

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND
DEPARTMENT OF HUMAN SERVICES:
BEHAVIORAL HEALTH SERVICES
FY 2017-18 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, January 3, 2017
1:30 – 4:30 pm

**QUESTIONS FOR THE DEPARTMENT OF HEALTH CARE POLICY AND
FINANCING**

1:30-1:45 INTRODUCTIONS AND OPENING COMMENTS

**1:45-2:15 ACCOUNTABLE CARE COLLABORATIVE (ACC) AND RELATED PAYMENT
REFORMS IN *R6 DELIVERY SYSTEM AND PAYMENT REFORMS***

- 1 Describe the overall goals of phase II of the Accountable Care Collaborative, and how the Department anticipates that the proposed changes to behavioral health service contracts will help achieve these goals.
- 2 Provide information about any concerns the Department has received from behavioral health clients, providers, or advocacy groups in response to the draft request for proposals (RFP) that was released November 4, 2016.
- 3 The Department proposes an implementation date of July 1, 2018. Given the upcoming changes in administration at the federal and state levels, does this timing make sense?
- 4 Why is the Department proposing contracts that last for seven years? Is this in the State's best interest?
- 5 The Department indicates that it plans to retain the capitation payment methodology for "core behavioral health services". Explain what services are considered "core" and will thus continue to be paid through a capitated rate, and which services will be paid using a different methodology.
- 6 The draft RFP allows for reimbursement for six behavioral health-related visits, per episode of care, that are provided in a physical healthcare setting. How does the Department plan to cover the cost of these visits and still achieve its cost savings/cost avoidance goals?
- 7 How does the Department plan to ensure continuity of care for those clients with severe mental illness or substance use issues both during and after the transition to the regional accountable entities (RAEs)?

- 8 Describe elements of the RFP that are designed to improve behavioral health care and care coordination for:
 - a. Individuals involved in the criminal justice system (including those individuals who are being released from the Department of Corrections);
 - b. Children and families involved in the child welfare system; and
 - c. Individuals who are in crisis and require urgent behavioral health services.
- 9 Explain why the Department anticipates that the federally required change from an actuarially certified rate range to a rate point will reduce behavioral health capitation rates.
- 10 Discuss the Department's plans to use incentive payments for improved performance to mitigate anticipated decreases in behavioral health capitation rates.
- 11 In *R6 Delivery system and payment reforms*, the Department proposes replacing a federally mandated decrease in capitated payments for behavioral health organizations in FY 2017-18 with performance-based payments beginning in FY 2018-19. How does the Department expect providers to manage the delay in payment?
- 12 What types of physical and behavioral healthcare services are covered by Medicaid when an individual is receiving inpatient psychiatric care (please differentiate services provided within the mental health institutes from those provided in other settings)? Does the Department's draft RFP propose any changes that would increase the physical or behavioral healthcare that is covered by Medicaid under these circumstances?

2:15-2:20 OTHER

- 13 Explain why the capitation rates for the "Individuals with disabilities up to age 64" eligibility category are so high relative to other categories.
 - 14 Describe the processes that the Department uses to recoup money from a behavioral health organization (BHO), whether the recoupment is due to an IT systems issue or the "risk corridor" that was placed on capitation rates for the expansion populations. How much notice does a BHO receive, and how does the BHO plan for such recoupments from a cash flow perspective?
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QUESTIONS FOR BOTH THE DEPARTMENT OF HUMAN SERVICES AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

2:20-2:40 WICHE STUDY CONCERNING BEHAVIORAL HEALTH FUNDING (DEC. 2016)

- 15 Discuss the findings of the WICHE Study. In particular, discuss the recommendations related to realigning responsibilities for behavioral health services at the state agency level and at the provider level to: (a) strengthen the coordination and equity of care provided to individuals across the state; and (b) improve the effectiveness and efficiency in the use of state and federal funds.
- 16 [WICHE Study Recommendation #6] Describe the current status of the proposal to modify the Medicaid Management Information System (MMIS) to allow for eligibility and payment processing for both Medicaid and non-Medicaid clients. Discuss whether this is likely to be a viable option for reducing the administrative burden on service providers and ensuring that the State is not paying twice for the same service.
- 17 [WICHE Study Recommendation #7] *Background information: Federal Medicaid rules allow states to suspend Medicaid eligibility for individuals in institutions for more than 30 days, including state hospitals, prisons, and juvenile facilities (for individuals who emancipate). Senate Bill 08-006 requires that persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, Department of Corrections (DOC) facility, or Department of Human Services facility shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement.* Explain the significant delay in implementing this act, describe what the Department has done to date to implement this act, and provide a time table that specifies the actions the Department will take to complete implementation for both DOC inmates and patients at the mental health institutes.

2:40-2:50 STATEWIDE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

- 18 What types of behavioral health crisis services do existing Medicaid capitation rates cover, and what services are (or should be) covered by General Fund appropriations to the Department of Human Services for the statewide behavioral health crisis response system?
- 19 What is the role of the statewide behavioral health crisis response system in addressing crises related to substance use?

2:50-3:10 CONTINUUM OF SUBSTANCE USE DISORDER SERVICES

- 20 Describe the various types of services that are necessary and effective for treating individuals with a substance use disorder.
- Identify which substance use-related services are currently covered under Medicaid, and which are not. For those services not covered by Medicaid, explain why.
 - Identify which substance use-related services are currently provided through the Department of Human Services, and describe the types of individuals who are eligible to receive such services.
- 21 The draft RFP for phase II of the Accountable Care Collaborative does not include significant reforms related to substance abuse and addiction. Given the growing complexity of substance abuse and the opioid epidemic, what is the Department of Health Care Policy and Financing’s plan to expand the role of the health community in addressing the costs associated with addiction?
- 22 *Background information: Managed service organizations (MSOs) manage a statewide substance use disorder treatment system for Colorado. There are seven MSO regions. As regional entities, MSOs support the delivery, expansion, and quality delivery of the entire continuum of substance use disorder treatment.* The draft RFP requires the regional accountable entity (RAE) contractor to include several specific providers as part of its health care delivery network (RFP, page 68). If one of the goals of the RAE is to implement coordination of services to “disincent duplication of services, overuse of low value services and fragmentation of care” (RFP, page 25), shouldn’t MSOs be included as an entity that the RAEs must work with to ensure benefit continuity and access to services not otherwise covered by Medicaid?
- 23 Legislators hear that there is a shortage of facilities that provide detoxification services (for both Medicaid-eligible clients and individuals who are not eligible for Medicaid). Provide any available data about the adequacy of detoxification services statewide.
- If there is a problem related to access to detoxification treatment, explain why (e.g., are the rates paid by the Medicaid program or the Department of Human Services too low)?
 - What are both departments’ plans to address the needs of individuals who repeatedly cycle through detox facilities?
- 24 *Background information: Senate Bill 16-202 requires each managed service organization (MSO) to assess the sufficiency of substance use disorder services in its geographic region, prepare a community action plan to address the most critical service gaps, and submit the plan to both departments by March 1, 2017. The Department of Human Services is responsible for posting these plans to its website and submitting a report summarizing the plans to various legislative committees (including the JBC) by May 1, 2017.* Would it be possible for the Department to provide any available information about the community action plans that it

receives in early March to allow the General Assembly to use this information when making funding decisions for FY 2017-18?

3:10-3:25 BREAK

QUESTIONS FOR THE DEPARTMENT OF HUMAN SERVICES (DHS)

3:25-3:40 INTRODUCTIONS AND OPENING COMMENTS

3:40-4:05 ROLE OF THE MENTAL HEALTH INSTITUTES

- 25 Describe the Department's recent and ongoing facility and operational planning processes concerning the mental health institutes and the State's role in providing direct care for individuals with serious mental illness. Please include a discussion of:
 - a. the Department's Facility Program Plan and Site Master Plan project that was funded in FY 2014-15 and the Department has indicated will be completed in early 2017;
 - b. the study conducted by the Western Interstate Commission on Higher Education (WICHE) concerning the state's current and future behavioral health needs (completed in April 2015);
 - c. the Department's Operational Program Plan that was finalized in August 2016; and
 - d. the study that was funded in FY 2015-16 and conducted by WICHE concerning the effectiveness of the Circle Program and related operational scenarios (completed September 2016).

- 26 How does the Department's FY 2017-18 capital construction request fit into this planning process?

- 27 How does the Department's FY 2017-18 capital construction request relate to the "contingent" budget request the Department submitted last year for facility-related changes at both mental health institutes?

- 28 What are the projected annual operating costs of the proposed 24-bed unit?

- 29 Provide data concerning the Department's compliance to date with the Settlement Agreement concerning the length of time pretrial detainees wait to receive competency evaluations and competency restoration treatment.

- 30 Provide any available data indicating the number of individuals who require inpatient competency evaluation and restoration services, and those who are better served in a jail or community setting.
- 31 Describe how the Department's projections concerning the need for inpatient competency evaluation and restoration services have been impacted by:
 - a. the recently approved expansion of the jail-based competency evaluation and restoration program; and
 - b. House Bill 16-1410, which included statutory changes to limit judicial discretion to order inpatient competency evaluations as well as resources to hire two secure transport staff to facilitate the transportation of defendants between jails, the mental health institutes, and the jail-based competency program.
- 32 Explain why the Department did not spend \$1,489,032 (62.9 percent) of the General Fund that was requested in September 2015 for the jail-based competency evaluation and restoration program as intended. How were these funds used, and why?

4:05-4:20 DATA SYSTEM FOR TRACKING PSYCHIATRIC BED AVAILABILITY

- 33 Clarify whether hospitals that are not designated or approved by the Department as 72-hour treatment and evaluation facilities pursuant to Section 27-65-105, C.R.S., have the statutory authority to hold an individual who has been placed on an involuntary mental health hold.
- 34 Does the Department recommend moving forward with the development and implementation of a real time statewide data system for tracking the availability of psychiatric beds for individuals placed on an involuntary 72-hour mental health hold? If so:
 - a. Clarify what role, if any, the Department envisions the behavioral health crisis response system hotline and mobile response units performing to facilitate admission of individuals on a mental health hold to appropriate psychiatric facilities.
 - b. Could this system be designed in a way or connected to the crisis response hotline in a way that would allow any person, provider, or facility to call for local recommendations on the appropriate type of mental health provider (i.e., providing a resource that is more fluid than just a bed registry)?
 - c. Clarify whether the proposed system could be used to track the availability of beds for individuals placed on an involuntary hold related to alcohol [Section 27-81-111 and 112, C.R.S.] or drugs [Section 27-82-107 and 108, C.R.S.].
 - d. Identify next steps, including any necessary legislative actions.

4:20-4:30 OTHER BUDGET PRIORITIES

R8 Crisis Services System Enhancements

- 35 The Department proposing reducing the appropriation for “Community Transition Services” by \$900,000 (from \$5,147,901 to \$4,247,901), a line item that provides funding for intensive behavioral health services and supports for individuals with serious mental illness who transition from a mental health institute back to the community, or who require more intensive services in the community to help avoid institutional placement.
- a. How much has the Department reverted from this line item in the last two fiscal years and why?
 - b. Why is the Department proposing a reduction in this line item going forward? Aren’t these services needed?
- 36 Why is the Department requesting a \$900,000 General Fund increase in the appropriation for the hotline (\$600,000) and marketing (\$300,000) components of the behavioral health crisis response system? How do the proposed increases actually serve people?

R14 Substance Use Disorder Treatment at the Mental Health Institutes

- 37 How would the 8.0 FTE certified addiction counselors be allocated between the two mental health institutes?

Other

- 38 Would any of the Department’s funding requests for FY 2017-18 address the behavioral health needs of military veterans?

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Tuesday, January 3, 2017
1:30 – 4:30 pm

QUESTIONS FOR THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

1:30-1:45 INTRODUCTIONS AND OPENING COMMENTS

Department of Health Care Policy and Financing

SUSAN BIRCH, EXECUTIVE DIRECTOR, DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

GRETCHEN HAMMER, MEDICAID DIRECTOR, DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

LAUREL KARABATSOS, DELIVERY SYSTEM AND PAYMENT INNOVATION DIVISION DIRECTOR AND DEPUTY MEDICAID DIRECTOR, DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

SHANE MOFFORD, PAYMENT REFORM SECTION MANAGER, DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department of Human Services

REGGIE BICHA, EXECUTIVE DIRECTOR, DEPARTMENT OF HUMAN SERVICES

NANCY VANDEMARK, PH.D. DIRECTOR, OFFICE OF BEHAVIORAL HEALTH, DEPARTMENT OF HUMAN SERVICES

PATRICK FOX, CHIEF MEDICAL OFFICER, DEPARTMENT OF HUMAN SERVICES

SARAH SILLS, DIRECTOR, DIVISION OF BUDGET AND POLICY, DEPARTMENT OF HUMAN SERVICES

**1:45-2:20 ACCOUNTABLE CARE COLLABORATIVE (ACC) AND RELATED PAYMENT
REFORMS IN *R6 DELIVERY SYSTEM AND PAYMENT REFORMS***

- 1 Describe the overall goals of phase II of the Accountable Care Collaborative, and how the Department anticipates that the proposed changes to behavioral health service contracts will help achieve these goals.**

The overall goals of Phase II of the Accountable Care Collaborative are to improve member health and life outcomes and to use state resources wisely. A primary contractual change to achieve these goals is to have one entity in each of the seven regions of the state that will be responsible for promoting physical and behavioral health for all members in the region. Combining contract administration under one entity is expected to improve member health and experience by addressing members' medical and behavioral health care needs in a seamless way and improving members' and providers' ability to navigate the system. An integrated delivery system will promote increased access to behavioral health services for all members requiring behavioral health support while also increasing access to primary care services for individuals with serious mental illness. The evidence regarding integrated care

service delivery models also indicates significant opportunity for the state to improve health outcomes and control spending growth.

Based on extensive work with the behavioral health provider community, the payment structure for the majority of behavioral health services will be a Capitated Behavioral Health Benefit. To achieve the goals of phase II of the Accountable Care Collaborative, the Department is shifting some dollars out of the capitation payment to reimburse the delivery of up to six behavioral health services within primary care settings through fee-for-service. These changes are designed to increase access to low acuity mental health and substance use services in a location that is most convenient for a member, whether in a primary care office or behavioral health practice. Furthermore, by addressing low acuity behavioral health issues, the Department expects to reduce the exacerbation of mental health, substance use, and chronic physical health conditions, thereby improving member health and functioning and controlling long-term costs.

The last major change to the behavioral health service contracts is a continuation of the drive for increased value by tying greater portions of payment to performance. Some of these changes are referenced in the Department's November 1, 2016 budget request R-6, 'Delivery System and Payment Reform.' The Department is currently testing value-based payment strategies as authorized under state statute by utilizing contractor performance on identified metrics to determine the Behavioral Health Organization's rate within the parameters set by the Centers for Medicare and Medicaid Services. For the next iteration of the Accountable Care Collaborative, the Department is seeking authority from the General Assembly and the Centers for Medicare and Medicaid Services to design an incentive program that will allow the Regional Accountable Entities to earn up to a 4 percent incentive on top of their behavioral health capitation for achieving key performance targets. These payment reforms will further support the goals of improving member health and life outcomes while using state resources wisely.

- 2 Provide information about any concerns the Department has received from behavioral health clients, providers, or advocacy groups in response to the draft request for proposals (RFP) that was released November 4, 2016.**

The Department has been in active conversation with behavioral health clients, providers and advocacy groups since 2014 regarding the development of the next phase of the Accountable Care Collaborative. Responses to the 2014 Request for Information revealed strong community support for the administrative integration of the Behavioral Health Organizations and the Regional Care Collaborative Organizations. Following the release of the Concept Paper in October 2015 with the announcement that the Department planned to eliminate the behavioral health capitation, the

Department engaged in a number of strategic conversations with behavioral health stakeholders regarding their concerns with this decision. Activities included a stakeholder forum with nearly 200 attendees, working sessions with the current vendors and other subject matter experts to identify alternative solutions, and meetings at behavioral health-related forums and task force meetings. As a result of these meetings, the Department developed a solution that retains the Capitated Behavioral Health Benefit while making adjustments to increase access to behavioral health services for all members, including those with low acuity behavioral health needs.

The Department released the draft Request for Proposals for the next phase of the Accountable Care Collaborative on November 4, 2016. Since that time, the Department has hosted or participated in 19 stakeholder meetings throughout the state, including webinars, to solicit comments on the Request for Proposals. The Department is requesting that all stakeholders submit comments by January 13, 2017 using an online form. All comments submitted through the online form are posted publicly on the Department's website.

At this time, the Department has not received many comments through the online form. The feedback received through the stakeholder meetings has been generally positive with strong support for the focus on the integration of physical and behavioral health. The questions asked tend to focus on technical aspects of the program design. In particular, there have been a number of questions regarding the member attribution process and its potential impact on certain populations, the six behavioral health services that can be provided in primary care settings, and the selected performance measures. This feedback is extremely helpful as we finalize the formal Request for Proposals and plan the operational details of the program. The Department will not make any final policy decisions on changes to the Request for Proposals until the public comment period has concluded.

3 The Department proposes an implementation date of July 1, 2018. Given the upcoming changes in administration at the federal and state levels, does this timing make sense?

The Accountable Care Collaborative is the administrative framework for the delivery system for Medicaid in Colorado and was in place prior to passage of the Affordable Care Act. The Affordable Care Act included significant changes related to Medicaid program eligibility and included the option for states to expand eligibility for Medicaid.

The current contracts for the Accountable Care Collaborative were originally five-year contracts; the Department requested and received extensions for two additional years. As part of this request, state agencies must submit a plan to the State Procurement Director that demonstrates how the revised procurement timeline will be met. The Department would face significant scrutiny from the State Procurement Director if it were to request an additional extension beyond June 30, 2018, and therefore must re-procure despite a changing federal landscape. Additionally, the Department's proposal for

integration of care and payment reforms outlined in the Accountable Care Collaborative Phase II Request for Proposals are critical components for improving the health status of members and reducing health care spending growth. This Colorado-based solution is aligned with other initiatives in both the public and private sector and should not be abandoned or delayed given changes at the federal level. The Department is closely tracking information on proposed changes the Medicaid program at the federal level. As more details about the proposals become available the Department will monitor their impact on the Accountable Care Collaborative and use established processes, hearings and meetings to communicate with the committees of reference, the Joint Budget Committee and stakeholders.

4 Why is the Department proposing contracts that last for seven years? Is this in the State's best interest?

Colorado procurement rules specify that state agencies can enter into multi-year contracts, but must secure written permission from the State Purchasing and Contracts Director for a contract period in excess of five years. Historically, the State Purchasing and Contracts Director has granted permission to state agencies for a longer contract period when the contract covers a large, complex scope of work, when the re-procurement itself will require a significant investment of time and resources and when transition between vendors is a lengthy process that impacts multiple systems. The Department pursues this option judiciously and only with large contracts such as the recent re-procurement for a new Medicaid Management Information System (MMIS). Given the fact that the Department will be combining two large scopes of work into one contract, the Department believed it was prudent to request a seven-year contract period. The Department has spent more than three years to develop the Accountable Care Collaborative Phase II and recently requested an extension of the current Accountable Care Collaborative contracts to allow enough time for program design activities, federal negotiation and stakeholder input. The Department does not feel it is a good use of resources to initiate this process only two years into a five-year contract as it is hard to assess the impact of the program in such a short period of time and to effectively identify opportunities for change and innovation.

It is important to note, however, that even though the Department has the authority to contract with the new Regional Accountable Entities for up to seven years, the Department always has the option to re-procure before that seven-year period, if appropriate. Additionally, while the procurement itself is for a seven-year period, the Department is required to contract with the Regional Accountable Entities one year at a time and will renew the contracts on an annual basis. This allows the Department to amend portions of the contract that may need modification.

- 5 The Department indicates that it plans to retain the capitation payment methodology for “core behavioral health services”. Explain what services are considered “core” and will thus continue to be paid through a capitated rate, and which services will be paid using a different methodology.

