AGENDA

FY 2007-08 Joint Budget Committee Hearing
Department of Health Care Policy and Financing (Medicaid Mental Health Only)
Department of Human Services, Mental Health and ADAD Programs; and

Friday, December 15, 2006
1:30 p.m. - 5:00 p.m.

1:30 - 1:45

Department of Health Care Policy and Financing

Goebel Lawsuit - Medicaid portion only discussed here (staff issue page 99 - 103)

The Medicaid funding for the Goebel program was transferred from the Department of Human Services to the Department of Health Care Policy and Financing on September 20, 2006. It is JBC staff's understanding that $870,000 of the $12,275,081 Medicaid funds that were transferred were not "certified" as a legitimate Medicaid expenditure by Colorado Access.

1. Please discuss why the funds were not certified (including a description of the programs which were not certified as Medicaid eligible) and explain what this means for Denver.

2. Given that the Goebel lawsuit settlement ended last year and given that the Department of Health Care Policy and Financing now administers $12,275,081 of the $19,051,716 total funds, please comment on whether it is recommended for the General Assembly to eliminate the statute which currently has Goebel oversight by the Department of Human Services.

Medicaid caseload and required cost inflators are driving the Medicaid mental health budget. The ability to manage the inflator factor could have a large impact on the state's budget. In the FY 2006-07 Long Bill, an inflator of 2.71 percent was approved by the General Assembly. However, on July 1, 2006, an inflationary factor of 3.85 percent was built into the Behavioral Health Organization (BHO) contracts. This inflationary factor differential, plus the actuarial adjustments, total $3.6 million ($1.7 million of which is General Fund).

3. Please discuss the reasons for and the fiscal impact of the July 1, 2006 rate adjustment(s) as compared to the FY 2006-07 Long Bill appropriation. What are the Department of Health Care Policy and Financing's plans to align its process for rate adjustments with the annual budget process?

AGENDA

FY 2007-08 Joint Budget Committee Hearing
Department of Health Care Policy and Financing (Medicaid Mental Health Only)
Department of Human Services, Mental Health and ADAD Programs; and

Department of Human Services

General Introductions and Overviews

1:45 - 2:15

Performance Measure Issue (Staff briefing issue pages 66 - 72)

4. How do your performance measures influence department activities and budgeting?

5. To what extent do the performance outcomes reflect appropriation levels?

6. To what extent do you believe that appropriation levels in your budget could or should be tied to specific performance measure outcomes?

7. As a department director, how do you judge your department's performance? What key measures and targets do you use?

8. Would the Department consider the following objectives as reasonable additions or alternatives to current performance measures?
   a) Clinically determined progress toward improvement or recovery where applicable (e.g., the Global Assessment of Functioning).
   b) Decreased rate of readmission to inpatient psychiatric facilities.
   c) Rate of recidivism in DOC or DYC from substance abuse related crimes.
   d) Recidivism in substance abuse programs after 12 months, 18 months, 2 years, 5 years.

9. How can the state use statewide performance measures to move between programmatic and funding silos to achieve statewide based results across divisions, departments, systems?

10. Please describe the process which occurs after an individual leaves detoxification services.

11. Is there a way to use a unique identifier that can follow a client everywhere throughout the system (e.g., DOC, mental health, child welfare, other)?

12. How does the Department choose its performance objectives to include in the budget?

13. Therapeutic Community followed by aftercare is effective with methamphetamine abusers. Please describe the state's activities in this area. What kind of success has the Department had?

14. Apparently there is a new concept being explored in a few states that is called performance-based contracting for providers. As it is understood, this system has the potential to directly tie the level of reimbursement received by a provider to the performance of the provider by utilizing various types of performance indicators. If this is actually workable, we should be able to get better results for the tax dollars we spend. The Committee would like to hear from ADAD about the process for building such a system. How long would it take to build it? How much would it cost? What specific cost/benefit ratios could be reasonably expected?

2:15 - 3:00

Mental Health Funding Options (Staff issue pages 73-85)

15. Please discuss the Population in Need study and its assumptions which resulted in an estimate of 66,453 clients with unmet mental health needs, including distribution around the state, client income thresholds, and assumed insurance levels.

16. Please describe the assumptions in the Department's cost/benefit analysis for mental health in Decision Item #8. (a) Why is only $33,000 in DOC and DYC savings anticipated from a mental health investment of $1.4 million? (b) Why are the projected inpatient hospital savings of 20 beds from the Department's cost benefit analysis not realized anywhere in the FY 2007-08 executive budget request? (c) What is the related anticipated bed savings/cost avoidance to the mental health institutes?

