DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Medicaid Mental Health Community Programs Only)
FY 2013-14 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, November 27, 2012
10:30 am – 11:00 am

10:30-10:35 INTRODUCTIONS AND OPENING COMMENTS

10:35-10:40 AFFORDABLE CARE ACT

1. More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?

10:40-11:00 SUBSTANCE USE DISORDER BENEFIT

2. The Department proposes shifting the current Medicaid substance use disorder benefit from a fee-for-service model to a managed care model. Why does the Department propose that the Behavioral Health Organizations (BHOs) should manage the benefit rather than the Managed Service Organizations (MSOs) that already administer the non-Medicaid substance use disorder program for the Department of Human Services?

3. If the Department's request to enhance the existing substance use disorder through the expansion of existing services and the addition of new services is funded, how will the savings in other areas of the budget (e.g. physical health care) be tracked?

4. Does the Department have any preliminary projections for future cost savings in other areas of the budget (e.g. physical health care) if the request is funded?

5. The Department has implemented Regional Care Collaborative Organizations (RCCOs) to connect Medicaid enrollees with providers offering services to Medicaid enrollees and to provide improved communication mechanisms to better coordinate care. If the Department's funding request for the substance use disorder benefit is granted and implemented as part of the BHO contracts, what impact (if any) will it have on the integration of behavioral health services and physical health services as it relates to the RCCOs?

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. The Joint Budget Committee has recently reviewed the State Auditor's Office *Annual Report of Audit Recommendations Not Fully Implemented* (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that

fall within the following categories, please provide an update on the implementation status and the reason for any delay.

a. Financial audit recommendations classified as material weaknesses or significant deficiencies;
b. Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.

HCPF JBC Hearing responses

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1. **More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?**

RESPONSE: If the State were to expand Medicaid eligibility for parents and Adults without Dependent Children (AwDC) beyond current categories, the Department does not anticipate that the new enrollees would be more likely to require behavioral services or have a higher per capita cost than existing enrollees. For the most recent expansion of Medicaid Parents from 60% of the federal poverty level (FPL) to 100% FPL, the behavioral health capitation rates for the expansion group were the same as those for the lower income parent categories. The Department anticipates that this would also likely be the case if eligibility for Medicaid Parents were to be further expanded. For Adults without Dependent Children (AwDC) with income at or below 10% FPL, the behavioral health capitation rates are between the existing low-income adult and disabled rates. If AwDC eligibility were to be expanded, the Department believes that the per capita cost may decrease as the higher income individuals are likely to be relatively healthier.

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RESPONSE: The Department proposes that the Behavioral Health Organizations (BHOs) should manage the Substance Use Disorder (SUD) benefits for a number of reasons. Moving the SUD services into the BHO contract addresses the importance of providing integrated services and does so in a way that is administratively feasible, effective and efficient. The inclusion of these services into the BHO contract is an important and logical step toward improving Colorado Medicaid's behavioral health system as a whole.

On both national and local levels, health care is moving towards integration and coordination of services. Integration efforts focus not only on integration of mental health and substance use disorder services into the comprehensive behavioral health system, but also on integrating behavioral health services with physical health care. Integrating SUD services into the BHO contract ensures that Colorado Medicaid's policy is aligned with national trends and best practices.

Integrating SUD services will also eliminate the need to create yet another siloed managed care entity or "carve out" and will help ensure that we provide more seamless and coordinated care for our clients. Research has shown that a high percentage of clients with mental health conditions have a co-occurring substance use disorder. Similarly, many individuals with a substance use disorder have an undiagnosed mental health condition. Providing integrated treatment for these co-occurring conditions is significantly more effective than treating each in isolation. By integrating SUD services into the BHO contract, treatment may be provided to the whole person in one delivery system, maximizing treatment outcomes, as well as improving our clients' experience of care.

In addition to supporting the goal of integration, moving the full SUD benefit into the BHO contract makes sense from an administrative perspective. BHOs already provide SUD and mental health services to clients with co-occurring conditions and are familiar with the provision of these services. The BHOs' main providers, Community Mental Health Centers (CMHCs), are all certified SUD services providers, and the Department is confident that BHOs could assume this scope of work and expand their contracting to include other SUD providers. BHOs have also been working on integration with physical health services, so it makes sense to align integration of mental health and SUD treatment with these efforts.

Finally, integration makes sense in terms of the Department's contracting and systems capabilities. The Department is currently under contract with the BHOs, so adding the SUD services into the BHO contract scope of work avoids a costly/lengthy procurement process. Technical systems are already set up to process BHO encounter data and can easily be revised to include SUD services. The Department is also working on a Request for Proposals (RFP) for the new behavioral health services contract for FY 2013-14. This RFP will include a strong focus on integration of not only mental health and SUD services, but physical health services, as well. MSOs and SUD providers are actively involved in the RFP stakeholder engagement process for the rebid, and the Department will encourage all qualified MSOs and behavioral health organizations to bid on the new scope of work.

3. **If the Department's request to enhance the existing substance use disorder through the expansion of existing services and the addition of new services is funded, how will the savings in other areas of the budget (e.g. physical health care) be tracked?**

RESPONSE: If the request is approved, the Department would account for any savings through future budget requests for Medical Services Premiums and Medicaid Community Mental Health Programs.