In the next phase of the Accountable Care Collaborative, the Department will retain the capitation payment methodology for all services currently funded under the Behavioral Health Organizations (BHOs); these services are referenced as core services.

The table below shows the list of “core behavioral health” services funded in the Accountable Care Collaborative Phase II under a behavioral health capitation.

Core Behavioral Health Services
Alcohol/Drug Screen Counseling
Assertive Community Treatment
Behavioral Health Assessment
Clubhouses
Drop-in Centers
Emergency/Crisis
Home-Based Services for Children and Adolescents
Inpatient Psychiatric Hospital
Intensive Case Management
Medication Assisted Treatment
Outpatient Hospital
Pharmacological Management
Physician
Prevention/Early Intervention
Psychosocial Rehabilitation
Psychotherapy (individual, group & family)
Recovery
Residential (Mental Health)
Respite Care
School-Based Mental Health
Social Ambulatory Detoxification
Specialized Services for Addressing Adoption Issues
Substance Use Disorder Assessment
Targeted Case Management
Vocational

In addition to the core services covered under the capitation, the Department will pay for up to six (6) sessions of behavioral health services for low acuity and brief episodic conditions (e.g., screening, assessment, psychotherapy) in physical health care settings. The sessions provided in primary care settings and billed by a primary care provider will be paid on a fee-for-service basis.

- 6 **The draft RFP allows for reimbursement for six behavioral health-related visits, per episode of care, that are provided in a physical healthcare setting. How does the Department plan to cover the cost of these visits and still achieve its cost savings/cost avoidance goals?**

The policy change to allow primary care physicians to deliver up to six sessions of low acuity behavioral health interventions in the primary care setting would be budget neutral. Utilization of services in a primary care setting and paid via fee-for-service would substitute for utilization of services paid under the behavioral health capitation. This change would cause a budget neutral shift in funding between line items in FY 2018-19, and the Department would account for any shift in expenditure via a budget action during the FY 2018-19 budget cycle.

Further, the Department anticipates reductions in the long-term cost trajectory of the Medicaid program as a result of this change to the managed care risk structure and other changes in the Accountable Care Collaborative Phase II. Promoting the use of low acuity behavioral health services in a primary care setting supports holistic care and reduces stigma. This model of care lends to early detection and intervention for behavioral health concerns; members are diverted from requiring more intensive and high cost services.¹

- 7 **How does the Department plan to ensure continuity of care for those clients with severe mental illness or substance use issues both during and after the transition to the regional accountable entities (RAEs)?**

The Department is taking several steps to prevent and minimize any disruptions to care for all members as we implement the Accountable Care Collaborative Phase II. As a first step, the Department has included a transition period as part of the procurement timeline during which both the incoming and outgoing vendors will be operating simultaneously. The Department's November 1, 2016 budget request R-11, 'Vendor Transitions,' would provide funding during this transition period to ensure the new Regional Accountable Entities have resources to effectively collaborate with the current Behavioral Health Organizations, Regional Care Collaborative Organizations, and network

¹ Unützer, J, Harbin, H., Schoenbaum, & Druss, B. (2013). The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. *Centers for Medicare and Medicaid Services Information Resource Center.*

providers prior to the operational start date to promote continuity of care and minimize disruptions in services.

To support the transition of responsibilities, the Department has included requirements regarding start-up periods and closeout periods in both the current vendor contracts and the drafts of the new contracts. To minimize the impact of the transition on members, the current contracts with the Behavioral Health Organizations and Regional Care Collaborative Organizations include requirements for closeout plans to ensure all necessary steps and milestones are met to transition the contracted services after termination of the existing contract. If the Department determines that a contractor has not completed all requirements of the closeout plan by the end date of the contract, the contractor will be held accountable until the Department determines all requirements have been fulfilled. For contracts with the Regional Accountable Entity, the Department will include requirements during the months prior to the official start date for transitioning the services described in the contract from the Behavioral Health Organizations and Regional Care Collaborative Organizations.

In addition to overall administrative requirements, the Department has included a number of continuity of care protections for members and behavioral health providers in the draft Request for Proposals.

- The Regional Accountable Entities will be required to establish and maintain a statewide network of mental health and substance use providers and they must offer contracts to any willing and qualified Community Mental Health Center in the state to enable member choice and promote continuity of care. As a result, the Department expects that most, if not all, existing contracted mental health and substance use providers will continue to provide services to their existing beneficiaries through contract arrangements with the Regional Accountable Entities.
- There will continue to be requirements for the Regional Accountable Entities to enroll licensed, non-contracted providers that a member has an existing relationship with and with whom the member wants to continue receiving services. If a provider chooses not to enroll, the Regional Accountable Entities will be expected to utilize single-case agreements with these providers to promote continuity of care when appropriate.
- The draft Request for Proposals includes requirements that comply with the new managed care regulations, including 42 CFR § 438.62(b)(1)(i), to ensure continued access to services when a member transitions from one Regional Accountable Entity to another.
- Regional Accountable Entities will be required to provide continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems, such as individuals receiving long-term services and supports, individuals involved with the criminal justice system, and children involved with child welfare.

- 8 **Describe elements of the RFP that are designed to improve behavioral health care and care coordination for:**
- a. **Individuals involved in the criminal justice system (including those individuals who are being released from the Department of Corrections);**
 - b. **Children and families involved in the child welfare system; and**
 - c. **Individuals who are in crisis and require urgent behavioral health services.**

The Department is implementing a number of policies and contract requirements as part of the Request for Proposals that are designed to improve behavioral health care and care coordination for vulnerable populations, such as individuals involved in the criminal justice system, children and families involved in the child welfare system, and individuals who are in crisis. These elements include broad administrative changes such as contracting with one Regional Accountable Entity, mandatory enrollment, and population health management requirements, as well as specific contract requirements around working with the unique systems that serve these individuals.

Having a single entity overseeing both physical health and behavioral health services increases accountability for addressing members' needs, regardless of whether they connect with the health system through physical health or behavioral health providers. As individuals involved in the criminal justice system and child welfare system often have a complex mix of behavioral health and physical health needs, the Regional Accountable Entity will be better positioned to monitor activities delivered in both delivery systems, identify gaps in care, and connect members with important services. Mandatory enrollment will also improve access to behavioral health care and care coordination as the member's Regional Accountable Entity and contracted Primary Care Medical Provider will be able to reach out to members more quickly to establish relationships and assist the member in accessing appropriate services.

For the next phase of the Accountable Care Collaborative, the Department has instituted stronger requirements related to managing the health of the contractor's entire enrolled population, including individuals involved in the criminal justice system and child welfare system. The Regional Accountable Entities will be required to develop and implement a population health management strategy that describes the contractor's stratification methodology, the interventions that will be made available for different populations, and who will deliver the interventions. The Department will approve and monitor the implementation of the population health management plan to ensure that it adequately addresses the unique needs of different populations, such as individuals involved in the criminal justice system and child welfare system.

The Request for Proposals includes some specific requirements regarding the coordination of care for individuals involved in the criminal justice system and child welfare system. First, the Regional Accountable Entity is required to ensure that care coordination is provided to these members. In

addition, the Regional Accountable Entity will be required to designate a staff person to serve as a single point of contact with the different systems and settings; provide specific guidance to care coordinators working with these populations that will smooth communications and ensure coordinated services; and participate in inter-agency workgroups to develop systemic approaches to improving services and coordination.

Phase II of the Accountable Care Collaborative also has a stronger focus on the health neighborhood and community. Through these requirements the Regional Accountable Entity will be responsible for establishing relationships with economic, social, educational, justice, recreational and other relevant organizations to optimize the physical and behavioral health of members. These activities will ensure more comprehensive support to those individuals with complex needs who receive services from a variety of agencies, such as the criminal justice system and child welfare.

The Department is working with the Colorado Department of Human Services and Centers for Medicare and Medicaid Services to design and implement an intensive Systems of Care to improve the health, well-being and functioning of children and youth with significant mental health conditions who are at risk for out-of-home placement, as well as their families and caregivers. Both agencies believe that this program would be a valuable resource to serve a number of children involved in the child welfare system. The Systems of Care is a comprehensive, community-based program to ensure that children and youth with significant mental health conditions and their families/caregivers receive services they need for success in home, school and Community. The Department has included components of the Systems of Care as part of the draft Request for Proposals but will not include the program in the Regional Accountable Entity contracts until the program is fully developed and authorized.

For individuals who are in crisis and require urgent behavioral health services, the next phase of the Accountable Care Collaborative will be better able to serve them through a single entity responsible for the seamless integration of care. Because of the new access to six visits without a diagnosis requirement, these members will be able to access urgent services in more settings, including primary care as appropriate. While someone in crisis or urgent need might ultimately require a higher level of care, this greater access should help with an immediate need. Lastly, the Accountable Care Collaborative will continue to have timeliness standards for the delivery of emergency behavioral health care. The Department is developing approaches to increase the monitoring of these timeliness standards and ensure greater adherence to established standards.

- 9 **Explain why the Department anticipates that the federally required change from an actuarially certified rate range to a rate point will reduce behavioral health capitation rates.**

Capitation rates are a forecast of the expected cost of providing services for a population. Because the rates are a projection and there are many moving pieces, there is a range of outcomes that are all equally likely from a statistical perspective. Historically, the Department has had the flexibility to select any payment rate within this range of values. Under the new managed care regulations, this flexibility is significantly reduced and the midpoint of the range will be used.

In the most recent rate setting cycle, the highest possible value was selected in almost all cases due to other changes in the rate setting methodology that put downward pressure on rates. This means that, holding all other factors constant, rates will be reduced from the upper bound (the highest possible value in the rate range), to the midpoint (point estimate). The Department estimates the impact of this effect to be an approximate 4 percent decrease in the capitation rates.

- 10 **Discuss the Department's plans to use incentive payments for improved performance to mitigate anticipated decreases in behavioral health capitation rates.**

The Department anticipates an approximate 4 percent decline in behavioral health capitation rates in FY 2017-18, relative to what the rates would be under the current rate setting methodology, as provisions of the federal managed care regulations are implemented. See Question 10 for additional context. The Behavioral Health Organizations (BHOs) have conveyed that the downward pressure on rates will limit their flexibility to provide interventions and invest in innovations that ultimately drive down total cost of care (physical and behavioral health care costs) for members by improving health outcomes. To address this issue, the Department's FY 2017-18 budget request R-6, "Delivery System and Payment Reform" asks to allow the Behavioral Health Organizations to earn a portion of the rate reduction back through incentive payments. If approved, specific metrics that support a quality improvement strategy would be identified and incorporated into the FY 2017-18 contracts for the BHOs. Performance on the metrics will be measured in FY 2017-18, and payments on the performance will be made to the current contractors early in FY 2018-19.

The Department anticipates that the behavioral health quality improvement strategy would be based on the collaborative work to date of the Department, the Office of Behavioral Health, and members of Colorado Behavioral Health Council. Over the last year, these parties worked together in preparation for potential participation in the Certified Community Behavioral Health Center Demonstration, a federal funding opportunity to drive improved access to high quality behavioral health services through Community Health Centers and affiliates. While we do not yet know if Colorado will be selected for participation in the Demonstration, there is ongoing commitment of all parties to

implement a behavioral health quality improvement strategy based on its framework whether or not Colorado is selected for participation.

Lastly, explicitly making the connection between Medicaid reimbursement and performance in the behavioral health capitation program is part of the Department's ongoing commitment to value-based purchasing. Aligning incentives across the different provider types to reinforce coordination, giving providers flexibility while holding them accountable for outcomes through performance metrics, and rewarding performance are core components of the Department's strategy to ensure access to high quality, cost-effective care for our members and the taxpayers.

- 11 ***In R6 Delivery system and payment reforms, the Department proposes replacing a federally mandated decrease in capitated payments for behavioral health organizations in FY 2017-18 with performance-based payments beginning in FY 2018-19. How does the Department expect providers to manage the delay in payment?***

While financed through the reductions, the proposed incentive payments are in addition to, not replacing, capitation rates that are certified by both the Behavioral Health Organizations' (BHO) actuary and the Department's actuary as sufficient to cover the cost of providing and managing services covered under the scope of the behavioral health managed care contract. The incentive payments are a mechanism that allows the BHOs to see an additional return on investment for activities that are not otherwise captured in the rate setting process, but that drive improvements in member outcomes. Further, using a payment mechanism that is attached to outcomes and not service volume adds an additional degree of financial flexibility should a BHO pursue the incentive payments.

If approved, specific metrics that support a quality improvement strategy would be identified and incorporated into the FY 2017-18 contracts for the BHOs. Performance on the metrics would be measured in FY 2017-18, and payments on the performance would be made to the current contractors early in FY 2018-19. While strategies for hitting performance targets will vary, in cases where the BHO must make an upfront investment, the BHOs can leverage cash reserve, profit, debt, or grant funding as they would for any other aspect of their businesses.

- 12 **What types of physical and behavioral healthcare services are covered by Medicaid when an individual is receiving inpatient psychiatric care (please differentiate services provided within the mental health institutes from those provided in other settings)? Does the Department’s draft RFP propose any changes that would increase the physical or behavioral healthcare that is covered by Medicaid under these circumstances?**

There are three types of psychiatric inpatient facilities reimbursed by Medicaid: private free standing psychiatric hospitals; psychiatric units licensed as part of a larger hospital; and state psychiatric institutions. Individuals admitted to a psychiatric facility must be in need of an inpatient level of 24-hour care. Once admitted to a psychiatric facility, room and board and all routine medical care and psychiatric treatment provided by the facility is covered by Medicaid and paid through per diem, all-inclusive payment. The exception is for adults ages 21-64 being treated in a free standing psychiatric facility or state psychiatric institute. Facilities such as these with more than 16 beds meet the federal definition of an Institution for Mental Disease (IMD). Federal IMD rules prohibit Medicaid from using federal financing to fund any services rendered to members covered under the IMD exclusion.

If an individual admitted to a psychiatric facility experiences an emergency medical condition and is transferred to a different medical unit or outside facility, Medicaid would pay for the emergency medical care provided. The exception again is for those adults ages 21-64 residing in an IMD as the IMD exclusion prohibits federal financing of any services, including those services rendered outside of the IMD. However, Colorado Medicaid utilizes a capitated managed care system to cover IMD inpatient stays less than 16 days through an “in lieu of” provision stipulated in the managed care regulations developed by the Centers for Medicare and Medicaid Services.

The Department’s draft Request for Proposals for Phase II of the Accountable Care Collaborative does not propose any changes to the physical or health care benefits covered by Medicaid. The General Assembly must authorize and appropriate funds to add new benefits in the Colorado Medicaid program. The Department’s FY 2017-18 budget request does not request any changes to the inpatient psychiatric benefit.

2:20-2:30 OTHER

- 13 **Explain why the capitation rates for the “Individuals with disabilities up to age 64” eligibility category are so high relative to other categories.**

Capitation rates vary from population to population based on the differences in utilization patterns. Higher rates reflect higher average utilization of services or higher cost services within a population.

The aid category "Individuals with Disabilities up to Age 64" is where the majority of individuals that became eligible for disability coverage due to serious and persistent mental illness are assigned. Consequently, this aid category has disproportionately higher average utilization than other categories, and that is reflected in the higher capitation rates.

- 14 **Describe the processes that the Department uses to recoup money from a behavioral health organization (BHO), whether the recoupment is due to an IT systems issue or the “risk corridor” that was placed on capitation rates for the expansion populations. How much notice does a BHO receive, and how does the BHO plan for such recoupments from a cash flow perspective?**

There are several different types of reconciliations in the BHO contracts, each with a different purpose and process. For all reconciliations, the plans are provided with a demand letter, supporting detail and calculations, and the opportunity to provide feedback on the methodology for calculating the recoupment amount. The various reconciliation descriptions, communication strategy, timing, and cash flow impacts are described below.

Expansion Parent Overpayment Reconciliation

The purpose of this reconciliation is to ensure the correct rate was paid for members in the Expansion Parent cohort. This recoupment is necessary due to a claims processing system issue in which the incorrect rate is systematically assigned (the Single Adult rate is assigned to Expansion Parents). The Department identifies the list of members, generally within a few days of the capitations being paid, and distributes the list to the plans. This allows the plans to hold funds that they know will be recouped. Although the lists of members are sent to the plans monthly, the recoupments take place every six months to reduce administrative burden on the plans and the Department. This issue has been addressed in the design of the new claims processing system to eliminate the need for this reconciliation.

Expansion Populations Risk-Corridor Reconciliation

This reconciliation has historically been required at the federal level as a mechanism to mitigate the risk assumed by both the plans and the Department due to forecast uncertainty with the newly eligible populations. In most cases, the reconciliation has resulted in a recoupment; however, if the rates were not adequate to cover the costs of the specific population the Department would make a payment to the plan to cover the extra costs. The parameters of the risk corridor reconciliation are agreed upon by the BHO through the annual contract renewal process, more than a year prior to any actual recoupment. The plans receive notice of this recoupment (or payment) after the data for the applicable time period has been processed, typically six to eight months after fiscal year end. The plans track the revenue and expenses associated with these populations for their own cash flow purposes.

Date of Death Recoupment

Each year there is a small number of capitations paid for members who have died. This occurs when there is a delay in the Department being notified of the member's death. Capitation payments that fall in this category are recouped as soon as the Department is notified of the member's death. Information is communicated to the plans promptly. These are generally very small dollar amounts that do not cause a cash flow issue for the plans.

Institutes for Mental Disease (IMD) Recoupment

Patients in IMDs are not eligible for Medicaid, therefore capitations need to be recouped when it is discovered that a member has been a patient in an IMD for a given month. This is a very small recoupment and does not have a significant impact on the plans' cash flow.

QUESTIONS FOR BOTH THE DEPARTMENT OF HUMAN SERVICES AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

2:30-2:45 WICHE STUDY CONCERNING BEHAVIORAL HEALTH FUNDING (DEC. 2016)

- 15 Discuss the findings of the WICHE Study. In particular, discuss the recommendations related to realigning responsibilities for behavioral health services at the state agency level and at the provider level to: (a) strengthen the coordination and equity of care provided to individuals across the state; and (b) improve the effectiveness and efficiency in the use of state and federal funds.

The following response was provided by both the Department of Human Services and Department of Health Care Policy and Financing:

In the fall of 2015, the Department of Human Services (Department) requested that the Office of State Planning and Budgeting (OSPB) procure the Behavioral Health Funding Study that was performed by WICHE. The Behavioral Health Funding Study confirms many of the Department's concerns and accurately reflects the challenges facing both the Department and the Department of Health Care Policy and Financing (HCPF).

In particular, the Departments support the recommendation that OSPB complete a review of State behavioral health programs and identify opportunities for streamlining funding to strengthen coordination of care and increase efficiency in the use of State and federal funds. Concurrently, the Department of Human Services and HCPF are collaborating to align contract requirements, develop shared performance goals in areas of access and service engagement, and develop common billing and reporting practices. These collaborative efforts are intended to enhance the coordination and accessibility of care at the client and provider level as well as to ensure the most efficient use of State funds.

The Departments also concur with the recommendation outlined in the Behavioral Health Funding Study that suggests alignment of contracting regions with the Regional Accountable Entities (RAEs) proposed in HCPF's Accountable Care Collaborative Phase II project. This would allow the Department to update the existing contracts with the Community Mental Health Centers and Managed Services Organizations that have not been re-procured for many years. The alignment of the Department's behavioral health contracting with the RAEs also has the potential to improve coordination of care for individual clients that are currently served by both Departments by creating a single care coordination and administrative entity where multiple parties are responsible.

- 16 **[WICHE Study Recommendation #6] Describe the current status of the proposal to modify the Medicaid Management Information System (MMIS) to allow for eligibility and payment processing for both Medicaid and non-Medicaid clients. Discuss whether this is likely to be a viable option for reducing the administrative burden on service providers and ensuring that the State is not paying twice for the same service.**

The following response was provided by both the Department of Health Care Policy and Financing and the Department of Human Services:

The Department of Health Care Policy and Financing (Department) supports this recommendation and is collaborating with the Department of Human Service's (DHS) Office of Behavioral Health (OBH) to determine how to best prevent duplicative billing and mitigate service costs charged to OBH that should be covered under Medicaid. Modifying the Department's new Medicaid Management Information System (MMIS), referred to as the Colorado interChange, is a viable solution to manage OBH claims processing and reduce the administrative burden on service providers. This system will be implemented in March 2017. Once implemented, the Department and OBH plan to design changes to simplify the eligibility and billing process for the providers, along with allowing the Department and the OBH to gain control and visibility of the services that are provided to these clients. At this time, an implementation date or cost estimate cannot be provided to modify the system to manage the OBH claims processing as the Department is undertaking a large amount of work to implement the Colorado interChange.