17. Please describe the Department's methodology for allocating appropriated funding to mental health centers. What is the Department's metric?

18. Please respond to the staff issue on the three different mental health funding proposals: (a) Department of Human Services; (b) Colorado Behavioral Health Council; and (c) Mental Health Planning and Advisory Council.

19. Please respond to the staff recommendation that the JBC appropriate dollars for mental

health based on outcome goals rather than the output goals (e.g., of clients served or mental health centers funded).

20. Are there mental health programs such as PACE, Assertive Community Treatment (ACT), H.B. 00-1034, Impact programs that could be funded or expanded statewide to help reduce the number of people who will enter the criminal justice system or to reduce recidivism?

21. (a) Would the cost of additional mental health services be offset by savings in areas of the budget? (b) What would be the lag time between an investment in mental health or alcohol and drug abuse services and anticipated savings?

22. Please provide information on the H.B. 00-1034 program. (a) Why was funding not set aside by the executive for FY 2007-08 for the continuation of this pilot? (b) Will the Department be seeking legislation to continue or modify the program in FY 2007-08? (c) What is the estimated savings from H.B. 00-1034 according to The Department of Human Services and to the Division of Criminal Justice in the Department of Public Safety? (d) If H.B. 00-1034 is not reauthorized, would there be costs in other (DYC) systems? (e) Have the other departments requested funding because there are no plans to seek reauthorization of the program? (f) What would be the fiscal impact of the bill to reauthorize the program in its current form? (g) With 200 more slots?

23. How much is the federal funding for the JERP program and when does it go away? What have been the findings/lessons learned from the JERP program thus far?

24. Please describe the Boulder PACE program and how its saves in (a) jail stays and (b) DOC. (c) What would be the fiscal impact of expanding the PACE program? (d) Of expanding the program to other communities in the state?

25. Please discuss the role of pharmaceuticals in helping clients succeed in the various alternatives to incarceration programs. (a) Do the PACE, Impact, and JERP programs succeed by insuring patients get their medication? (b) What happens once the clients leave the program? (c) Will clients continue to receive and to use their medications?

26. As JBC staff has reported before, research supports impressive success of the Short Term Intensive Residential Remediation Treatment (STIRRT) programs as a means to decrease recidivism in high risk offender populations, most notably offenders with substance

abuse problems who also have mental illness or have substance abuse problems and have children. (a) Given our exploding trend lines in the Corrections Department, how would expanding STIRRT programs fit into an overall strategy of reducing recidivism across the board? (b) What resources would be needed to expand STIRRT programs aimed at the high risk populations of offenders with the dual issues of substance abuse problems combined with mental illness or who have children?

Other Area

27. The Committee understands that a few inpatient providers are seeing a marked and disproportionate increase in psychiatric emergency inpatient placement of indigent (non-Medicaid) clients. These patients are very complex and costly to care for and, without any supporting revenue stream, maintaining care for them is unsustainable. (a) What is the Department hearing from the provider community about this trend and the implications to care for this population? (b) What are the current services for this population and how are they funded? (c) What are the Department's suggestions for funding scenarios to sustain needed care to this population?

3:00 - 3:15 BREAK

3:15 - 4:30

Competency and Backlog Issue (Staff issue page 86-93; also Supplemental Write-up)

The Department submitted a "1331" emergency supplemental request for $1,681,918 General Fund and 20.5 FTE for FY 2006-07 for the Mental Health Institute at Pueblo (MHI-Pueblo). This request annualizes (funds a full year) to $3,456,502 General Fund and 49.1 FTE in FY 2007-08. The request seeks to reopen a 20-bed inpatient, medium-security unit at Pueblo. The 20 bed unit would do competency evaluations and restorations in order to eliminate the current backlog of waiting patients within one year. Because the unit was closed by the hospital within only two years ago, the request indicates that no new capital construction dollars would be necessary to renovate/update the unit. The Department indicates that the waiting list for inpatient competency evaluations has grown from 30 to 81 people waiting in jail to be admitted. This wait represents a substantial legal liability to the state. This fall, the MHI-Pueblo Superintendent was served by the Denver District Court with a contempt of court citation regarding failure to admit a patient in a timely manner per court order. The case is proceeding as one of punitive contempt because the wait list problem has still not been resolved by the

Department.

