows for faster reinstatement of Medicaid benefits which leads to better coordinated care and more timely access to services.

16. **Describe the Department's actions and plans to ensure that county departments of human services, jails, the Department of Corrections, the Department of Human Services' Division of Youth Services, and the Department of Human Services' mental health institutes are aware of and know how to effectively use this new functionality to ensure continuity of care for Medicaid clients as they transition back to the community.**

RESPONSE

Since the suspend function went live on March 1, 2017, the Department has conducted numerous outreach activities to impacted stakeholders including county departments of Human Services, the Department of Corrections, and county jails and sheriffs. Efforts included the release of a policy memo describing the suspend function to stakeholders and an Eligibility Policy paper to Colorado Benefits Management System (CBMS) users at the counties and Medical Assistance sites. Guidance can be found at: POLICY MEMO NUMBER: HCPF PM 18-003.[3] The Department has also presented on the suspend function to organizations such as the Colorado Coalition for Criminal Justice Reform so they can share information within their stakeholder community. The Department can conduct additional outreach, as requested, to other stakeholders including the Mental Health Institutes to effectively leverage the suspend functionality. The Department does not have a dedicated resource to perform this outreach, so it cannot provide a specific plan or action at this time. In addition, the Department has engaged with the Mental Health Institutes to assess their interest and ability in becoming Medical Assistance sites which would enable them to update Medicaid eligibility information.

[3] https://www.colorado.gov/pacific/sites/default/files/HCPF%20PM%2018-003%20CBMS%20Limited%20Medicaid%20Benefits%20for%20Incarcerated%20Individuals%20.pdf

JBC Behavioral Health Hearing

Kim Bimestefer, Executive Director;
Laurel Karabatsos, Interim Medicaid Director;
Shane Mofford, Rates Director

December 19, 2018

https://www.colorado.gov/hcpf/legislator-resource-center

COLORADO
Department of Health Care Policy & Financing

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Achievements in Behavioral Health: Highlights

- Integrated Behavioral Health and Substance Abuse care coordination.
- Added new benefit increasing access to short-term Behavioral Health Services in the primary care setting.
- Expanded types of providers able to issue Substance Use Disorder benefits.
- Secured funding and legislation to cover Inpatient Substance Abuse Disorder.
- Improved care at Pueblo Regional Center, lifting the moratorium, so new patients can access care.

Behavioral Health & Colorado Health Care Affordability Roadmap

Constrain prices, especially hospital and prescription drugs

Champion alternative payment models

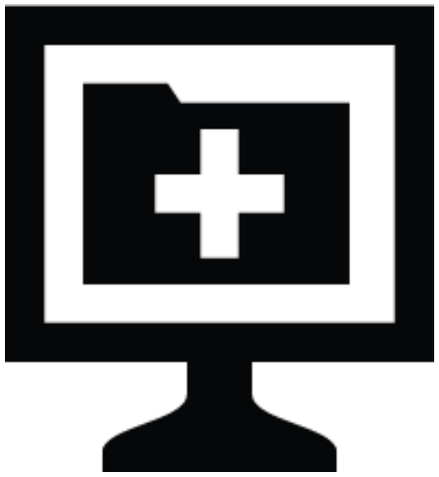
Align and strengthen data infrastructure

Improve our population and behavioral health

Maximize innovation

Behavioral Health Roadmap Work Group Research Areas

- Payment and Delivery System Opportunities
- Criminal Justice
- School Resources, Partnerships, and Focus
- Data and Insights to Inform Root Causes and Policy
- Community Based Priorities
- Movement & Fitness