OBH client records could be consolidated in the Colorado interChange, providing benefit coverage information in real-time, i.e. Medicaid or OBH eligibility status, for the providers. Consolidating the client records in the Colorado interChange would also simplify the billing process for the providers. Providers would submit all claims to the Colorado interChange, eliminating the need for the provider to maintain multiple electronic billing standards. The Colorado interChange would adjudicate all of the claims and would then deny the claims appropriately by preventing duplicate payments or eliminating payments for those clients that have other types of insurance, including Medicaid. These edits are already built in the Colorado interChange. The system will also process the claims into the correct benefit plan, Medicaid or non-Medicaid plan as established by the OBH, and reimburse based on the criteria established in each plan. The Colorado interChange allows for different payment methodology and/or rates for each benefit plan.

The proposed Colorado interChange solution could also deliver more accurate and insightful analytics for the services provided to the OBH clients. The client and claims data will be retained in the Department's enterprise data warehouse solution and can be shared with other Departments.

In addition, the Department is willing to restart conversations to have Community Mental Health Centers serve as Medical Assistance sites. This would allow them to process a client's application for Medicaid, and for other social services programs, when the client receives care. Most Federally Qualified Health Centers and hospital systems already provide application assistance or are Medical Assistance sites to reduce the number of uninsured they serve and provide Medicaid coverage when appropriate. This could help the Community Mental Health Centers simplify the Medicaid eligibility process for their clients.

- 17 **[WICHE Study Recommendation #7] *Background information: Federal Medicaid rules allow states to suspend Medicaid eligibility for individuals in institutions for more than 30 days, including state hospitals, prisons, and juvenile facilities (for individuals who emancipate). Senate Bill 08-006 requires that persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, Department of Corrections (DOC) facility, or Department of Human Services facility shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement. Explain the significant delay in implementing this act, describe what the Department has done to date to implement this act, and provide a timetable that specifies the actions the Department will take to complete implementation for both DOC inmates and patients at the mental health institutes.***

The following response was provided by the Department of Health Care Policy and Financing:

SB 08-006 Suspend Medicaid for Confined Persons (Boyd/Solano) provides that confined persons will continue to be eligible for Medicaid benefits if Medicaid benefits were being received immediately prior to designation as a confined person, provided availability of Federal funds. CMS requires that clients who become incarcerated have their eligibility re-determined. Once incarcerated, the client becomes a household of one - making them ineligible for Medicaid as Colorado Medicaid did not traditionally cover single adults when the bill was passed. Until the Adults without Dependent Children (AwDC) expansion, created by HB 09-1293, there was no category available for single adults under Colorado Medicaid. Then prior to January 1, 2014, there were enrollment limits for Adults with Dependent Children. The Department began the implementation of this legislation once all AwDC eligibles could qualify for Colorado Medicaid under the eligibility expansions as authorized under the Affordable Care Act and SB 13-200. However, the Department found that it could not fully implement this bill due to the high cost to implement in Colorado Benefit Management System (CBMS), the Department eligibility determination system, and the current Medicaid Management Information System (MMIS), the Department's claims processing system. The Department has built in the functionality to suspend eligibility for an incarcerated individual in the new MMIS, which is scheduled for implementation in March 2017. In September 2016, a CBMS project was implemented

which enables incarcerated individuals to remain eligible for Medicaid. With the implementation of the new MMIS, incarcerated individuals will be placed in a limited benefits plan that will only pay for services that are incurred while in-patient at a hospital for a stay of 24 hours or more. When the inmate is released, they will be placed back into a full Medicaid benefits plan as long as they remain eligible for a category of Medicaid. The Department relies on the correctional facilities to communicate the incarceration date and release date to an authorized eligibility technician who can update the proper eligibility status in CBMS.

Suspending eligibility for Colorado Mental Health Institute patients is more complicated, as the federal Institutions of Mental Disease (IMD) exclusion allows for appropriate Medicaid payments for individuals under the age of 21 and over the age 64. Now that the functionality exists in CBMS, the Department stands ready to restart the conversations with the mental health institutes to provide them direct access to CBMS or PEAKPro (a module of CBMS which the Department of Corrections current uses to determine a client's eligibility) so they can serve as an authorized eligibility technician who can update the individual's eligibility status when he/she is admitted or released from the IMD. This will allow the individual to be placed back into a full Medicaid benefits plan when they are released from the IMD, as long as they remain eligible for a category of Medicaid. If the Mental Health Institute decides that they do not want to directly use CBMS or PEAKPro, the Department will connect them with a County Department of Human/Social Services or Medical Assistance site who can update the individual's status.

2:40-2:50 STATEWIDE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

- 18 **What types of behavioral health crisis services do existing Medicaid capitation rates cover, and what services are (or should be) covered by General Fund appropriations to the Department of Human Services for the statewide behavioral health crisis response system?**

The following response was provided by the Department of Human Services:

The majority of the clinical services provided in crisis walk-in centers, crisis stabilization units and respite programs are covered services under the Medicaid Capitation benefit and in many cases are also covered by private insurance. In the event that a service is not covered by Medicaid or private insurance these costs are covered by General Fund appropriations. General Fund appropriations also cover services to individuals who are uninsured. Finally, specific services that are not tied to an individual client such as outreach to community partners and coordination of care are not covered by Medicaid or private insurance. The services provided by the statewide crisis hotline and the staffing of mobile response teams are not covered under the Medicaid Capitation benefit and therefore funded completely by General Fund appropriations.

Contractors submit an invoice that reduces the amount billed by the amount recovered from Medicaid and private insurance.

The following response was provided by the Department of Health Care Policy and Financing:

As required in federal Medicaid Managed Care Regulations, the current behavioral health capitation program covers emergency services needed to evaluate or stabilize an emergency medical condition and post-stabilization care services provided after a client is stabilized to maintain the stabilized condition. The behavioral health capitation program also covers a broad range of services, that while not specifically classified as emergency services, are provided following the medical emergency and post-stabilization care services. These services include traditional outpatient behavioral health services and community based services which can be provided to support the individual in the community and prevent or minimize exacerbation of an emergency medical condition.

19 What is the role of the statewide behavioral health crisis response system in addressing crises related to substance use?

The following response was provided by the Department of Human Services:

When an individual who is experiencing a crisis and is intoxicated or has a substance use disorder contacts the crisis hotline, the hotline staff assesses the nature of the crisis along with other behavioral health concerns and makes referrals for services as appropriate. This may include referrals to the other components of the Crisis Response System, mental health or substance use disorder treatment, or detoxification services.

The Department's contracts with the regional crisis service contractors require that they treat individuals with substance use disorders in addition to individuals with mental health disorders. This is a requirement across all crisis response services. The Department's goals for the crisis response system include further integration of services for substance use disorders and mental health disorders. The Department expects that as the system matures, the contractors will be able to maximize cost offsets from Medicaid and private insurance. This will free funds for additional integration of substance use disorder services in walk-in crisis centers and crisis stabilization centers and minimize the separations between the two systems of care.

2:50-3:10 CONTINUUM OF SUBSTANCE USE DISORDER SERVICES

20 Describe the various types of services that are necessary and effective for treating individuals with a substance use disorder.

The following response was provided by the Department of Health Care Policy and Financing:

The field of addictions has evolving research and literature addressing the necessary and effective treatment services for individuals with a substance use disorder (SUD) but this research does not draw a single or simple conclusion as to which services are most efficacious when treating someone with these disorders. The effectiveness of treatment is dependent upon many variables including the availability of diverse treatment options, provider training, qualifications and experience, the presence of coordinated transitions between points of service, and the availability of peer and community-based recovery supports. Staff at the Department of Health Care Policy and Financing (HCPF) work collaboratively with the Office of Behavioral Health in the Department of Human Services, the state’s federally authorized Single State Authority for substance abuse, to address each of these variables.

The following response was provided by the Department of Human Services:

The American Society of Addiction Medicine (ASAM) defines a continuum of care in the treatment of substance use disorders. This continuum extends from prevention/early intervention to hospital-based care. The decision about the most appropriate type of care considers the substance or substances used, the amount or frequency of use, the kinds of problems the individual faces in day-to-day functioning and the other problems or needs present such as co-occurring mental illness, homelessness, or unemployment. The typical substance use disorder service continuum is illustrated in Table 1.

Table 1: Continuum of Services for Substance Use Disorder (SUD) Treatment		
Service	Examples of Service	Examples of Settings
Prevention/Early Intervention	-Curriculum or media based prevention programs -Screening tools -Brief educational interventions	-Schools -Media -Primary care practice -Web-based applications
Outpatient Treatment	-Weekly 45-50 minute session with licensed clinician	-Specialty SUD or mental health clinics

Table 1: Continuum of Services for Substance Use Disorder (SUD) Treatment

Service	Examples of Service	Examples of Settings
	<ul style="list-style-type: none">-Medications to reduce withdrawal or craving	<ul style="list-style-type: none">-Primary care health or school-based health clinics-Hospital outpatient program-Homes, housing sites-Other human services sites
Opioid Medication Assisted Treatment (OMAT)	<ul style="list-style-type: none">-Medications such as Methadone dispensed to reduce withdrawal or craving-Counseling and support-Monitoring substance use, withdrawal and physical health	<ul style="list-style-type: none">-Specialty SUD clinic (must be licensed as OMAT to dispense controlled medications for treatment of opioid/opiate addiction)
Intensive Outpatient Treatment	<ul style="list-style-type: none">-Multiple weekly treatment contacts-Often includes groups, family and individual treatment-May include medications for reduction of withdrawal or craving	<ul style="list-style-type: none">-Specialty SUD or mental health clinic-Hospital outpatient program
Residential Treatment	<ul style="list-style-type: none">-24-hour supportive care-Daily counseling ranging from 2-10 hours per day-Time-limited (generally 30 days to 6 months)-May include medications for reduction of withdrawal or craving-Often provides counseling for other needs such as parenting, mental illness, criminal thinking- Often provides assistance with employment-May include 24-hour nursing care	<ul style="list-style-type: none">-Small home with 24-hour staff and support for fewer than 10 people-Larger 24-hour treatment facility with medical staff
Detoxification	<ul style="list-style-type: none">-24-hour withdrawal monitoring	<ul style="list-style-type: none">-24-hour residential care settings

Table 1: Continuum of Services for Substance Use Disorder (SUD) Treatment

Service	Examples of Service	Examples of Settings
Services	-May include medication to ease withdrawal -May include 24-hour medical staff on site -Includes screening and referral to treatment or support	-Hospitals
Inpatient Treatment	-24-hour medical care -Counseling and support -Often addresses co-occurring mental or physical health concerns -Often using medications to ease withdrawal from alcohol or benzodiazepines	-Hospital

Source: American Society for Addiction Medicine

<http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about>

- a. Identify which substance use-related services are currently covered under the Medicaid, and which are not. For those services not covered by Medicaid, explain why.

The following response was provided by the Department of Human Services:

The primary service not covered under Medicaid is inpatient substance use disorder treatment. In addition, Medicaid does not cover room and board. Table 2 outlines covered services for Medicaid and OBH and identifies broad treatment and network adequacy gaps, as well as the regulatory, licensing and oversight of programs by OBH.

Table 2: Substance Use Disorder (SUD) Services Covered Medicaid and Office of Behavioral Health (OBH)

Service Category	HCPF/ Medicaid	CDHS/ OBH	Responsibility for Payment and Oversight	Service Capacity or Adequacy Gaps
Outpatient Treatment (including intensive outpatient)	Yes	Yes	-Medicaid BHO contract covers -OBH covers uninsured -OBH licenses	-BHO utilization management may impose session limits -Limited number of programs offering intensive outpatient
Vocational/ Employment	No	Yes	-OBH monitors implementation to evidenced-based standards -OBH supports job development and other costs not attributable to an individual Medicaid member and for uninsured	-Not uniformly available for SUD clients. Typically is available for clients with serious mental illness -OBH plans to expand program statewide
Prevention/ Early Intervention	Yes	Yes	-Medicaid and OBH support these services when a Medicaid number is provided -Outreach to vulnerable communities/populations generally covered by OBH if not a billable service for a Medicaid member	-School-based services not available in all schools
Peer Recovery Services	Yes	Yes	-Medicaid BHO contract covers these services - OBH covers training and supports that are uncovered by Medicaid and services for uninsured	-Utilization of peers is not consistent across the State

Table 2: Substance Use Disorder (SUD) Services Covered Medicaid and Office of Behavioral Health (OBH)

Service Category	HCPF/ Medicaid	CDHS/ OBH	Responsibility for Payment and Oversight	Service Capacity or Adequacy Gaps
Opioid Medication Assisted Treatment (Methadone)	Yes	Yes	-Cost of Methadone delivery is not covered by Medicaid -OBH licenses in compliance with federal law -OBH covers uncovered costs for Medicaid members and uninsured	-No capacity in most rural parts of the State Waitlists of 6 weeks in metro area -Network adequacy concerns for Medicaid and OBH
Medication Assisted Treatments (other than Methadone)	Yes	Yes	-Medications covered under the Medicaid Pharmacy benefit -Associated counseling covered in BHO capitation -OBH covers uncovered costs for Medicaid members and uninsured	-Significant gap in access/capacity statewide due to lack of physician providers available to work with population and lack of awareness of effectiveness of medication assisted treatment statewide
SUD Residential	No	Yes	-Not a covered service in the Medicaid program -OBH supports for all -OBH is the licensing authority	-Insufficient capacity for adults, adolescents, women with children, co-occurring mental health disorders cited by stakeholders
Detoxification (Non-Hospital)	Partially	Yes	-Medicaid covers certain clinical intervention in BHO capitation -OBH supports the unreimbursed costs to operate facilities including room and board	-Insufficient statewide coverage -Medicaid coverage for certain clinical services in 15 minute increments with cap on number

Table 2: Substance Use Disorder (SUD) Services Covered Medicaid and Office of Behavioral Health (OBH)				
Service Category	HCPF/ Medicaid	CDHS/ OBH	Responsibility for Payment and Oversight	Service Capacity or Adequacy Gaps
Inpatient detoxification	Yes	No	-Medicaid covers inpatient only in Fee for Service benefit not covered by BHO capitation	-Required for withdrawal from benzodiazepines and alcohol and high risk individuals such as pregnant women

- b. Identify which substance use-related services are currently provided through the Department of Human Services, and describe the types of individuals who are eligible to receive such services.

The following response was provided by the Department of Human Services:

The Department provides support for treatment through regional Managed Service Organizations. Each region is required through contract to provide outpatient services, detoxification services and Opioid Medication Assisted Treatment (OMAT: clinics licensed to dispense controlled substances such as methadone) within their regions. In addition, each Managed Service Organization is required to offer residential treatment either within their region or through contract outside their region. The Department also provides funding for medication assisted treatment using medications that do not require an OMAT license.

In addition to the core funding distributed through the Managed Services Organization, the Department supports a variety of specialized programs including services for women with substance disorders and their children, residential and outpatient services for individuals at risk involved with the criminal or juvenile justice system. The Department also supports harm reduction services such as distribution of naloxone, a medication that can reverse the effects of an opiate/opioid overdose, and case management programs for individuals who cycle through detoxification programs. In addition, the Department funds communities to implement substance abuse prevention strategies as required by the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant.

The Department also operates the Circle Program, located at the Colorado Mental Health Institute at Pueblo. The Circle Program is a 90-day inpatient treatment program for adults with co-occurring

mental health and substance use disorders who require residential treatment. Individuals served through the Circle Program may voluntarily enter the program or are referred as a condition of probation, and some patients are committed to the program under the State's alcohol and drug involuntary commitment statutes.

A large portion of the funding the Department uses to support substance use disorder treatment is SAPT Block Grant. Federal funding requires priority admission be granted to pregnant women, individuals using injection drugs, and parenting women. The Department requires the Managed Services Organizations to ensure adherence to this prioritization for treatment admission by contracted providers, regardless of the payer source. The Department's contracts with the Managed Services Organizations require that funding is used for services to Medicaid members that are not covered by Medicaid and services for individuals who do not have health insurance and have incomes lower than 300% of the federally-defined poverty level.

- 21 **The draft RFP for phase II of the Accountable Care Collaborative does not include significant reforms related to substance abuse and addiction. Given the growing complexity of substance abuse and the opioid epidemic, what is the Department of Health Care Policy and Financing's plan to expand the role of the health community in addressing the costs associated with addiction?**

The following response was provided by the Department of Health Care Policy and Financing:

The draft Request for Proposal for the next phase of the Accountable Care Collaborative describes the changes the Department will implement to more effectively administer the Medicaid benefits currently authorized by the General Assembly. The Request for Proposals does not discuss changes or additions to the Department's Medicaid benefit packages as those require legislative and budgetary approvals. Because of this distinction in processes, it would not be appropriate to include significant reforms related to substance abuse and addiction treatment benefits in the draft Request for Proposals.

A significant reform in the Request for Proposals is the administrative integration of physical health and behavioral health services, which includes the integration of substance use treatment. In the definition section of the Request for Proposals the Department clearly states that behavioral health refers "to both mental health and substance use." By combining the administration of the Department's mental health and substance use benefits with the oversight of physical health services, the Department is striving for greater coordination of services, improved access to appropriate services, and ultimately improved member health. The promotion of integrated behavioral health and primary care is extremely important for substance use treatment as primary care is often a place to initially identify individuals

who may have problems with substance use. Primary care providers are also an important part of the substance use treatment model by delivering medication assisted treatments for addictions.

The six behavioral health services for low acuity behavioral health conditions that can be delivered in primary care offer an important opportunity to intervene early with substance use problems and engage individuals in understanding their potential risks and options for assistance. One of the Department's current benefits is for SBIRT (Screening, Brief Intervention, and Referral to Treatment), an approach frequently used in primary care to identify and offer early interventions for individuals with substance use disorders and those at risk of developing these disorders. Many primary care providers currently struggle with finding time and resources to perform brief interventions and identifying appropriate referral sources for individuals who need additional treatment. These six behavioral health services can be used to perform brief interventions around substance use, as well as initial substance use treatment. Furthermore, when an individual is diagnosed with a substance use disorder in a primary care practice, the practice can access the Regional Accountable Entity to support the individual in accessing appropriate substance use treatment.

The Department has also been implementing a number of initiatives over the past few years to address issues related to the opioid epidemic including improving access to treatment for opioid addictions, controlling utilization of opioids, and providing assistance to providers who have patients dealing with pain issues or addictions.

For example, the Department covers products which are used to treat addiction and to save people who overdose, such as buprenorphine and naloxone. The Department is also sponsoring a Chronic Pain Disease Management Program that is focused on supporting providers who prescribe buprenorphine. It is designed for providers who are licensed to prescribe buprenorphine/Suboxone to connect with specialists to gain greater insights and experience in treating clients with opioid addiction. In the first year of this program, there are 9 practices participating. The Department also continued its other ACC Chronic Pain Disease Management Program, which connects providers with multi-disciplinary team of chronic pain specialists to review client cases and learn evidence-based interventions for treating clients with complex conditions. It is in its second year and there are 25 practices participating (there were 42 last year).

The Department also supports providers by giving all Medicaid providers access to PainNET, which is a flexible online learning community to engage primary care providers and practices and offer the tolls and resources to learn about pain, collaborate with experts, and transform care with evidence-based practices. They can participate in discussion forums, community consults, and access the video library and resources library.