28. There was a significant amount of discussion last session about using other means to address the competency and evaluation backlog. Subsequent to these meeting, the General Assembly added footnote #63 to ask the Department to look into solutions to this problem. Please discuss the Department's efforts since the footnote was authorized by the General Assembly to look at other providers and plans to help address this issue as was requested in the footnote.

29. Why have the number of competency evaluations required increased in the last five years?

30. Currently, about 80 percent of competency evaluations are contracted out and performed in the community. Is there any way the number of outpatient competency evaluations can be increased relative to impatient competency evaluations performed at the MHI-Pueblo?

31. Are the 80 percent of evaluations done in jail by private providers? With enhanced funding, could the Department contract out 100 percent and eliminate the inpatient competency reviews from the process? Why does the MHI-Pueblo have to do any of the competency evaluations?

32. According to the 2005-2007 Colorado report to the federal government on the federal block grant, the Neiberger lawsuit settlement ends December 31, 2006. What opportunities for management flexibility at the mental health institute does this create? The forensics unit's beds occupied are 241 out of a 278 capacity bed unit, a difference of 37 beds (or 15 percent of capacity).

33. The Department's funding request for $1.4 million for community mental health is sufficiently limited in its ability to address the core issue of providing services to the mentally ill. Thus, it is unlikely that there will be a decrease in the rate of mentally ill clients in jails needing competency evaluations based on the request. Should funding be targeted to clients likely to commit crimes, such as prior offenders in order to address the long-term nature of this problem (after the short-term backlog is addressed)?

34. This problem is complex and the solution is most likely complex as well. What are the Department's strategic planning short-term and long-term efforts in this area?

35. Please discuss the evaluations which are contracted out for outpatient evaluations. How long do these evaluations take? How much does the state pay per evaluation? Why are outpatient evaluations done so much more efficiently than done on an inpatient basis at the MHI-Pueblo?

36. Is there a fear counties will sue the state because of the backlog? Is this different then the Neiberger case?

37. Why is the Department requesting dollars for FTE, furniture, and supplies to reopen a unit when the Department did not lose dollars when the unit was closed?

38. Why is the Department requesting 49.1 FTE for the new unit when it has been reverting FTE over the last few years?

39. The General Hospital at Pueblo's mental health institute is only 38.5 percent occupied. Could some of the vacant beds at the General Hospital be used to perform competency evaluations (if the inpatient hospital services were performed at local hospitals and the beds instead used for this purpose)?

40. Could the Department update the data on competency/evaluations, and restorations from FY 2004-05 to FY 2005-06 and identify projections for FY 2006-07?

41. Please reconcile the data above with the Department's observation last year that "During the first five months of FY 2004-05 the number of referrals from the courts has accelerated at a rate 60 percent higher than the previous year . . . the waiting list has remained consistently over 30 individuals with a high of 37 individuals waiting in jail up to two months for admission."

    It appears that the waiting list has more than doubled since December 2005 to nearly 80 individuals waiting in jail up to five months for admission to MHI-Pueblo for evaluations and or restorations. Please explain.

42. Is the capacity created by the Department's "1331" emergency FY 2006-07 request sufficient to offset the increase in demand since FY 2004-05? To what extent will the new capacity reduce the waiting list?

43. The state has a short-term emergency backlog problem and a long-term workload

problem. The Department has submitted a request that addresses the backlog problem with FTE which would continue once the backlog is eliminated in the spring of FY 2008. Please respond.

44. Is the Department willing to consider alternatives such as:

(a) Contract with community-based facilities to provide inpatient competency/sanity evaluations which do not require maximum or medium level of security. Colorado West indicated one year ago that it could complete these evaluations for less than half of the cost at MHI-Pueblo. Could Colorado West and other "27-10 CRS" designated hospitals absorb the nine (9) bed capacity in the current proposal (45 percent of the proposed new capacity at a cost to the state significantly below 45 percent of the $3.5 million request)?

(b) Explore efficiencies with the courts to reduce the ALOS (length of stay) for restorations? A reduction of 28 days or 16 percent of the current 172.4 day length of stay would free up 10.51 beds per day (28 * 137 = 3,836/365) or roughly the proposed new 11 bed capacity for restorations.

45. Has the Department reviewed utilization of the forensics beds not devoted to evaluations/restorations to determine if there are alternatives which could increase capacity in particular for restorations which require maximum or medium levels of security?