Phase II Goals

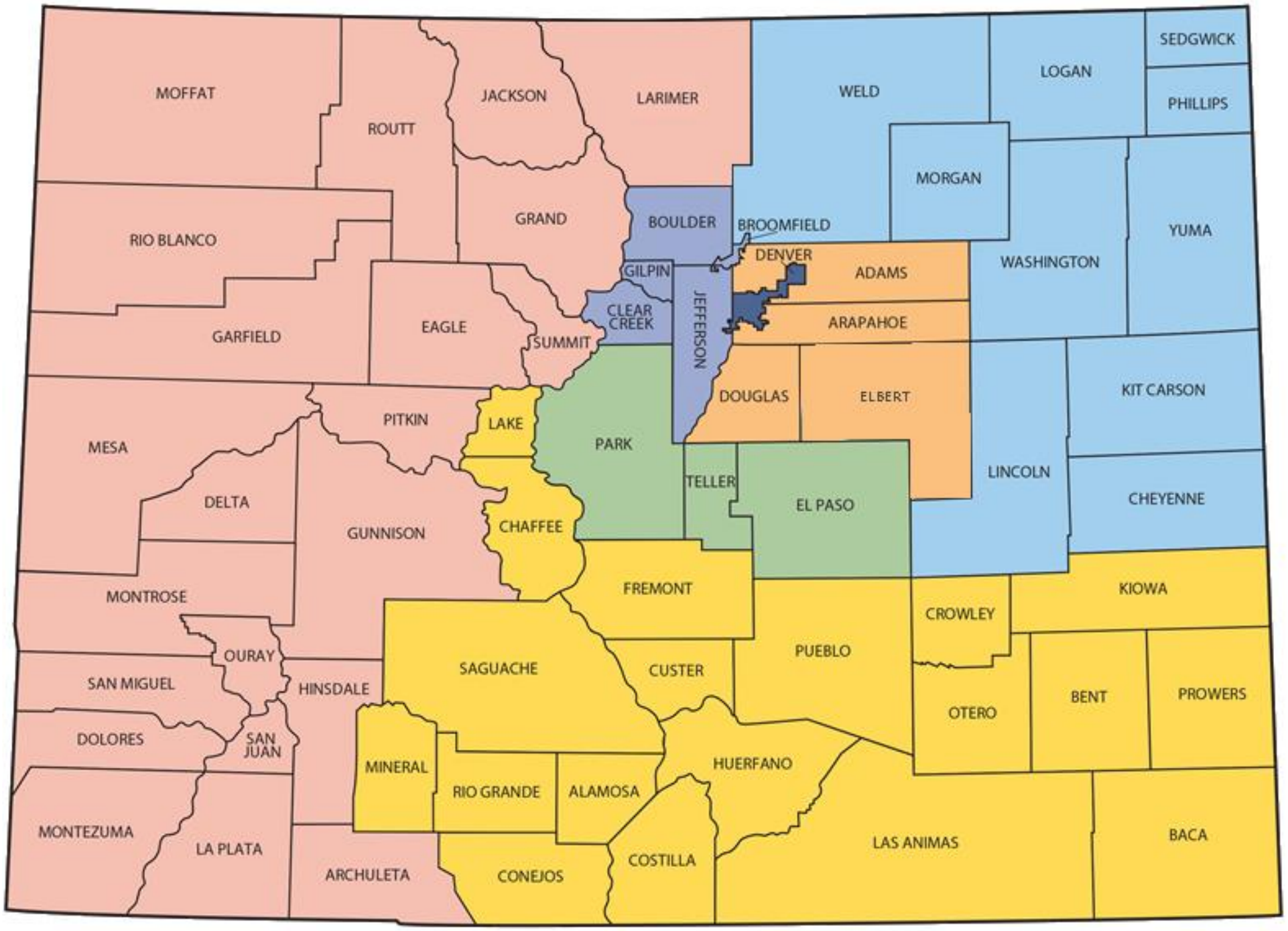
- To improve member health & reduce costs

Phase II Objectives

- **Join physical and behavioral health under one accountable entity**
- Strengthen coordination of services by advancing team-based care and health neighborhoods
- Promote member choice and engagement
- Pay providers for the increased value they deliver
- Ensure greater accountability and transparency

Regional Accountable Entity

Physical Health Care	Behavioral Health Care
Per Member / Per Month	Behavioral Health Capitation



Region 1	Rocky Mountain Health Plans	Region 5	Colorado Access
Region 2	Northeast Health Partners	Region 6	Colorado Community Health Alliance
Region 3	Colorado Access	Region 7	Colorado Community Health Alliance
Region 4	Health Colorado, Inc.		

Substance Use Disorder Benefit Implementation Update

- On September 21st, 2018, prior to the October 2018 deadline, HCPF sent a letter to the Federal Centers for Medicare and Medicaid Services (CMS) seeking formal and ongoing engagement with CMS regarding the 1115 waiver.
  - Bi-weekly meetings with CMS have begun.
- The first stakeholder meeting occurred in late October 2018.
- Progress made on obtaining the resources factored into the bill to ensure evidence-based benefit for persons who meet the nationally recognized level of care criteria:
  - HCPF has met with several potential consultants and other interested policy-makers;
  - And is in the process of hiring a Department FTE to lead the effort.
- Currently, finalizing a webpage on HCPF's website outlining the work related to the initiative and concept paper.
- The timeline outlined in the fiscal note of HB 18-1136 identifies a July 1st, 2020 implementation date for the benefit.

Questions 1-16

Thank You