The Department has also taken a number of steps to address opioid overutilization. These efforts have resulted in a reduction in the number of claims for opiates of 1.3% and a gross cost decrease of 6.4% (net of drug rebates) from FY 2014-15 to FY 2015-16. These efforts included a quantity limit on short-acting opioids, continued dosing limitations on long-acting opioids, and an overall morphine equivalent dosing limit. These efforts were also supported by provider education through Drug Utilization Review letters to providers who have patients receiving high doses of opioids and/or are receiving prescriptions from multiple providers and consultations with a pain expert. The Department also has a Pain Management Resources page on the Department website that provides a wealth of information for providers related to opioids including information about the drugs, pain guidelines, risk assessments, tapering and discontinuing information, naloxone information, opioids and pregnancy, patient education, and substance use disorder assistance/prevention.

To assist with many of these initiatives, the Department is currently evaluating whether to seek a statutory change to allow the Department access the prescription drug monitoring program (PDMP) database which is overseen by the Board of Pharmacy in the Department of Regulatory Agencies. Currently by only seeing the claims paid by Medicaid, the Department does not have a complete picture of who may be struggling with opioid addiction. The Department would use the information in the PDMP to help identify clients who are paying cash for opioid prescriptions in addition to using their Medicaid benefit and get them connected to a case manager. This has become a national best practice and 25 states have successfully utilized their PDMPs to help clients struggling with opioid addiction get substance abuse treatment.²

Finally recognizing that the issue is larger than Medicaid and the Medicaid population, the Department has continued its partnership with the statewide Consortium for Prescription Drug Abuse Prevention.

The next iteration of the Accountable Care Collaborative also focuses on effectively leveraging and coordinating the broader health neighborhood and community resources to support a comprehensive, multi-disciplinary approach to improving member health. Treatment for addiction often involves multiple providers and community resources, such as Alcoholics Anonymous and other peer- and faith-based interventions. The Regional Accountable Entity will have responsibility to work with and leverage existing community infrastructures to facilitate member access and engagement in evidence-based and promising local programs for addiction, reduce duplication of activities, and identify and work with communities to find ways to address any gaps in addiction programming or services.

² Wachino, Vikki. Best Practices for Addressing Prescription Opioid Overdose, Misuse and Addiction. Baltimore: Center for Medicaid and CHIP Services, 2016. Accessed May 24, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>; Mercer. State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose. Phoenix: Mercer, 2014. Accessed June 7, 2016.

Through these methods and continued partnership with the Office of Behavioral Health, the Department expects to address some of the costs associated with addiction.

- 22 ***Background information: Managed service organizations (MSOs) manage a statewide substance use disorder treatment system for Colorado. There are seven MSO regions. As regional entities, MSOs support the delivery, expansion, and quality delivery of the entire continuum of substance use disorder treatment. The draft RFP requires the regional accountable entity (RAE) contractor to include several specific providers as part of its health care delivery network (RFP, page 68). If one of the goals of the RAE is to implement coordination of services to “disincent duplication of services, overuse of low value services and fragmentation of care” (RFP, page 25), shouldn’t MSOs be included as an entity that the RAEs must work with to ensure benefit continuity and access to services not otherwise covered by Medicaid?***

The following response was provided by the Department of Health Care Policy and Financing:

As the Managed Service Organizations are an important part of the Health Neighborhood, the Department expects the Regional Accountable Entities to establish collaborative relationships with the Managed Service Organizations to ensure coordination of services and arrange for the full continuum of substance use disorder treatment, particularly those services not covered by Medicaid. That said, it is not appropriate to include Managed Service Organizations in the list of required network service providers referenced on page 68 as the Managed Service Organizations are managed care entities not direct service providers. The requirement on page 68 of the Request for Proposal defines the minimum types of direct service providers that must be included in the Regional Accountable Entity’s contracted network in order to serve all members. It is expected that the Regional Accountable Entities will contract directly with providers within the Managed Service Organization networks who meet Medicaid provider enrollment criteria. The Department recognizes the important role of the Managed Service Organizations and their providers and will partner with them to deliver comprehensive substance use treatment to improve member health.

- 23 **Legislators hear that there is a shortage of facilities that provide detoxification services (for both Medicaid-eligible clients and individuals who are not eligible for Medicaid). Provide any available data about the adequacy of detoxification services statewide.**

The following response was provided by the Department of Human Services:

Detoxification services may be provided in multiple settings. The American Society for Addiction Medicine (ASAM) defines detoxification as encompassing ambulatory or outpatient detoxification,

clinically managed detoxification, medically monitored detoxification and medically managed detoxification.

The detoxification programs funded by the Department are typically clinically managed (24 hour clinical monitoring with limited medical staff) or medically monitored detoxification (with medical staff on site but that do not administer medication for withdrawal). The Department does not contract for ambulatory detoxification or medically managed detoxification (typically provided in a hospital setting).

Table 3 lists the detoxification facilities licensed by the Department, their location and if they receive contract funds from the Department.

Table 3: Licensed Detoxification Facilities as of November, 2016			
Agency	Location	# Beds	CDHS Funded
North Range	Greeley	23	Yes
Arapahoe House	Wheat Ridge	30	Yes
Arapahoe House	Commerce City	30	Yes
Arapahoe House	Aurora	28	Yes
Denver Health	Denver	100	Yes
Parker Valley Hope	Parker	10	No
CeDAR	Aurora	10	No
El Paso County	Colorado Springs	40	Yes
Shadow Mountain Recovery	Colorado Springs	14	No
Park View Medical Center	Pueblo	10	No
RESADA	Las Animas	6	Yes
Crossroads' Turning Points	Pueblo	30	Yes
Crossroads' Turning Points	Alamosa	11	Yes
Crossroads' Turning Points	Trinidad	12	Yes
Axis Health	Durango	16	Yes
Mind Springs	Frisco	4	Yes
Mind Springs	Grand Junction	15	Yes
Mental Health Partners	Boulder	20	Yes
Source: OBH Licensing Database			

The Department does not have data comparing the need for detoxification services statewide, however SB 16-202 requires that the Managed Services Organizations complete a community assessment to be delivered to the Department by March 31, 2017. The Department anticipates that this report will inform the State about the adequacy of clinically managed and medically monitored detoxification services statewide.

- a. **If there is a problem related to access to detoxification treatment, explain why (e.g., are the rates paid by the Medicaid program or the Department of Human Services too low)?**

The following response was provided by the Department of Human Services:

The Department is aware of anecdotal reports of problems related to rural and frontier accessibility of detoxification due to distances traveled but does not have data on the extent of this problem. The problems of detoxification program accessibility in rural and frontier areas stem in part from the high unit costs of very small programs, the challenges of siting programs that are accessible across wide geographic areas and the need for these programs to be funded as local, State and federal partnerships. The Department has heard from contractors that the capacity funding model that is used by the Department to ensure that the amount reimbursed to contractors is offset by collections from Medicaid, local government and private insurance is burdensome. The Department, in coordination with HCPF, is working with the contractors to modify the billing procedures associated with the capacity model to reduce the burden.

The following response was provided by the Department of Health Care Policy and Financing:

The process for Medicaid clients to obtain clinically appropriate detoxification services is not intuitive. Depending on the level of detoxification required, services can potentially be funded and administered through three separate delivery systems (fee-for-service Medicaid, under Medicaid's capitated behavioral health program, and through the Office of Behavioral Health in the Department of Human Services). The only inpatient level of detoxification covered by Medicaid is an inpatient hospital stay for withdrawal and medical stabilization; it is covered under Medicaid's physical health benefits, and therefore is not actively managed by the BHOs. Medical detoxification is only available when members require 24-hour nursing care and daily physician visits for severe and unstable withdrawal. Residential detoxification is a level of care between inpatient hospitalization and community-based detoxification. It is facility-based treatment for individuals contending with moderate withdrawal, but who need 24-hour clinical treatment and support to complete detoxification. Residential detoxification

services are currently not a Medicaid covered benefit, but are provided to some Medicaid members through the Office of Behavioral Health.

HCPF pays a capitation rate to the Behavioral Health Organizations (BHO) that covers all services under the scope of the contract. Rates are required to be actuarially sound, which means that they must be sufficient to ensure access to services and the financial viability of the managed care organization when well managed. The BHOs also certify the rate as sufficient to cover the costs of providing all services they are contracted to provide as is required by state statute. The actual payment arrangement between the BHOs and the providers of community-based detoxification services will vary, but HCPF expects that arrangements between the BHOs and providers are designed to ensure sufficient access for clients given the BHO is at significant financial risk when clients' needs are not met and their condition worsens. Rates do not appear to be the reason for any issues with access to detoxification services.

b. What are both departments' plans to address the needs of individuals who repeatedly cycle through detox facilities?

The following response was provided by the Department of Human Services:

Of the 23,439 people who were admitted to CDHS licensed detoxification services in FY 2015-16, 45.2% experience only one admission, 21.6% were admitted twice and 32.6% were admitted three or more times. Currently, the Department supports targeted intensive case management teams co-located in the selected detoxification sites serve the largest number of individuals with repeat admissions. The case management teams work with clients to engage them into treatment and support services in order to interrupt the cycle of relapse and reduce the harm associated with excessive alcohol and drug use. Many of the individuals who cycle through detoxification services also struggle with homelessness. In the upcoming contract year, the Department intends to expand requirements and funding for intensive case management teams located at all of the detoxification programs it funds. These expanded services will include access to housing support and an evidence-based supported employment model called Individual Placement and Support.

The following response was provided by the Department of Health Care Policy and Financing:

Linkage and timely access to appropriate care following detoxification is necessary for successful recovery from a substance use disorder. The current BHO contracts require care coordination for individuals with a substance use disorder diagnosis who are in need of outpatient SUD treatment. HCPF is in the process of reviewing BHO network adequacy for outpatient SUD services to ensure

each region has an adequate network of qualified Medicaid providers. Increasing access to outpatient SUD services will help to mitigate the repeated cycling of individuals through detoxification facilities.

- 24 *Background Information: Senate Bill 16-202 requires each managed service organization (MSO) to assess the sufficiency of substance use disorder services in its geographic region, prepare a community action plan to address the most critical service gaps, and submit the plan to both departments by March 1, 2017. The Department of Human Services is responsible for posting these plans to its website and submitting a report summarizing the plans to various legislative committees (including the JBC) by May 1, 2017. Would it be possible for the Department to provide any available information about the community action plans that it receives in early March to allow the General Assembly to use this information when making funding decisions for FY 2017-18?*

The following response was provided by the Department of Human Services:

Yes, the Department expects that it will be able to make available the community action plan produced by the Managed Services Organizations by March 31, 2017, in advance of the statutorily required date of May 1, 2017.

3:10-3:25 **BREAK**

QUESTIONS FOR THE DEPARTMENT OF HUMAN SERVICES (DHS)

3:25-3:40 INTRODUCTIONS AND OPENING COMMENTS

3:40-4:05 ROLE OF THE MENTAL HEALTH INSTITUTES

- 25 Describe the Department's recent and ongoing facility and operational planning processes concerning the mental health institutes and the State's role in providing direct care for individuals with serious mental illness.

The Department's recent and ongoing facility and operational planning process concerning the Mental Health Institutes and the State's role in providing direct care for individuals with serious mental illness is a complex process requiring thoughtful and careful evaluation. The goal of any change, however, will be to ensure a true safety net for the most vulnerable individuals. In order to facilitate this planning process, the Department is reviewing the results of:

- The April 2015 *Needs Analysis: Current Status, Strategic Positioning and Future Planning*, prepared by the Western Interstate Commission for Higher Education (WICHE);
- The Department's Operational Program Plan (OPP) that was finalized in August 2016;
- The September 2016 *Circle Program: Effectiveness and Operational Scenarios* study conducted by WICHE regarding the effectiveness of the Circle Program;
- The November 2016 *Behavioral Health Funding Study*, conducted by WICHE; and
- The information from the Facility Program Plan (FPP) and Site Master Plan (SMP), which is anticipated to be completed in early 2017.

Once the Department has analyzed the results of all of these studies and plans, it will be better informed to make a decision as to the direction of the Mental Health Institutes and the State's role in providing direct care for individuals with serious mental illness.

Please include a discussion of:

- a. the Department's Facility Program Plan and Site Master Plan project that was funded in FY 2014-15 and the Department has indicated will be completed in early 2017;

In FY 2014-15, the Department received funding to complete the Facility Program Plan and Site Master Plan (FPP/SMP) for both the Mental Health Institute at Fort Logan (CMHIFL) and Pueblo (CMHIP) in order to address future facility needs related to continued care for individuals with mental health illnesses. The FPP and SMP for the Institutes are anticipated to be completed by early 2017. The FPP and SMP are inclusive of the L2 Unit in that they assume the expansion project can occur as

needed without affecting the long term planning process at CMHIP. The expansion of the L2 unit is a solution that will most swiftly meet the existing and growing need for mental health hospital beds, especially since any new construction based on the FPP/SMP would be many years out.

The purpose of the SMP and FPP follows:

- SMP - A Site Master Plan determines the actual physical use and physical relationships between the main element(s) of a FPP to a specific site or campus.
- FPP - The purpose of a Facility Program Plan is to provide guidelines that detail the individual facility size, configuration, location, function, and other specifics related to a proposed facility.

- b. **the study conducted by the Western Interstate Commission on Higher Education (WICHE) concerning the state's current and future behavioral health needs (completed in April 2015);**

The FPP and SMP are based, in part, on the April 2015 *Needs Analysis: Current Status, Strategic Positioning and Future Planning*, prepared by the Western Interstate Commission for Higher Education (WICHE) and the Operational Program Plan (OPP) for the Institutes. The FPPs/SMPs will comprehensively assess facility and site needs and make future recommendations for both Mental Health Institutes.

- c. **the Department's Operational Program Plan that was finalized in August 2016; and**

The Operational Program Plan was intended to provide a programmatic and operational blueprint for the subsequent development of an architectural Facilities Program Plan (FPP) which will describe proposed facilities that, if approved, can meet the future operational needs of the Colorado Mental Health Institutes and the State mental health system.

- d. **the study that was funded in FY 2015-16 and conducted by WICHE concerning the effectiveness of the Circle Program and related operational scenarios (completed September 2016).**

The Department is reviewing the Summary of Major Findings and Recommendations within the *Circle Program: Effectiveness and Operational Scenarios*, and as a first step may publish a request for information (RFI) to determine the extent to which community providers are interested and capable of providing services at a reduced cost to the State through overall cost reductions and/or leveraging other sources of funding.

26 How does the Department's FY 2017-18 capital construction request fit into this planning process?

The "CC-05 Institute Hawkins Building L2 Unit" (CC-05) capital construction request is in alignment with the planning process for the Mental Health Institutes. The Department believes that the expansion of the L2 Unit at Hawkins is the most effective way to increase bed capacity while minimizing costs. Its construction will enable the Department to better meet the needs of civil patients as well as maintain the terms of the Settlement Agreement related to the timely admission of defendants ordered for inpatient competency evaluation or restoration. Construction of the High Security Forensic Institute in 2009 was done in a way to support the expansion of additional units. The Department is able to address this now, through the CC-05 capital construction request, and the L2 Unit will not have any implications on future MHI construction plans on other parts of the campus.

The need for the Hawkins Building L2 Unit expansion is reflected in the Operational Program Plan (OPP). The Department has submitted an FY 2017-18 capital construction budget request "CC-05 Institute Hawkins Building L2 Unit" which requests funds to add a single unit to expand the capacity of Hawkins by 24 beds. The Hawkins facility was designed for a potential expansion of three 24-bed units. The WICHE study and the OPP recommended expanding the capacity of the Hawkins facility by 24 beds to accommodate immediate need.

27 How does the Department's FY 2017-18 capital construction request relate to the "contingent" budget request the Department submitted last year for facility-related changes at both mental health institutes?

The budget request submitted last year as a contingency request and the capital construction request submitted this year are for two different client populations.

Last year, the Department submitted, as a contingency, a request titled "Program Relocation for Improved Safety and Beds." This request still represents an urgent need at CMHIP based on the identified risks within the Adolescent Behavioral Treatment Unit (ABTU) and increased acuity experienced on the unit over the past year. The request would have relocated the adolescent population into a more secure treatment setting. The request would have also provided an increase of additional 20 transitional beds, which would assist the Department greatly in preparing patients for a successful discharge into the community and in making available additional beds within the hospital's current units to treat civil or forensic patients.

Due to current budget constraints of General Fund, the Department did not re-submit the contingency request as part of its FY 2017-18 budget. However, the Department will continue to assess the needs identified in the contingency request and will address these needs as necessary.

The FY 2017-18 CC-05 Institute Hawkins Building L2 Unit capital construction request will address the need for additional beds in the high security units, for patients with higher acuity or security needs. The construction of L2 could afford the Department the opportunity to transfer the E2DW patients to L2 and place an alternate patient unit in the E2DW space.

28 What are the projected annual operating costs of the proposed 24-bed unit?

The FY 2017-18 CC-05 Institute Hawkins Building L2 Unit capital construction request has an estimated project start date of July 1, 2017 and completion date of June 30, 2020. The Department does not anticipate submitting an operation budget request until FY 2019-20 for funding in FY 2020-21. If construction is completed sooner than anticipated, the Department will submit a budget request through the annual budget cycle process.

29 Provide data concerning the Department's compliance to date with the Settlement Agreement concerning the length of time pretrial detainees wait to receive competency evaluations and competency restoration treatment.

The Settlement Agreement sets forth specific timeframes for admission to CMHIP for inpatient competency evaluations and restoration treatment, and the Department is currently in compliance with those timeframes. Additionally, the Settlement Agreement sets forth specific timeframes for the completion of outpatient competency evaluations; the Department is currently in compliance with those timeframes as well. Table 4 illustrates the number of pretrial detainees ordered for admission since FY 2012-13.

**Table 4: Number of Pre-trial Detainees Ordered for Admission,
Since July 1, 2012 Settlement Effective Date**

Fiscal Year	Number of Pre-trial Detainees Ordered for Admission for Competency Evaluations or Restorations	Number of Pre-Trial Detainees Ordered for Admission for Competency Evaluations or Restorations that Exceeded the 28-Day Timeframe	Percent of Orders that Exceeded the 28-Day Timeframe
2012-13	463	0	0%
2013-14	503	0	0%
2014-15	586	7	1%
2015-16	705	297*	42%
2016-17 (as of 12/14/16)	317	1	0%
Total	2,574	305	12%

Source: Anticipate database, lawsuit compliance tracking system.

*Note: A large number of admissions exceeded the 28-day timeframe during the period that CDHS invoked Departmental Special Circumstances due to staffing and safety concerns. Admissions were slowed to address these concerns, resulting in fewer pretrial detainees being admitted within 28 days.

Table 5 illustrates the number of outpatient evaluations for pre-trial detainees related to the Settlement Agreement since FY 2012-13.

**Table 5: Outpatient Competency Evaluations for Pre-Trial Detainees related to the
Settlement Agreement, Since July 1, 2012 Settlement Effective Date**

Fiscal Year	Total Number of Orders for Outpatient Competency Evaluations Subject to the Settlement Agreement	Number of Outpatient Evaluations That Exceeded the 30-day Timeframe	Percent of Outpatient Evaluations that Exceeded the 30-day Timeframe
2012-13	110	0	0%
2013-14	347	0	0%

Table 5: Outpatient Competency Evaluations for Pre-Trial Detainees related to the Settlement Agreement, Since July 1, 2012 Settlement Effective Date

Fiscal Year	Total Number of Orders for Outpatient Competency Evaluations Subject to the Settlement Agreement	Number of Outpatient Evaluations That Exceeded the 30-day Timeframe	Percent of Outpatient Evaluations that Exceeded the 30-day Timeframe
2014-15	426	2	0%
2015-16	572	0	0%
2016-17 (as of 12/14/16)	307	1	0%
Total	1,762	3	0%

Source: The Anticipate database, lawsuit compliance tracking system.

30 Provide any available data indicating the number of individuals who require inpatient competency evaluation and restoration services, and those who are better served in a jail or community setting.

Table 6 illustrated the number of court-ordered inpatient and outpatient referrals for competency evaluations and restorations since FY 2012-13.