46. CIRCLE is a 20 bed unit that treats dual diagnosed people with substance abuse and mental health disorders at Pueblo. (a) Could the CIRCLE program be transferred to community providers, thus freeing up existing bed space at the Mental Health Institute at Pueblo to address competency evaluations? (b) Could the staff and bed capacity at the CIRCLE program be part of a broader solution to the forensic and bed allocation issues if there was a cost-effective, clinically equivalent community-based alternative to treat the clients served by the CIRCLE program?

47. The state's bed allocation plan between Pueblo and Fort Logan is severely out-dated. Currently, a client from Larimer County needing services will need to drive past Fort Logan in Denver, to Pueblo, to receive services. This geographic issue also has a programmatic impact since clients have better outcomes when they are closer to home. Can the bed allocation be considered in the competency and evaluation debate? What changes in this area are being considered in the Division's strategic plan?

AGENDA

FY 2007-08 Joint Budget Committee Hearing
Department of Health Care Policy and Financing (Medicaid Mental Health Only)
Department of Human Services, Mental Health and ADAD Programs; and

4:30 - 4:45

HB 99-1116 Program (staff issue page 94-98)

The Children's Mental Health Treatment Act was designed to give parents the option of having their children placed in institutional residential services for mental health treatment without requiring a "dependency and neglect" determination through the local county departments of social services or the courts. In the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General), there were a host of concerns noted about residential treatment services, something the report referred to as the second most restrictive form of care for children. The Surgeon General's concerns generally point to questions about the actual impact or benefit of said care for children based on research cited. In the FY 2005-06 Long Bill, the JBC authorized an increase of $200,000 General Fund for the program to assist with transition activities. The Department's budget indicates that only a fraction of the $200,000 for transitional activities was expended in FY 2005-06. If new admissions into institutional services continue as estimated, this program will surpass $1.0 million this year.

48. Discuss the staff proposal to create a community wrap-around alternative to institutionalizing children. (a) What kind of programmatic changes might occur? (b) What kind of benefits would this have for children and families, if any? (c) What might be the difference in the fiscal impact?

49. What are the one, three, and five-year funding estimates for this program?

50. Why was only approximately $43,000 of the $200,000 General Fund appropriated for this program for post-institutional transition into the community in the FY 2005-06 Long Bill spent on transition?

51. Why is the youth length-of-stay for this program so much longer than placements made and managed by the Behavioral Health Organizations (BHOs)?

52. What are the end-outcomes or improvements that have been achieved for youth through this program over the last three years?

53. What suggestions does the Department have for creating community preventative wrap around services specifically targeted for this population?

54. Is the Medicaid portion of the funding for the treatment residential child care faclities (TRCCFs) for the H.B. 99-1116 program worth the money to fund a more expensive service? What alternatives does the Department recommend?

4:45 - 5:00

Goebel Lawsuit (staff issue page 99 - 103)

The Goebel lawsuit settlement was dismissed with prejudice on March 31, 2006. On September 20, 2006, the JBC authorized the transfer of the Medicaid funding for Goebel from the Department of Human Services to the Department of Health Care Policy and Financing in order to comply with CMS requirements. Other changes to reorganize the budget in reaction to this "new world" without the settlement requirements are also necessary. The court settlement agreement required an hours based management model for Goebel (as opposed to an outcome based or managed care model). The court settlement agreement has ended, yet the Department of Human Services continues to require a unique service provision and oversight for these clients. Such changes would increase system and departmental efficiency and improve outcomes for clients while maintaining necessary funding levels for clients in Denver.

55. Given that the lawsuit has been dismissed with prejudice, why is the Department still requiring an hours based management of mental health clients through its contract?

56. Given that the bulk of the funding for Goebel has been transferred from the Department of Human Services to the Department of Heatlh Care Policy and Financing, leaving the Goebel line item with only the non-Medicaid and the 2.0 FTE portion of the program. What is the Department's response to staff's recommendation to transfer the funding for Denver programmatic (previously Goebel lawsuit) dollars from the "Goebel" line item to the Indigent mental health line item to continue to fund Denver's mental health services?

57. The Goebel lawsuit was dismissed with prejudice but 2.0 FTE still are funded at The Department of Human Services to oversee and monitor Denver's work on the Goebel lawsuit settlement. Please respond to staff's recommendation that these staff not be eliminated but rather transferred to the Mental Health Administration line item to offset division workload.

58. Given that the Goebel lawsuit settlement ended last year and given that the Department

of Health Care Policy and Financing now administers $12,275,081 of the $19,051,716 total funds, please comment on whether it is recommended for the General Assembly to eliminate the statute which currently has Goebel oversight by the Department of Human Services.