Table 6: Court-Ordered Referrals for Competency Evaluations and Restorations, Inpatient and Outpatient (including the RISE Program), Since July 1, 2012 Settlement Effective Date

Fiscal Year	Orders for Outpatient Competency Evaluations	Orders for Inpatient Competency Evaluations	Orders for Competency Restoration Where the Inmate Was Directed to RISE or a Community Setting for Restoration	Orders for Inpatient Restoration Services at CMHIP
2012-13	713	355	45	271
2013-14	915	378	107	282
2014-15	1,118	415	193	375

Table 6: Court-Ordered Referrals for Competency Evaluations and Restorations, Inpatient and Outpatient (including the RISE Program), Since July 1, 2012 Settlement Effective Date

Fiscal Year	Orders for Outpatient Competency Evaluations	Orders for Inpatient Competency Evaluations	Orders for Competency Restoration Where the Inmate Was Directed to RISE or a Community Setting for Restoration	Orders for Inpatient Restoration Services at CMHIP
2015-16	1,373	326	221	450
2016-17 (as of 12/1/16)	648	127	114	208
Total	4,767	1,601	680	1,586

Source: Avatar, the Institutes' primary health information system.

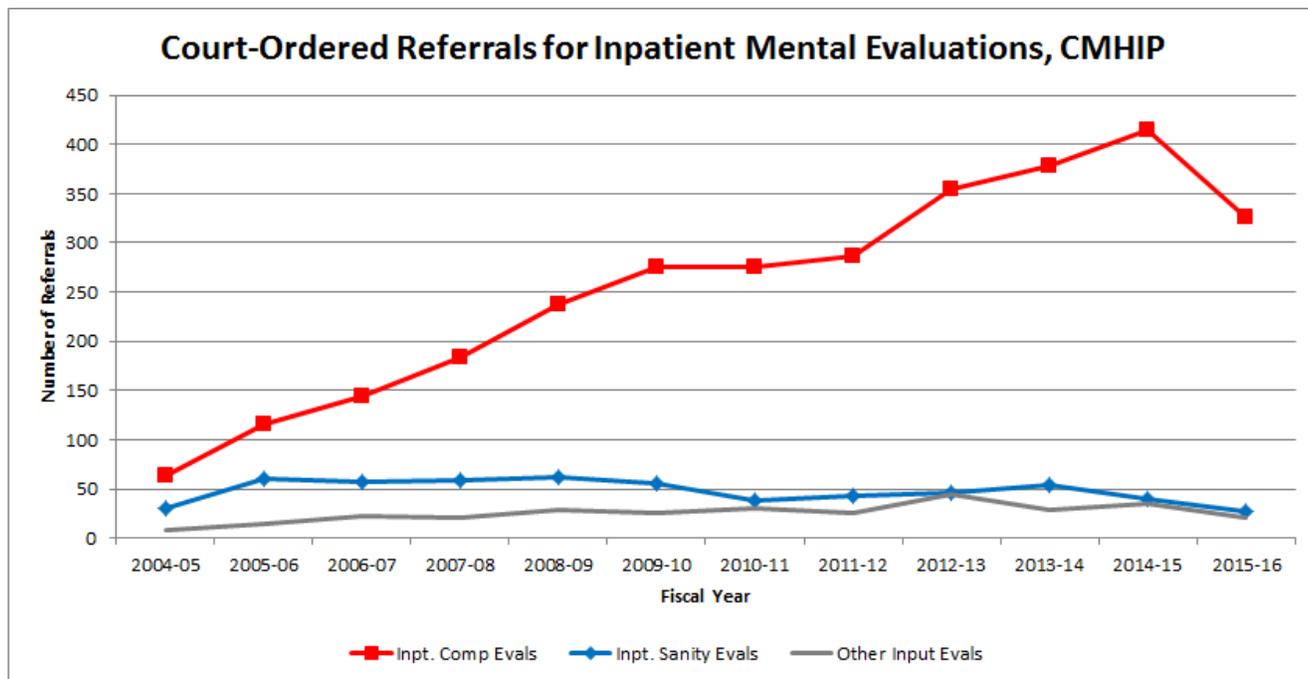
The level of care necessary to deliver effective competency evaluation and restoration services for an individual is largely determined by mental health acuity. If a defendant is assessed to be a significant risk of danger to self or others, or if the individual is medically compromised, the hospital would be the most appropriate environment in which the defendant can be evaluated and treated. Those that are capable of being housed in an open-setting (lower risk of aggression), with minimal medical needs, can often be treated in a jail-based program. Individuals who are deemed low risk of harm (not suicidal, homicidal and able to care for self) can typically be treated in a community setting.

Of note, the reduction in inpatient court orders for competency evaluations was largely due to the efforts made by CMHIP in cooperation with the courts.

- 31 Describe how the Department's projections concerning the need for inpatient competency evaluation and restoration services have been impacted by:
- a. the recently approved expansion of the jail-based competency evaluation and restoration program; and

The recently implemented expansion of the jail-based competency evaluation and restoration services has not impacted the Department's projections. However, it has increased the available beds into which those referred for competency evaluation and restoration can be served. The expanded beds enable the Department to admit defendants ordered for inpatient evaluation and restoration sooner,

providing an additional resource to ensure that the Department can meet its obligations. The reduction in the number of inpatient competency evaluations from in FY 2015-16 is the result of extensive collaboration between CMHIP and the courts to refer for inpatient competency evaluation only those defendants whose clinical condition requires inpatient care. The courts changed the orders of defendants initially ordered for inpatient competency evaluation who were appropriate for an outpatient competency evaluation, reducing the total number of inpatient evaluations. This decrease has allowed for increased capacity to serve those in need of inpatient competency evaluation and restoration treatment.



- b. **House Bill 16-1410, which included statutory changes to limit judicial discretion to order inpatient competency evaluations as well as resources to hire two secure transport staff to facilitate the transportation of defendants between jails, the mental health institutes, and the jail-based competency program.**

The changes to 16-8.5-105, C.R.S. (2016) that resulted from HB 16-1410 have been in effect since July 1, 2016. The Department continues to receive competency evaluation orders from courts based on the old criteria for an inpatient competency evaluation. The Department has taken steps to educate judges about the change in statute, such as sending memos to judges when the Department receives an improper order and presenting at the State Judicial Conference in September 2016. It is too early to see to what extent this change has impacted the number of inpatient competency evaluation orders the

Department receives. The Department needs to assess the impacts of implementation of the legislation over several months before it can determine how the statutory change will impact the Department's projections in the long term. The impact of the provided funding for the Department to hire two secure transport has been more immediate, as admissions and transfers of competency evaluation or restoration defendants is no longer delayed by the lack of an available transporter. This has significantly improved the Department's ability to make optimal use of its available beds.

- 32 **Explain why the Department did not spend \$1,489,032 (62.9 percent) of the General Fund that was requested in September 2015 for the jail-based competency evaluation and restoration program as intended. How were these funds used, and why?**

The Department requested funding through a September 2015 Emergency Supplemental to expand the RISE program, with an implementation date of December 2015. However, the RISE expansion was not fully operational until August 2016 due to construction delays at the Arapahoe County Detention Center. As a result, the Department redirected the funding to a temporary solution to ensure compliance with the Settlement Agreement.

The Department requested \$2,393,180 to create additional bed capacity of 30 beds by expanding the jail-based restoration and evaluation program, also known as the RISE program, based on a start date of December 2015. During the startup process, the vendor experienced significant unforeseen challenges related to the renovations and infrastructure at the Arapahoe County Detention Center (such as the floors not able to bear the weight of a necessary wall). These delays resulted in 16 of the 30 beds opening on February 1, 2016 and the remaining 14 beds opening August 2, 2016. The funding approved in the emergency budget request was based on 7 months (December 2015 through June 2016) of 30 online beds at a rate of \$307.50 per bed per day. As a result of these delays, the Department was unable to spend the full appropriation during FY 2015-16.

Because the entire Jail-based Restoration appropriation could not be spent due to unforeseen delays in start-up, the Department utilized its Mental Health Institute transfer authority to ensure continued Institute operations and adhere to the Settlement Agreement timeframes.

Specifically, the Colorado Mental Health Institute at Pueblo (CMHIP) increased the use of overtime, pool staff, and added 43 staff positions (33 temporary 9-month positions, 10 regular part-time positions) to ensure adequate staffing levels necessary to address the higher patient acuity and to increase the daily census closer to licensed bed capacity levels.

Additional costs in FY 2015-16 include the 43 positions at a cost of \$383,196, increased overtime, and an increased utilization of part-time FTE (not including the 10 new regular positions referenced above).

The Department monitors the appropriation lines daily in order to manage the budget. As a result of the additional Personal Services expenses related to ensuring compliance with the Settlement Agreement timeframes, CMHIP intended to utilize the transfer authority to mitigate the shortfalls, providing a temporary solution given the jail-based expansion was not fully operational.

4:05-4:20 DATA SYSTEM FOR TRACKING PSYCHIATRIC BED AVAILABILITY

- 33 **Clarify whether hospitals that are not designated or approved by the Department as 72-hour treatment and evaluation facilities pursuant to Section 27-65-105, C.R.S., have the statutory authority to hold an individual who has been placed on an involuntary mental health hold.**

If a hospital is not designated by the Department's Executive Director as a 72-hour evaluation and treatment facility, a hospital has no statutory authority to hold an individual under Section 27-65-105, C.R.S. (2016).

- 34 **Does the Department recommend moving forward with the development and implementation of a real time statewide data system for tracking the availability of psychiatric beds for individuals placed on an involuntary 72-hour mental health hold?**

The Department supports the recommendations of the Mental Health Hold Task Force, which has not recommended the adoption of a bed tracking system. The Task Force recommends that the Crisis Services Contractors take a more active role in partnering with small emergency departments to facilitate transfers to designated facilities.

If so:

- a. **Clarify what role, if any, the Department envisions the behavioral health crisis response system hotline and mobile response units performing to facilitate admission of individuals on a mental health hold in appropriate psychiatric facilities.**

Neither the Department nor the Mental Health Hold Task Force have current proposals to use the hotline to facilitate admissions to psychiatric facilities.

- b. **Could this system be designed in a way or connected to the crisis response hotline in a way that would allow any person, provider, or facility to call for local**

recommendations on the appropriate type of mental health provider (i.e., providing a resource that is more fluid than just a bed registry)?

The Department supports the recommendations of the Mental Health Hold Task Force that proposes to facilitate stronger regional partnerships to assist in identification of psychiatric facilities. The statewide hotline currently maintains a database with referral resources across the State and shares these resources with callers.

The Department has reviewed the options illustrated in Table 7 for tracking the availability of beds for individuals placed on an involuntary hold.

Table 7: Bed Tracking Options Considered by the Department				
Line Description	Bed Tracking Options Summary Description	Estimated Costs	Pros	Cons
Option #1- 24/7 Designated Hotline Facilitation (only)	The option employs a hotline/warmline post that will be available 24 hours per day, 7 days per week, year round. Duties include: tracking bed availability in 27-65 facilities, providing information to first responders, police, general public via telephone	\$165,000	-Good customer service -Can be incorporated into existing crisis line	-Separate system from 911 dispatch and crisis line
Option #2- Web-based Bed-Reporting System (only)	This option employs the build of a web-based 27-65 designated bed-tracking system. This system would require that 27-65 facilities update the web-based bed tracking system multiple times per day in order for it to be accurate.	\$600,000 Fiscal Year 1 \$25,000 Fiscal Year 2 and beyond	-Real time knowledge of system capacity -Supports hospitals in disposition planning	-Existing hospital divert database managed by CDPHE -Staff will still need to call facilities to determine clinical appropriateness -Cost
Option #3 Web-based	This is a hybrid option combining 24/7 year round	\$765,000 Fiscal Year 1	-Good customer service	-Potential redundancy with

Table 7: Bed Tracking Options Considered by the Department

Line Description	Bed Tracking Options Summary Description	Estimated Costs	Pros	Cons
Bed-Reporting System and 24/7 Designated Hotline Facilitation	hotline staff post along with the Web-based bed reporting system.	\$190,000 Fiscal Year 2 and beyond.	-Can be incorporated into existing crisis line -Real time knowledge of system capacity -Supports hospitals in disposition planning	existing services. -Staff will still need to call facilities to determine clinical appropriateness -Cost
<p>Option #4: The Department considered large health IT infrastructure and would need to appropriately vet new projects through the E-Health Commission to ensure consideration within the statewide infrastructure.</p>				

As noted in the Department’s response to the Long Bill FY 2016-17 Request for Information #1, submitted to the Joint Budget Committee on November 1, 2016, although an electronic bed tracking system could assist in ensuring access to appropriate mental health care, there are a number of steps to be taken to ensure the system will be effective.

1. Identify the basic information that will be available to describe the facility. To ensure that the information is useful, at a minimum, the database should include:
 - a. Name, address and license type of each designated facility;
 - b. Admission and exclusion criteria for each designated facility to include gender, age, medical complications, diagnoses or behaviors excluded such as intellectual or developmental disabilities, substance use disorders, traumatic brain injury, or histories of violence;
 - c. Payer sources accepted by each designated facility; and
 - d. Designated facility contact information to be used to arrange admissions.

2. Identify the type of data to be entered on bed availability and the frequency of reporting. This would include the number and types of beds available and restrictions such as age or gender. To be maximally useful, the information would need to be entered at least every shift and ideally in real-time as admissions and discharges occur.

3. Identify how the reporting requirements would be enforced. Requirements could be included in licensing or designation rule and enforced by OBH or the Colorado Department of Public Health and Environment within the current statutory authority.
4. Determine whether the bed search and coordination of transfer will be centralized at the state level, regional or completely dispersed.

The success of this system will be dependent on a statewide stakeholder agreement of procedures and processes for searching, locating and arranging for admission to a facility once a bed has been located.

- c. **Clarify whether the proposed system could be used to track the availability of beds for individuals placed on an involuntary hold related to alcohol [Section 27-81-111 and 112, C.R.S (2016)] or drugs [Section 27-82-107 and 108, C.R.S. (2016)].**

Based on the recommendations of the Mental Health Hold Task Force, the Department does not currently propose to add a bed tracking system.

- d. **Identify next steps, including any necessary legislative actions.**

The Department anticipates that statutory changes would be needed to create an effective system of bed tracking. The Department or the Colorado Department of Public Health and Environment would require the authority and budget to enforce real time reporting of bed availability and development and oversight of the bed tracking data system. Ideally, this authority would enable the Department to require facilities to accept individuals who are waiting for a bed regardless of their clinical characteristics or payer source.

4:20-4:30 OTHER BUDGET PRIORITIES

R8 Crisis Services System Enhancements

- 35 **The Department proposing reducing the appropriation for “Community Transition Services” by \$900,000 (from \$5,147,901 to \$4,247,901), a line item that provides funding for intensive behavioral health services and supports for individuals with serious mental illness who transition from a mental health institute back to the community, or who require more intensive services in the community to help avoid institutional placement.**

- a. How much has the Department reverted from this line item in the last two fiscal years and why?

Table 8 illustrates the reversion amounts from the past two fiscal years for the 8(D) Integrated Behavioral Health Services; Community Transition Services line item.

Table 8: 8(D) Integrated Behavioral Health Services; Community Transition Services Revision History		
Line Description	FY 2014-15	FY 2015-16
Final Appropriation	\$7,722,398	\$5,147,901
Actual Expenditures	<u>\$4,801,597</u>	<u>\$3,890,935</u>
<i>Reversion</i>	<i>\$2,920,801</i>	<i>\$1,256,966</i>
Source: FY 2017-18 Governor's Budget Request, Department of Human Services (Schedule 3) page 241.		

The primary reason for the reversion was that a large portion of the original appropriation was based upon two 16-bed enhanced Assisted Living Residences (ALR) at the approximate total cost of \$4,000,000. However, prior to establishing the two 16-bed ALRs, the Department consulted with the State of Delaware regarding the use of ALR type facilities in their State. During the consultation, the State of Delaware informed the Department that they were eliminating their use of their congregated ALR facilities due in part, to their Olmstead [(Olmstead v. L.C. 527 U.S. 581 (1999))] settlement with the U.S. Department of Justice, Office of Civil Rights. The Supreme Court's ruling on the Olmstead case requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. As a result of this information, the Department decided that implementation of a person-centered planning process with flexible resources and scattered housing for clients was a more appropriate strategy. The Department subsequently altered its spending and implementation plan to a person-centered approach in which services are individualized with the goal of providing housing or residential care in the client's home community coupled with individualized wraparound services. Therefore the original assumptions underlying the appropriation were changed.

Additionally there were start-up and market factors that contributed to the reversions in this line including:

- A delay in start-up of the person-centered approach in FY 2014-15 because of the need to procure and contract for services. The contractor was awarded \$2,797,995 with half of the fiscal year remaining to ramp up this program and therefore vacancy savings resulted from the

timing associated with recruiting and hiring new staff, training and accepting and processing referrals.

- Barriers to hiring staff in FY 2015-16 due to the behavioral health workforce shortages that had disproportionate impact on the western slope. As a result, vacancy savings were realized for much of the year.
- Limited availability of community-based housing and residential settings has slowed the intake of clients into the program. Clients cannot be moved from the hospital until a safe housing situation is located in the community.
- Success on the part of the contractor in locating placements in less restrictive residential settings that are covered by other funding streams such as nursing homes, traumatic brain injury placements, and other Medicaid residential waiver options has reduced the costs per client when placements can be located.

b. Why is the Department proposing a reduction in this line item going forward? Aren't these services needed?

The Department is proposing a reduction in the 8(D) Integrated Behavioral Health Services; Community Transition Services line for the following reasons:

- The Department's original FY 2013-14 decision item projection of 429 clients was based on the information available at the time. The actual number of clients served in FY 2014-15 was 114 and in FY 2015-16 was 162. In the first quarter of FY 2016-17, 38 clients were served. If this pattern remains the same for the remainder of FY 2016-17, 278 clients will be served, which is well below the original estimate.
- The Department and its contractor face limited control of their ability to locate and admit clients to housing and residential placements and this limits the intake of individuals into the program. As a result of the lack of viable residential placements for transitioning inpatient clients, the client turnover rate is slower than originally estimated. The lack of affordable housing is expected to continue to present challenges into the future.
- The Department expects that many of the person-centered wrap-around services will continue to be covered by Medicaid.

The wrap-around services and intensive case management services are needed. However, the original assumptions present at the time of the appropriation have changed. The Department, through the last three years, has gained additional information that suggests that the entire appropriation will not be expended into the future. The Department would like the General Assembly to consider re-purposing \$900,000 for other competing needs with the Department's Crisis Services program.

36 **Why is the Department requesting a \$900,000 General Fund increase in the appropriation for the hotline (\$600,000) and marketing (\$300,000) components of the behavioral health crisis response system? How do the proposed increases actually serve people?**

The Department is requesting to increase the appropriation to the Crisis Response system in order to increase access to the crisis hotline/warmline by expanding the marketing reach and ensuring timely call response. Figure A demonstrates the increase in utilization of the statewide crisis hotline/warmline since its inception in 2014. Despite the continuing escalation of call volume, the Department routinely hears reports that local communities are not aware of the statewide crisis hotline/warmline services. Increased access to these services has the potential to reduce reliance on law enforcement and emergency departments by providing support and referrals before the situation becomes an emergency.

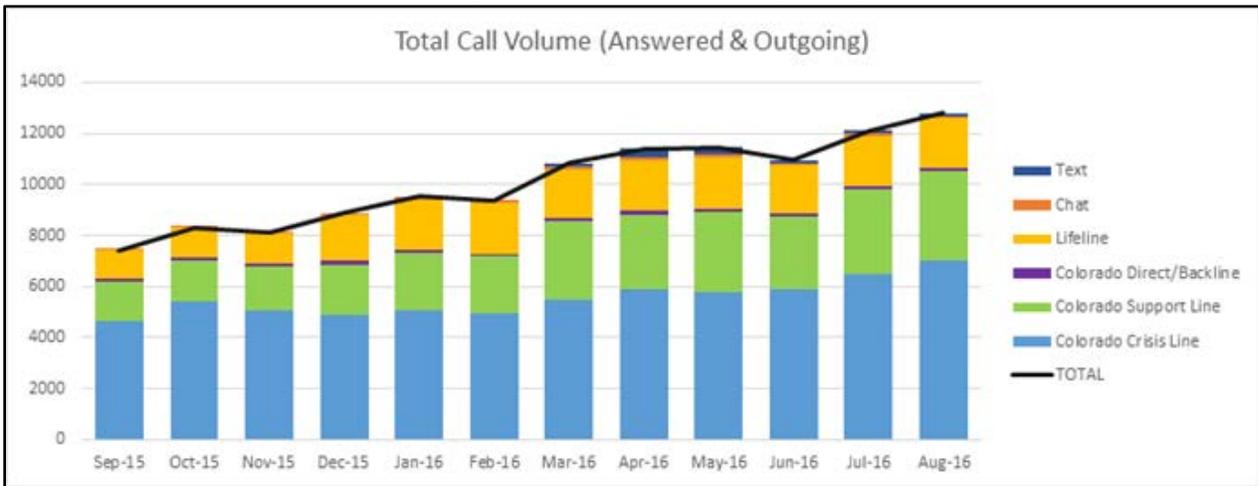
The Department is requesting \$300,000 for Crisis Response system marketing to increase outreach and marketing so that more Coloradans are aware of available crisis services throughout the State. The Colorado Health Foundation's "2016 Colorado Health Report Card Data Spotlight Mental Health" indicates that despite many improvements in the behavioral health care system there is still room to:

- Reduce Colorado's national suicide ranking from 5th in the nation;
- Target marketing to the highest risk populations identified by the Suicide Prevention Commission including older adults, active duty military personnel and veterans, working age men, LGBTQ youth, and Hispanic/Latina youth; and
- Reduce the stigma related to seeking help for mental health concerns.

In addition to the request for \$300,000 for additional marketing and outreach of the Crisis Response system, the Department is requesting to increase the appropriation for the statewide crisis hotline/warmline by \$600,000 to ensure that there is adequate staffing and operating costs to meet call volume demands and to maintain acceptable call wait times. The request of \$600,000 will add 13.0 full time equivalents (FTEs) to the contracted hotline/warmline. All of the proposed FTE will be direct hotline/warmline staff and will serve people who call into the hotline/warmline on a consistent basis.

The crisis hotline/warmline staffing is currently insufficient to meet the increase in projected utilization. Figure A illustrates how call volume has consistently increased since its inception. Specifically, call volume between March 2016 and August 2016 has increased by 18% (1,963 calls). Additionally, call duration trends are also creating the need for increased staffing as well as support costs for increased phone, data utility costs and accompanying information technology service costs.

**Figure A: Colorado Crisis Services System Monthly Call Volume
For the Period September 1, 2015 through August 31, 2016**



Source: Metro Crisis Services dba: Rocky Mountain Crisis Services Partners database for the period September 1, 2015 through August 31, 2016.

Average call duration has increased nearly 5 minutes per call for the period June 2016 through August 2016. The average duration of the crisis hotline/warmline calls in Colorado are on average 13 minutes longer than 8 minute national call duration average cited by National Council on Behavioral Health. This increase in call duration is attributed to increasing severity of the concerns answered by the hotline including the need to stay on the line until law enforcement or mobile crisis teams can respond.

Other indicators that demonstrate the need for more crisis hotline/warmline staff include:

- Increases in call abandonment rates from 2.1% in June of 2015 to 5.2% in June of 2016;
- Escalation in average call wait times from 11.3 seconds in June of 2015 to 30.69 seconds in June of 2016; and
- Turnover rate of 47% among the contractor’s counseling and peer staff totaling from June 2015 to June 2016.

If the current staffing of the crisis hotline/warmline does not increase to meet projected demand, community needs will go unmet. The contractor anticipates that staff turnover may continue to increase as a result of the stress of less recovery time between calls and that call abandonment rates and caller wait times will continue to increase. This may result in the contractor failing to meet national standards established by the American Association of Suicidology that prescribes caller safety assessment protocols, warm hand-offs, and follow-up calls to provide additional support.

R14 Substance Use Disorder Treatment at the Mental Health Institutes

37 **How would the 8.0 FTE certified addiction counselors be allocated between the two mental health institutes?**

The 8.0 FTE certified addiction counselors will provide 3.0 FTE to the Colorado Mental Health Institute at Fort Logan, and 5.0 FTE to the Colorado Mental Health Institute at Pueblo.

Other

38 **Would any of the Department’s funding requests for FY 2017-18 address the behavioral health needs of military veterans?**

The FY 2017-18 “R-14 Substance Use Disorder Treatment at the MHIs” request would provide additional certified addiction counselors at both Fort Logan and Pueblo. In Table 9, 29 of the 51 identified veterans served in FY 2014-15 and 17 of the 27 veterans served in FY 2015-16 reported difficulties in functioning due to substance use.

The Department’s FY 2017-18 “R-08 Crisis Services Enhancements” request does not specifically target military veterans. However, it is anticipated that military veterans will be reached through additional Crisis Response system marketing efforts and may subsequently engage in the array of crisis services that are available. If funded, military veterans may be served in a more timely basis through additional crisis hotline/warmline staffing.

Table 9 illustrates the number and percentage of military veterans served through the Department’s Office of Behavioral Health in FY2014-15 and FY 2015-16.

Table 9: Percent of Clients who are Veterans for FY 2014-15 and FY 2015-16						
	FY 14-15			FY 15-16		
	Veteran	All	Percent	Veteran	All	Percent
Mental Health ¹	4,098	210,134	1.95%	4,700	224,770	2.09%
Substance Abuse ²	605	19,732	3.07%	574	19,819	2.90%
Crisis System ³	N/A	N/A	N/A	578	11,474	5.0%
Mental Health Institutes ⁴	51	1,526	3.34%	27	1,451	1.86%

Table 9: Percent of Clients who are Veterans for FY 2014-15 and FY 2015-16

Source: ¹ Colorado Client Assessment Record (CCAR).

² Drug and Alcohol Coordinated Data System (DACODS).

³ Crisis System Data Spreadsheets (spreadsheets) pulled December 14, 2016 (Collection of Veteran Status on Crisis System clients began July 1, 2016).

⁴ MHI data source for veteran status is the Colorado Client Assessment Record (CCAR) and the number for all patients is from Avatar for unique patients served.

Joint Budget Committee Hearing: Behavioral Health Services

January 3, 2017

Susan E. Birch, MBA, BSN, RN, Executive Director



COLORADO

Department of Health Care
Policy & Financing

Our Mission

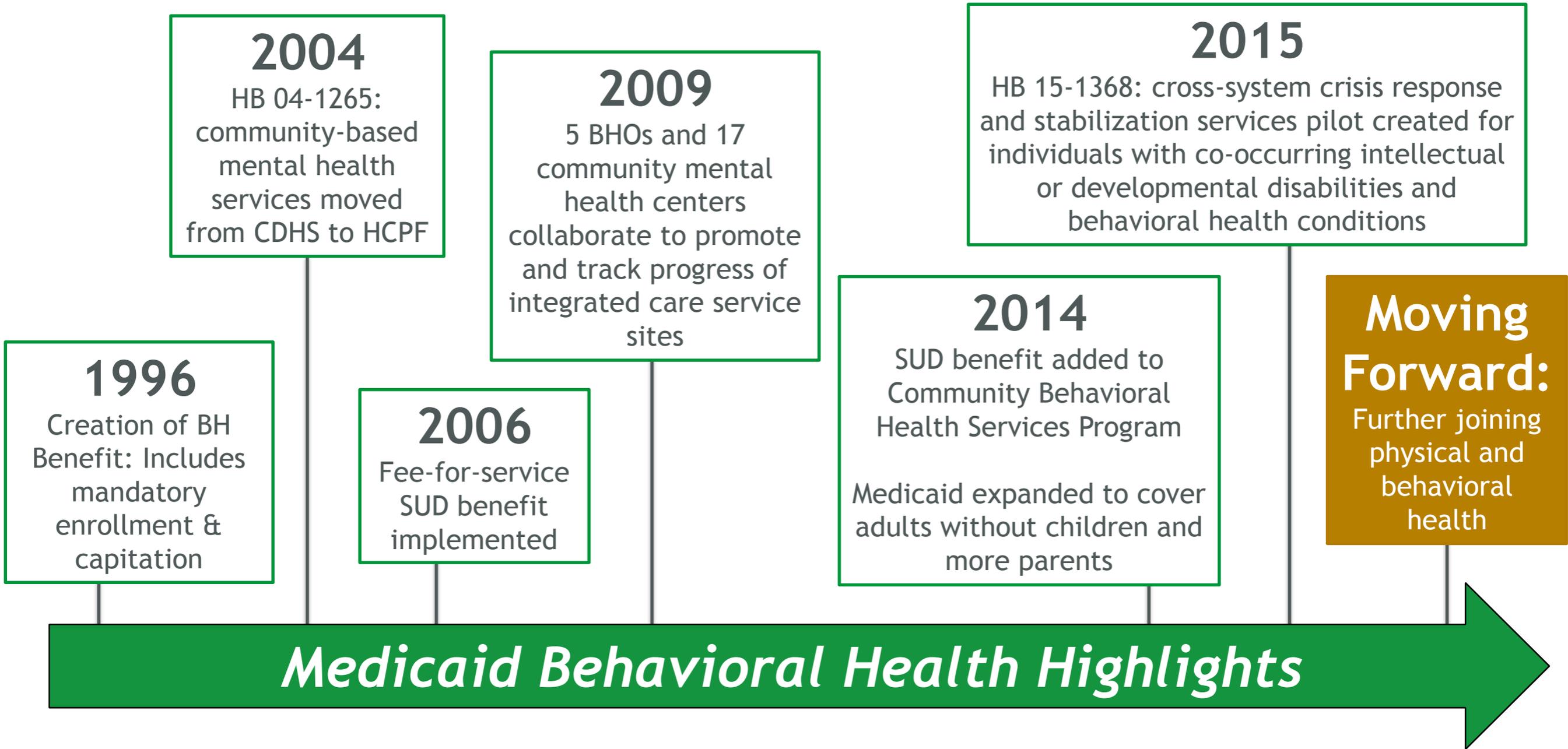
Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**



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Department of Health Care
Policy & Financing

History



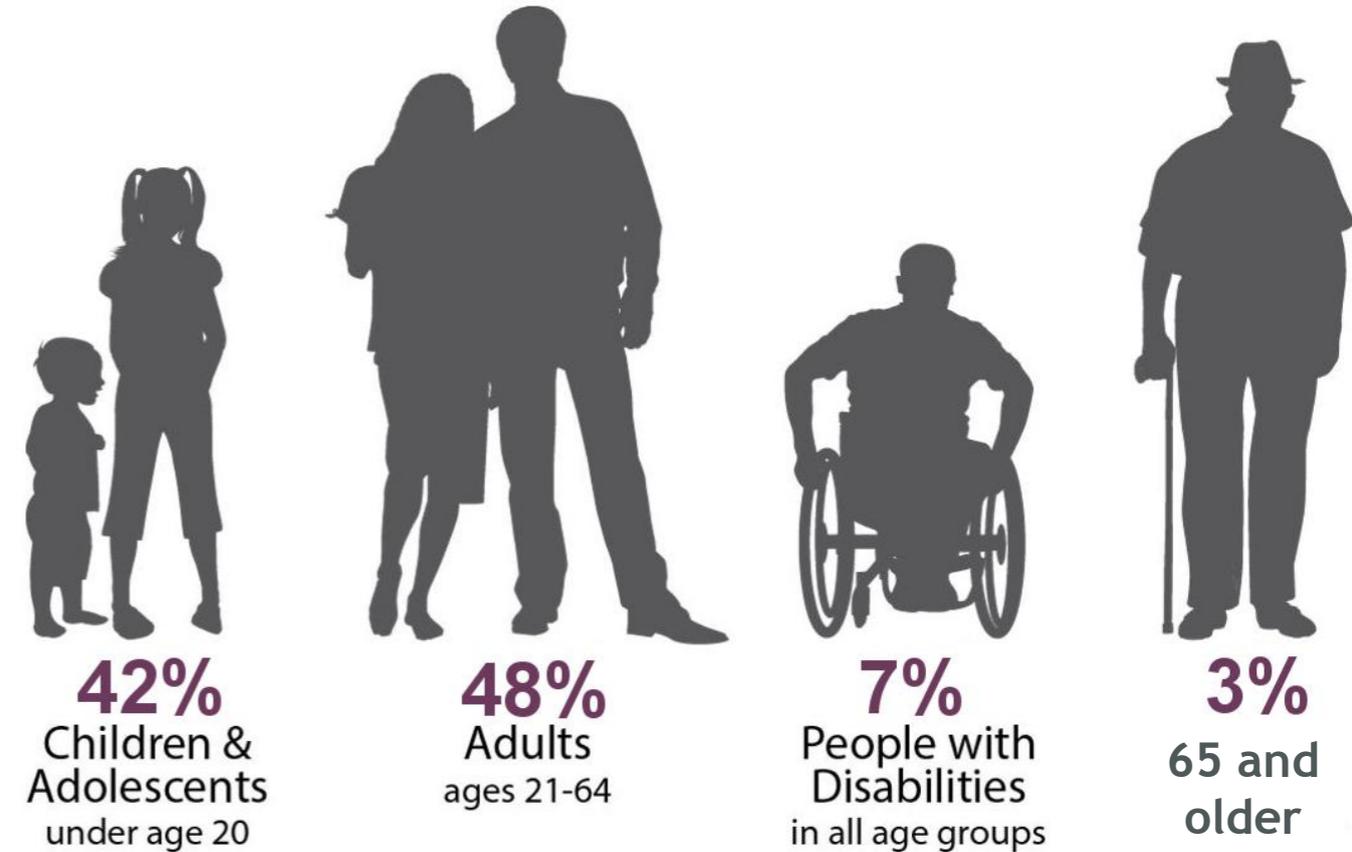
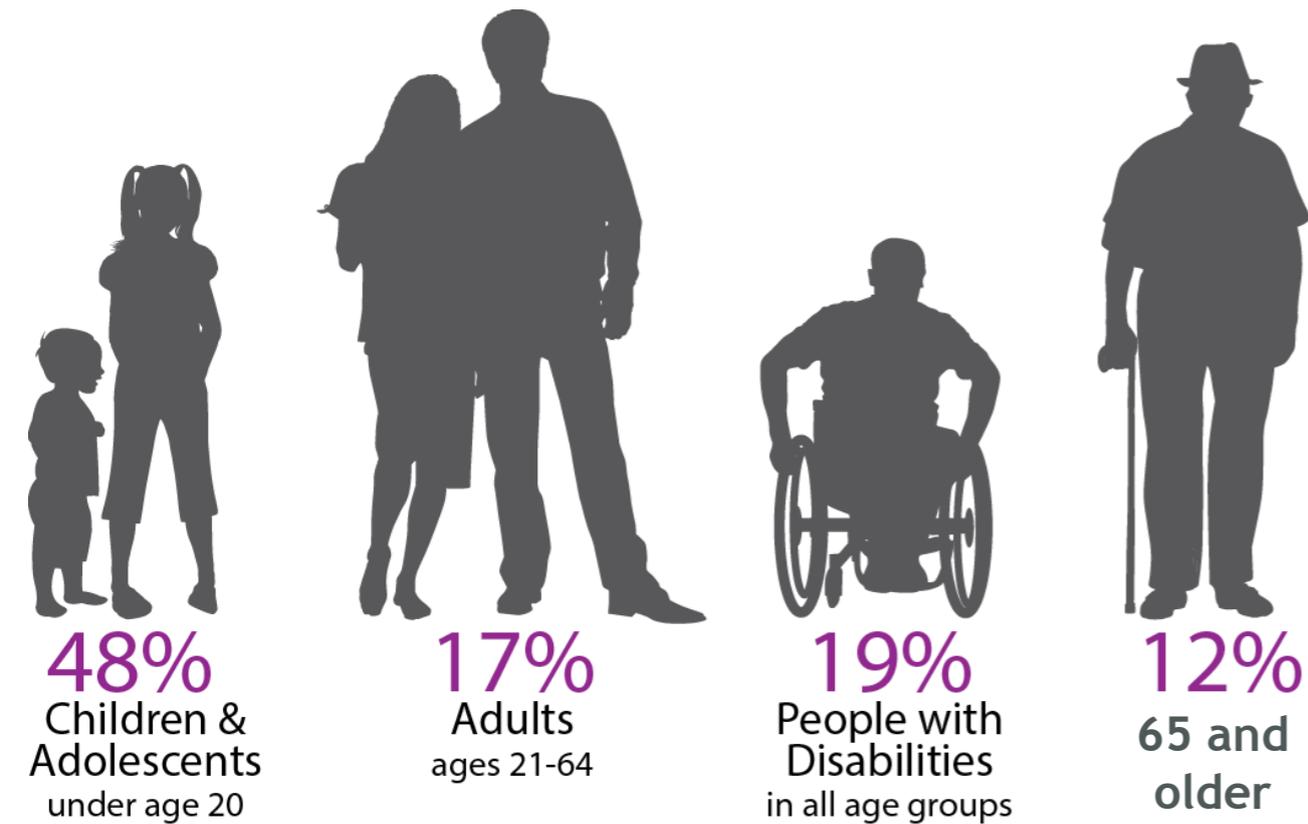
Medicaid's Evolving Population

FY 1995-96

Medicaid Case Load

FY 2015-16

Medicaid Case Load



Evolving Behavioral Health Landscape

Now...

- Greater understanding of relationship of physical and behavioral health
- Colorado Medicaid serves a more diverse population with diverse physical and behavioral health needs
- Role of Medicaid in response to community health issues



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Department of Health Care
Policy & Financing

Emerging Issue: Opioids

Evolving our programs and developing solutions

Products to treat addiction

Products to save people who overdose

Provider access to PainNET

Chronic Pain Disease Management Program

Opioid overutilization management

Statewide Consortium for Prescription Drug Abuse Prevention

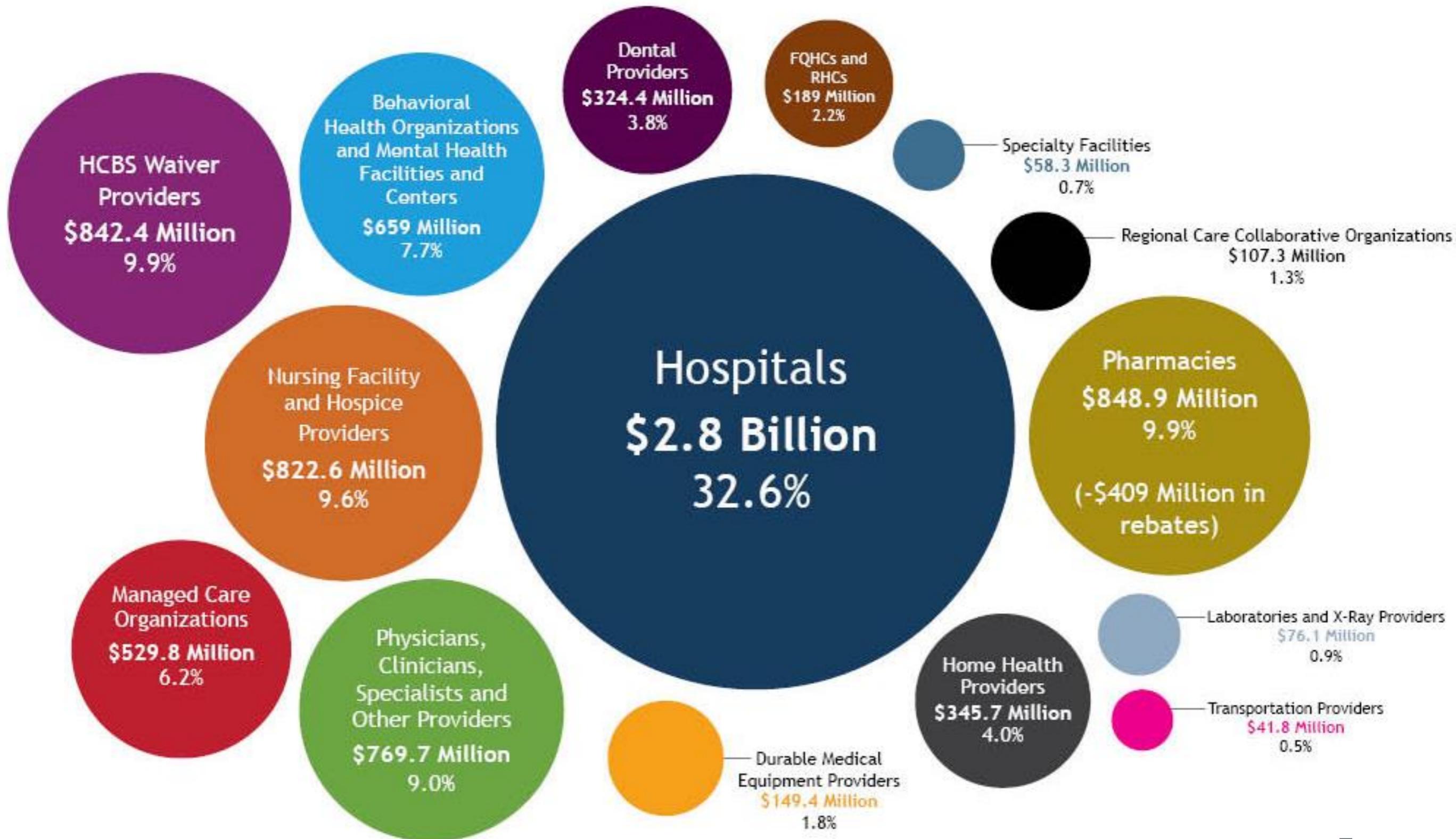
Exploring use of prescription drug monitoring program database



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Department of Health Care
Policy & Financing

Who Gets Payments for Services



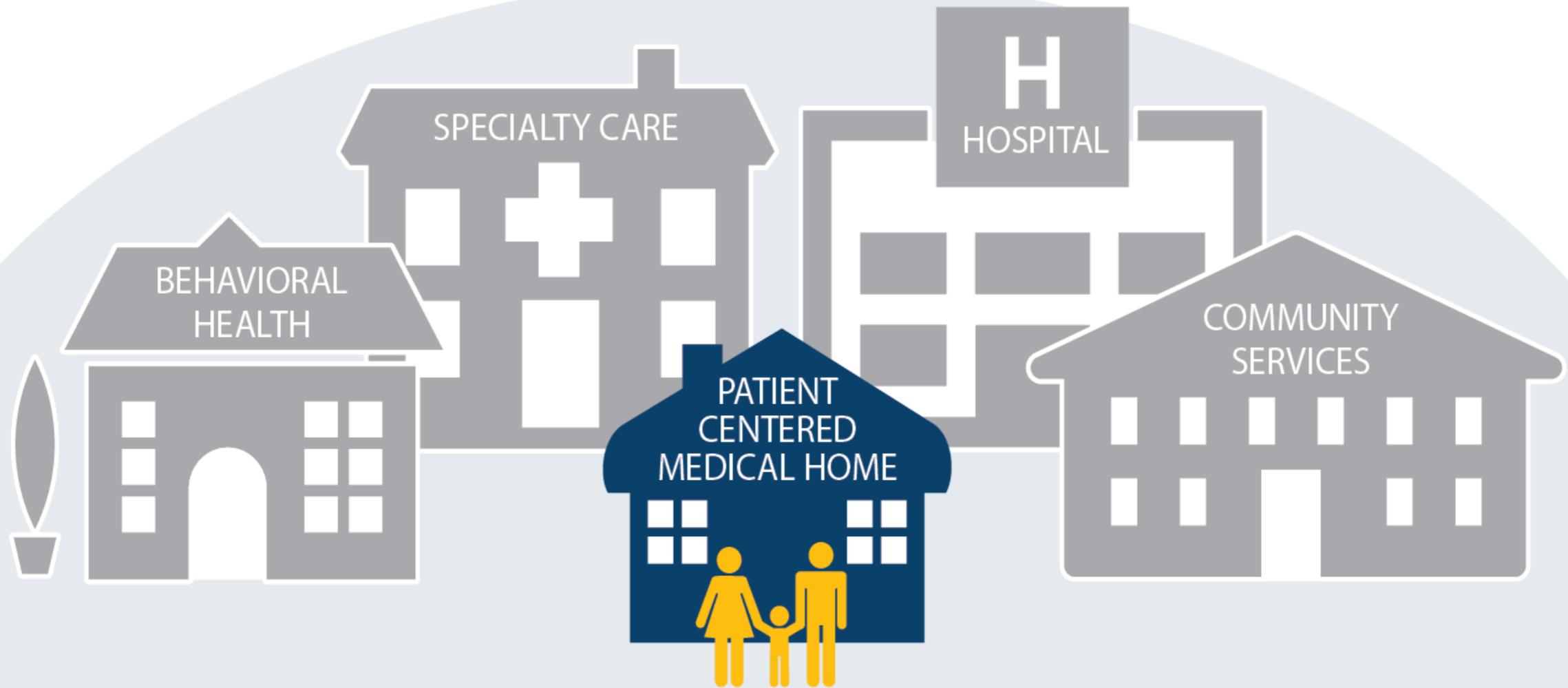
***R-6 Accountable Care
Collaborative - Delivery System
and Payment Reforms
Questions 1-12***



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Policy & Financing

Regional Accountable Entity



Data & Analytics

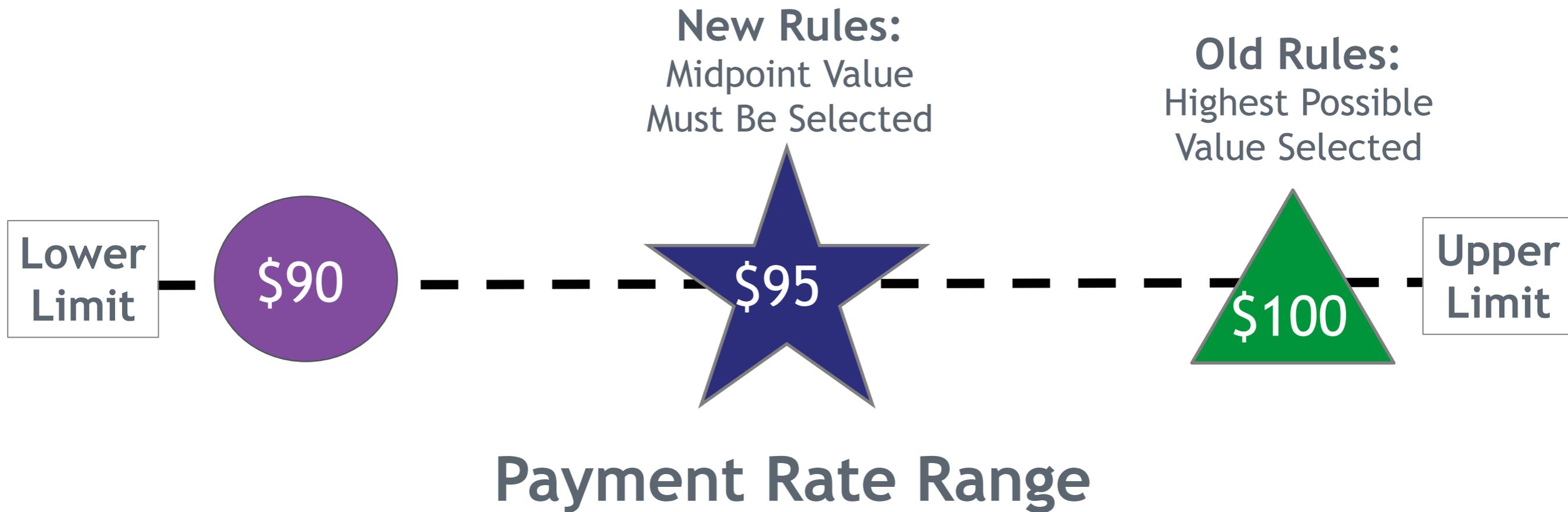


Core Behavioral Health Services

Alcohol/Drug Screen Counseling	Prevention/Early Intervention
Assertive Community Treatment	Psychosocial Rehabilitation
Behavioral Health Assessment	Psychotherapy (individual, group & family)
Clubhouses	Recovery
Drop-in Centers	Residential (Mental Health)
Emergency/Crisis	Respite Care
Home-Based Services for Children and Adolescents	School-Based Mental Health
Inpatient Psychiatric Hospital	Social Ambulatory Detoxification
Intensive Case Management	Specialized Services for Addressing Adoption Issues
Medication Assisted Treatment	Substance Use Disorder Assessment
Outpatient Hospital	Targeted Case Management
Pharmacological Management	Vocational
Physician	



Actuarially Certified Rates: New Federal Rules



Other Questions 13-14



COLORADO

Department of Health Care
Policy & Financing

Joint Questions with Human Services and Health Care Policy & Financing

WICHE Study

Questions 15-17

Joint Questions with Human Services and Health Care Policy & Financing

Statewide Behavioral Health Crisis Response System Questions 18-19

Joint Questions with Human Services and Health Care Policy & Financing

Substance Use Disorder Services

Questions 20-24

Thank You



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Department of Health Care
Policy & Financing



COLORADO
Department of Human Services



FY 2017-18 Joint Budget Committee Hearing

Department of Human Services:
Office of Behavioral Health
January 3, 2017

Mission, Vision, and Values

Mission

Collaborating with our partners, our mission is to design and deliver high quality human services and health care that improve the safety, independence, and well-being of the people of Colorado.

Vision

The people of Colorado are safe, healthy and are prepared to achieve their greatest aspirations.

Values

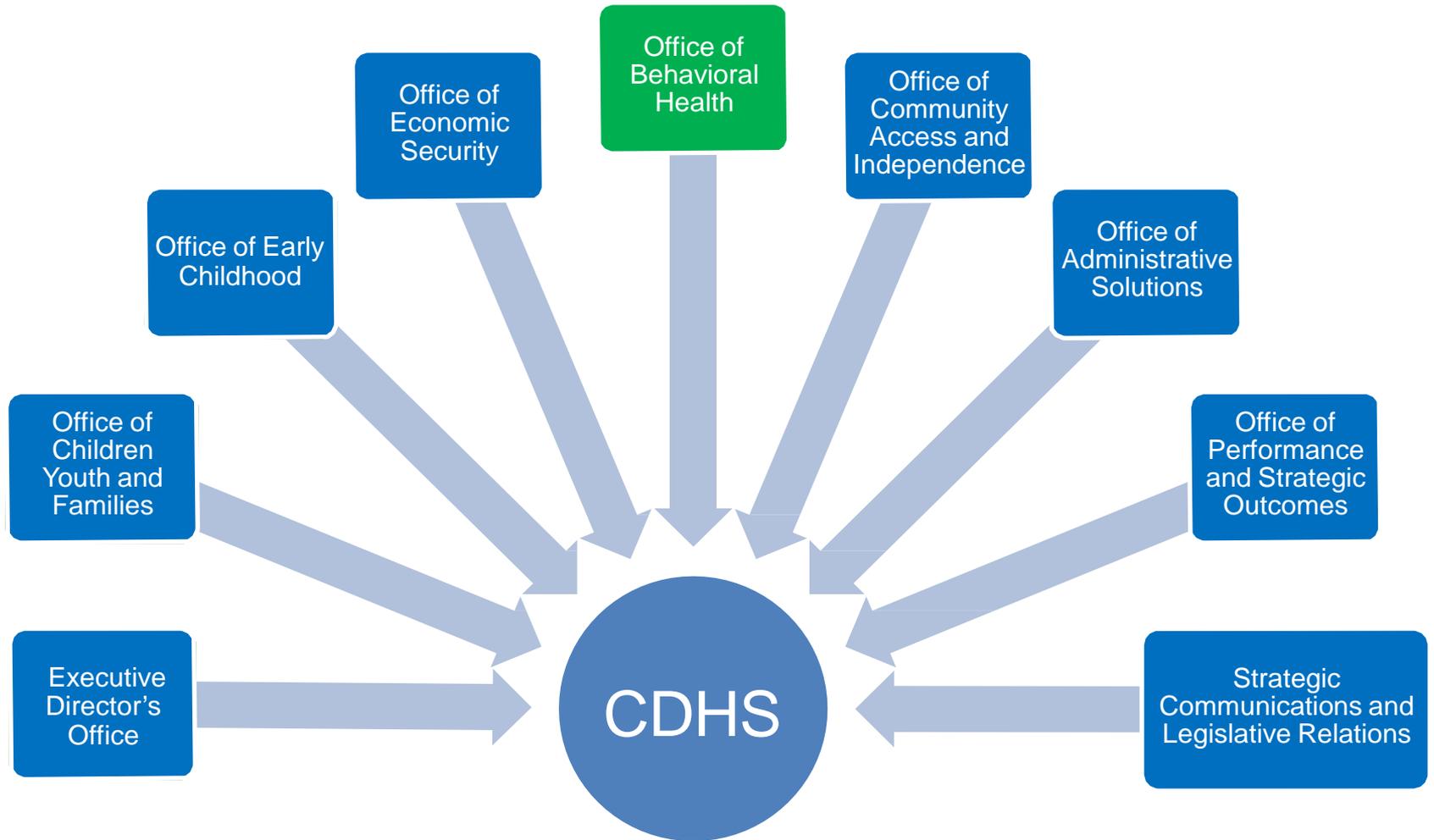
The Colorado Department of Human Services will:

- Make decisions with and act in the best interests of the people we serve because Colorado's success depends on their well-being.
- Share information, seek input, and explain our actions because we value accountability and transparency.
- Manage our resources efficiently because we value responsible stewardship.
- Promote a positive work environment, and support and develop employees, because their performance is essential to Colorado's success.
- Meaningfully engage our partners and the people we serve because we must work together to achieve the best outcomes.
- Commit to continuous learning because Coloradans deserve effective solutions today and forward-looking innovation for tomorrow.

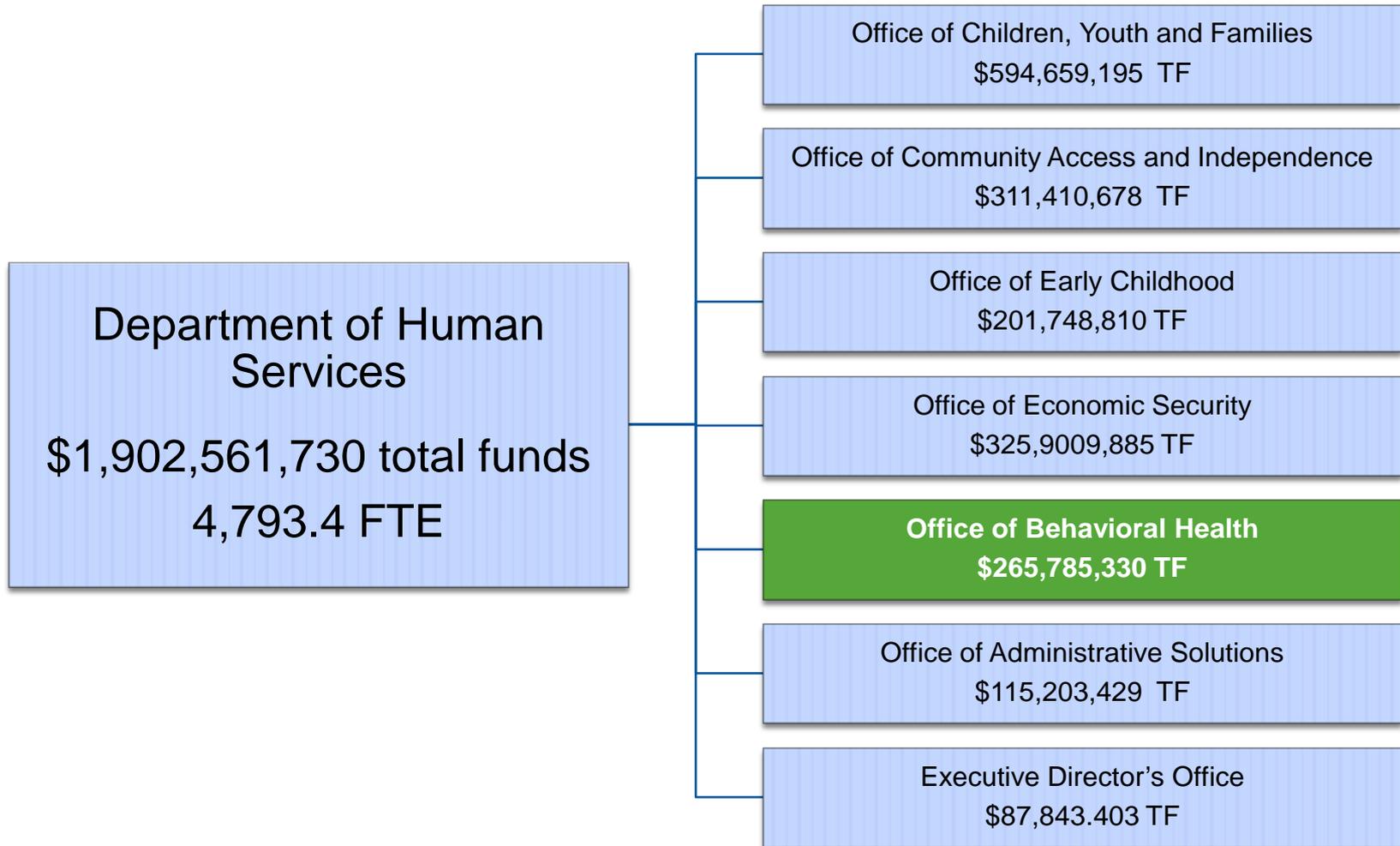


At the Colorado Department of Human Services,
we are *People Who Help People*:

- Thrive in the community of their choice
- Achieve economic security through meaningful work
- Prepare for educational success throughout their lives



FY 2016-17 Department Appropriation

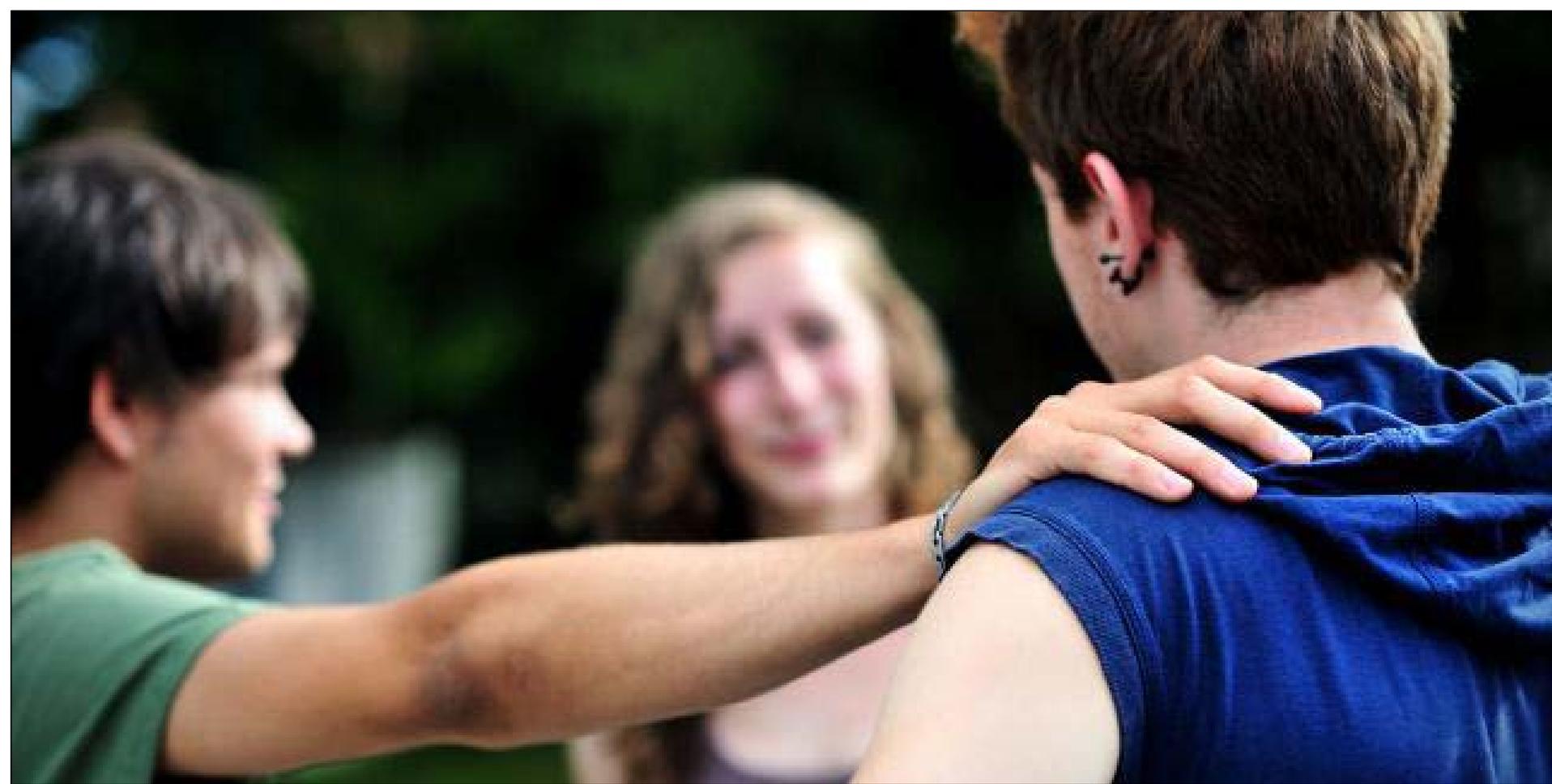


Colorado Department of Human Services FY 2017-18 Budget Requests

Office of Behavioral Health

- Crisis Services System Enhancements: \$0 technical adjustment
- MHI Security Enhancements: \$610,000
- Marijuana Tax Cash Fund Substance Use Disorder Treatment at the Mental Health Institutes: \$662,000 and 8.0 FTE
- Mental Health Institutes Capital Outlay: \$350,000
- Institute Hawkins Building L2 Unit: \$5.4 million
- CMHIP Capital Renewal: \$29.1 million
- CMHIFL Capital Renewal: \$8.5 million





Office of Behavioral Health



COLORADO
Department of Human Services



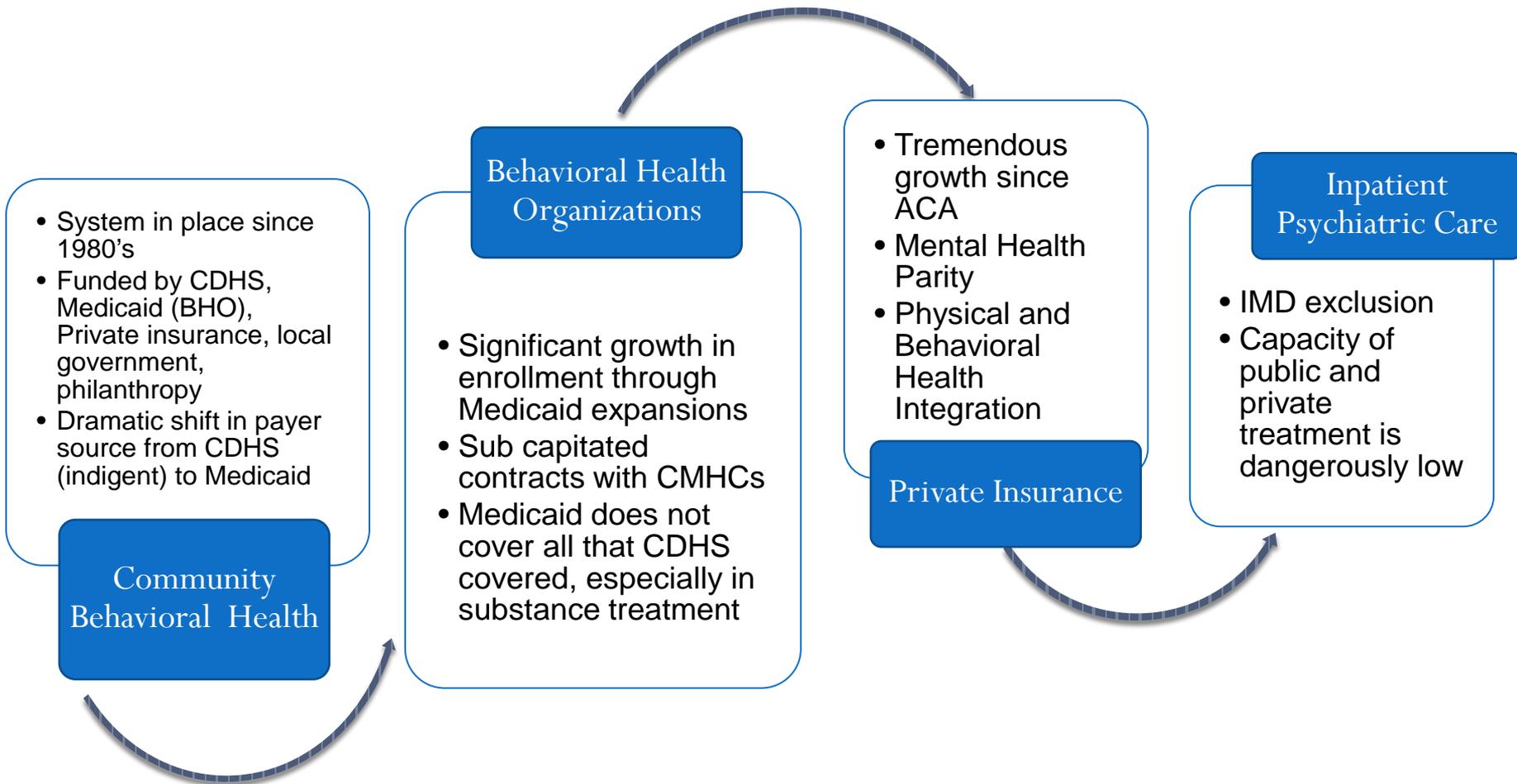
COLORADO
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Office of Behavioral Health

Role of the Mental Health Institutes

Shifting Landscape of Behavioral Health



Mental Health Institutes



	Fort Logan	Pueblo	Total
Beds	94	449	543
FTE	218.6	1,013.0	1,231.6
Populations	Adult	Adult and adolescents	

*According to a Pew Report, the Institutes should have 620 beds.



MHI Facility and Operational Planning

Apr
2015

- *Needs Analysis: Current Status, Strategic Positioning and Future Planning*, prepared by the Western Interstate Commission for Higher Education (WICHE)

Aug
2016

- Department's Operational Program Plan (OPP) that was finalized

Sep
2016

- *Circle Program: Effectiveness and Operational Scenarios* study conducted by WICHE

Dec
2016

- *Behavioral Health Funding Study*, (OSPB study) conducted by WICHE

Spring
2017

- Facility Program Plan (FPP) and Site Master Plan (SMP)



Institute Hawkins Building L2

- Increase capacity by 24 beds at the CMHIP Hawkins Building L2.
- Enhance our ability to provide timely evaluation of defendants and restoration to competency.
- Add the Hawkins addition to improve treatment outcomes and increase patient and staff safety for patients who would have previously been transferred to the Department of Corrections (DOC).
 - Statute no longer allows CDHS to transfer patients with dangerous behaviors to DOC.
 - When E2 was remodeled to house individuals formerly transferred to DOC, it was noted as a temporary solution.
- Occupy Hawkins Building L2 36 months after funding becomes available.

Task	Start Date	Completion Date
Design	7/2017	3/2018
Project Bid + award	4/2018	6/2018
Construction	6/2018	9/2019
Equipment + Furnishing Install	9/2019	2/2020
Completion and Occupancy	2/2020	6/2020



CLA v. Bicha Settlement Agreement

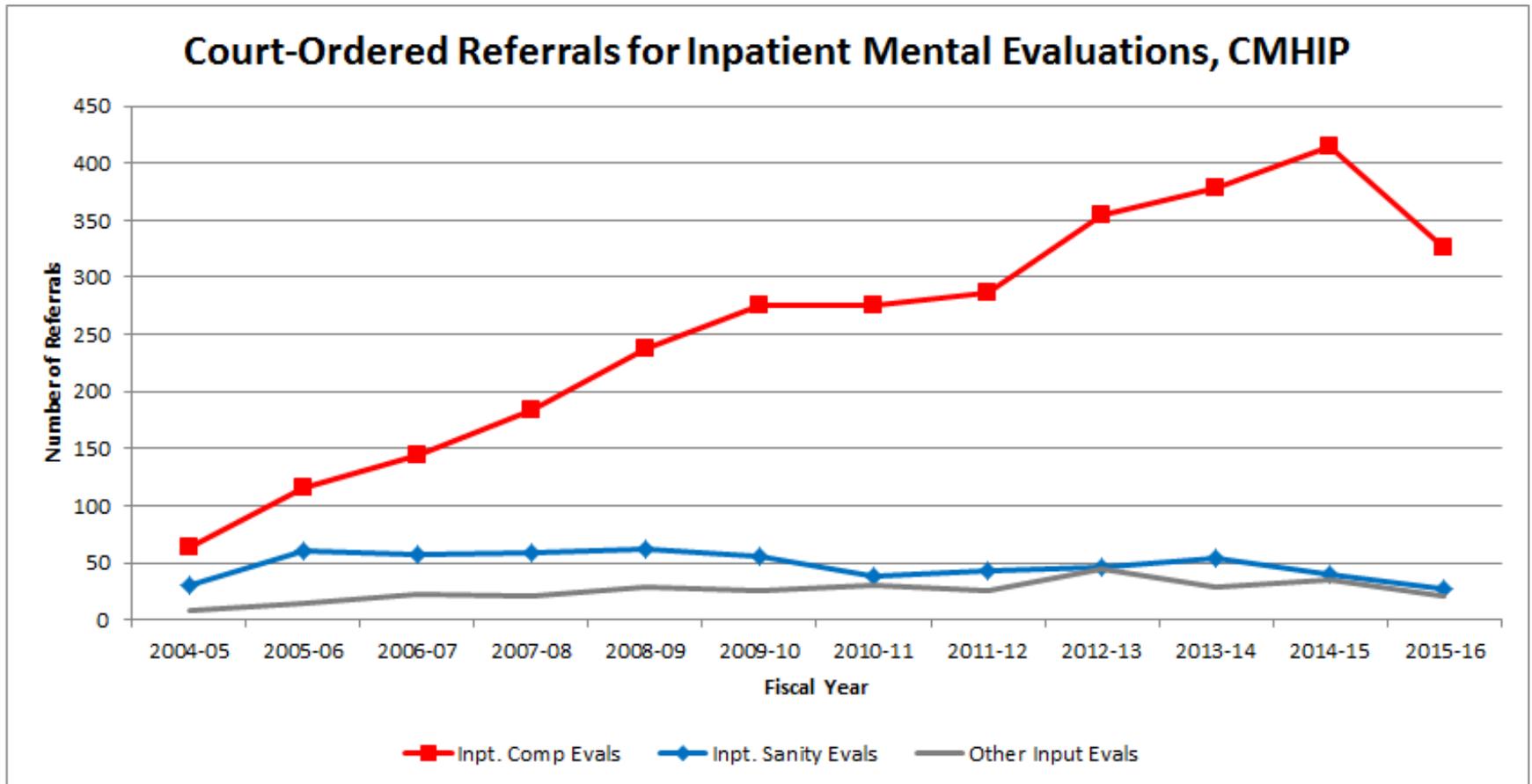
- Sets forth specific timeframes for admission to CMHIP for inpatient competency evaluations and restoration treatment

Number of Pre-trial Detainees Ordered for Admission since July 1, 2012 Settlement Effective Date

Fiscal Year	Number of Pre-trial Detainees Ordered for Admission	Number of Pre-Trial Detainees Ordered for Admission that Exceeded the 28-Day Timeframe	Percent of Orders that Exceeded the 28-Day Timeframe
2012-13	463	0	0%
2013-14	503	0	0%
2014-15	586	7	1%
2015-16	705	297	42%
2016-17 (as of 12/14/16)	317	1	0%
Total	2,574	305	12%



Court Ordered Referrals for Inpatient Mental Evaluations, CMHIP



R14 Substance Use Disorder Treatment at the Mental Health Institutes

Patients at MHI have dual diagnosis treatment needs – mental health and substance use disorder treatment

Current

- 3.0 Certified Addiction Counselors at the MHIs
 - None allocated to Fort Logan
 - 3.0 FTE allocated to Pueblo
- Services provided:
 - Fort Logan: None
 - Pueblo: Assessments, individual and group therapies to the NGRI population, Circle program

Proposal

- Add 8.0 Certified Addiction Counselors at the MHIs
 - 3.0 FTE allocated to Fort Logan
 - 5.0 FTE allocated to Pueblo
- Proposed Services: diagnosis, intervention, assessment, education, group education and therapy, motivational interviewing, psychoeducation, case management (community reintegration and relapse prevention efforts)





COLORADO
Department of Human Services



Office of Behavioral Health

Mental Health Hold Task Force

Mental Health Hold Task Force

Gov. Hickenlooper directed CDHS to create a task force to address the underlying problems with Colorado's involuntary civil commitment process.

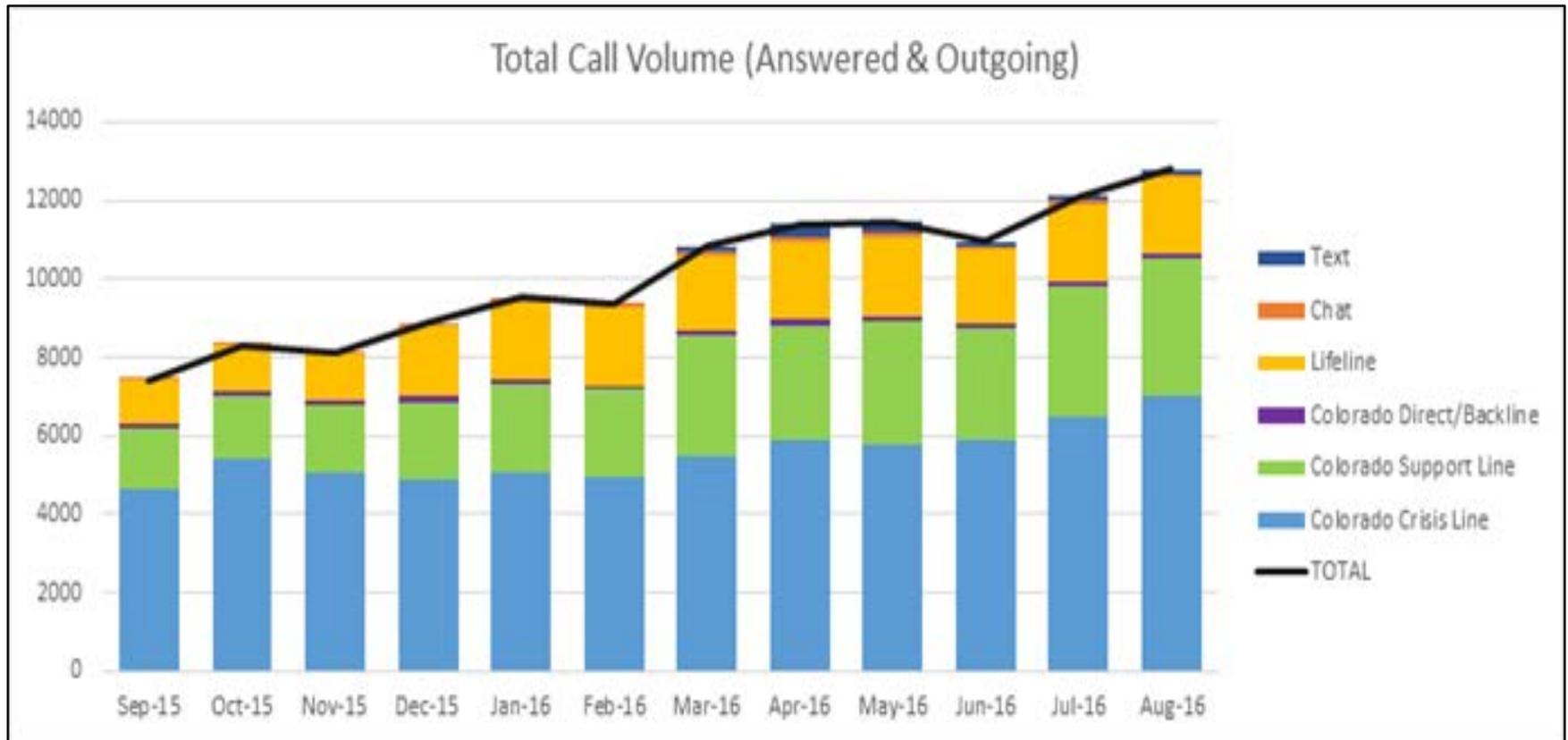
Recommendations

1. End the Use of Law Enforcement Facilities for M-1 Holds
2. Streamline Regulations and Establish a Stronger System of Accountability
3. Establish a Tiered System for Carrying Out M-1 Holds
4. Ensure Network Adequacy
5. Expand and Extend the Behavioral Health Workforce
6. Create a Sustainable and Reliable Data Monitoring System
7. Ensure Proper Payment for treatment of individuals on Mental Health Holds
8. Identify and Pilot Transportation Solutions that Reduce the Costs, Stigma, and Trauma Associated with M-1 Transport



Colorado Crisis Services Call Volume

Governor Hickenlooper's 2013 Behavioral Health Initiative invested \$25 million to create a comprehensive statewide crisis response system including a hotline/warmline, mobile crisis, walk-in centers, and marketing campaign.



September 1, 2015 through August 2016



Bed Tracking Data System Options

24/7 Designated Hotline Facilitation

Hotline/warmline available 24/7

Duties include:

Tracking bed availability in 27-65 facilities,
Providing information to first responders, police, general public via telephone

Est Cost. \$165,000

Web-based Bed Reporting System

Build of a web-based 27-65 designated bed-tracking system. This system would require that 27-65 facilities update the web-based bed tracking system multiple times per day in order for it to be accurate.

Est. Cost \$600,000 (Year 1)
\$25,000 (Ongoing)

24/7 Designated Hotline Facilitation and Web-base Bed-Reporting System

Hybrid option combining 24/7 year round hotline staff post along with the Web-based bed reporting system.

Est. Cost \$765,000 (Year 1)
\$190,000 (Ongoing)



Bed Tracking Data System Options

24/7 Designated Hotline Facilitation

Hotline/warmline available 24/7

Duties include:

Tracking bed availability in 27-65 facilities,
Providing information to first responders, police, general public via telephone

Est Cost. \$165,000

Web-based Bed Reporting System

Web-based 27-65 facilities. This system requires 27-65 facilities to have a computer and internet access. This system requires 27-65 facilities to have a computer and internet access. This system requires 27-65 facilities to have a computer and internet access.

Est. Cost \$600,000 (Year 1)
\$25,000 (Ongoing)

24/7 Designated Hotline Facilitation and Web-base Bed-Reporting System

Hybrid option combining 24/7 year round hotline staff post along with the Web-based bed reporting system.

Est. Cost \$765,000 (Year 1)
\$190,000 (Ongoing)





COLORADO
Department of Human Services



Office of Behavioral Health

Other Budget Priorities

FY 2017-18 MHI Budget Requests

- MHI Security Enhancements: \$610,000
 - Security staff active shooter training
 - Security staff equipment/gear
 - Security camera replacements in Seclusion and Restraint rooms
- Mental Health Institutes Capital Outlay: \$350,000
 - Equipment replacement strategy
 - Maintain safe and functional medical equipment, patient furnishings, and kitchen equipment.
 - Total Equipment Investment / Useful Life of Equipment = Targeted Equipment Annual Replacement



Reggie Bicha

Executive Director

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