It is not clear if the Department will be able to identify savings specifically attributable to an enhanced substance use disorder treatment benefit. In its November 2010 performance audit on

the existing Medicaid outpatient substance use disorder treatment benefit, the Office of the State Auditor found that it was not "…able to determine whether the reduction in medical costs

was the direct **result of, or 'caused by,'** Substance Abuse Benefit services provided to clients" (**emphasis** original). This finding was in part because state databases, including the Department's Medicaid Management Information System (MMIS) and information available from the Department of Human Services, were not designed "…to collect data on underlying factors impacting clients' medical costs for research or experimental studies." As a result, the Office of the State Auditor was not able to establish a causal relationship between the benefit and reductions in cost.

As was the case at the time of the performance audit, the Department does not have access to the needed information that would allow for this type of analysis, and as a result, the Department may not be able to specifically attribute savings to an enhanced substance use disorder treatment benefit. However, if savings do occur, they would lead to a lower request for Medical Services Premiums in future years.

The Office of the State Auditor did perform a number of additional analyses to examine cost trends for clients who used the existing substance use disorder benefit, and found "…the trends in medical costs for clients who utilized the Medicaid Substance Abuse Benefit are promising and indicate that the benefit may have a positive impact." The Department would be able to perform similar analyses in the future to examine if there was evidence of savings, even if a causal relationship cannot be established.

The Department believes that the implementation of an expanded benefit in a managed care delivery model – specifically, the state's Behavioral Health Organizations – has the potential to provide for better data that may allow for a causal relationship to be established in the future. The Department, in conjunction with its Statewide Data and Analytics Contractor (SDAC), which is primarily focused on analysis related to the Accountable Care Collaborative, are collaborating on finding ways to better measure the impact of programmatic changes. The results to date have been positive; the Department's response to the November 1, 2012 Legislative Request for Information #6, discussing the results of the Accountable Care Collaborative, would not have been possible without the statistical and technical help of the SDAC. If this request is approved, the Department fully intends to evaluate and analyze utilization of services of clients accessing SUD to determine impacts on client's overall health outcomes and utilization, and incorporate any savings achieved in a future budget request.

4. **Does the Department have any preliminary projections for future cost savings in other areas of the budget (e.g. physical health care) if the request is funded?**

RESPONSE: The Department did not include a savings estimate as part of its request. As described in the Department's response to question 3, in the most recent performance audit of the current program, the Office of the State Auditor was unable to determine whether the reduction in costs was a result of the treatment or other factors. Therefore, the Department did not believe that it would be appropriate to prospectively include a savings estimate in the request.

However, the Department believes that providing treatment greatly improves the overall health of the client as it reduces clients' risks for a variety of health conditions and accidents and could therefore reduce costs. This view is supported by research from the National Center for Addiction and Substance Abuse at Columbia University, which has found that untreated addiction alone causes or contributes to more than 70 other diseases requiring hospitalization. In Washington, substance use disorder treatment was shown to save $311 per month in medical costs for Medicaid members. In California, substance use disorder treatment reduced ER visits by 39%, hospital stays by 35% and total medical costs by 26% (Substance Abuse and Mental Health Services Administration (SAMHSA)). Further, beyond direct health outcomes, research by the National Center for Addiction and Substance Abuse at Columbia University has found that health-related costs represent only 26 cents of every dollar spent on substance use disorder. The other 74 cents goes to the justice system, education, child/family services and other costs. By providing appropriate and sufficient treatment to individuals with substance use disorders, the overall burden to State government for related costs may be reduced.

Therefore, while the Department has not provided a preliminary savings estimate in the request, the Department is hopeful that the request will lead to lower costs and better outcomes in the future. As noted in the Department's response to question 3, the Department is optimistic that it will be able to provide a more detailed assessment of savings in the future.

5. **The Department has implemented Regional Care Collaborative Organizations (RCCOs) to connect Medicaid enrollees with providers offering services to Medicaid enrollees and to provide improved communication mechanisms to better coordinate care. If the Department's funding request for the substance use disorder benefit is granted and implemented as part of the BHO contracts, what impact (if any) will it have on the integration of behavioral health services and physical health services as it relates to the RCCOs?**

RESPONSE: Including the current fee for service substance use disorder (SUD) benefit in the Behavioral Health Organization (BHO) contracts will positively impact the Accountable Care Collaborative (ACC) program and support current Department efforts to further integrate behavioral health and physical health care services. The Regional Care Collaborative Organizations (RCCOs) continue to increase their focus on achieving integrated care, and moving all behavioral health services under the BHO contracts will further promote their ability to effectively coordinate services and impact integrated service delivery for their members.

Over the past several years the Department has placed progressively greater emphasis on the integration of behavioral and physical health care services in Medicaid. Prior to the development of the ACC program, the BHOs were responsible for helping clients obtain a focal point of physical health care and coordinating mental health care with other health care services. Over time, the BHOs have pursued additional initiatives focused on integrated care. These integration strategies include co-located behavioral health care in primary care clinics, information sharing and consultation to facilitate better integrated care, and embedded physical care services in behavioral health provider sites.

Under the ACC, the BHOs have continued to make progress in the integration of care by actively working with the RCCOs to integrate behavioral health care with Primary Care Medical

Providers (PCMPs), who serve as medical homes for ACC members. Moving forward, the Department is currently developing the next Request for Proposals (RFP) for the behavioral health services contracts to begin in FY 2013-14. The RFP will include a continued strong focus on integration of behavioral health and physical health services, incorporating a number of new requirements in this area. The new integration requirements will help inform the Department and its BHO and RCCO partners on the most effective ways to further integrate behavioral health and physical health care. Integrating SUD and mental health services in a more robust way under the BHO contract is a significant step towards continuing to build a strong relationship between the behavioral health system and physical health care and towards the Department's long-term goal of a fully integrated health care delivery system.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

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    a. **Financial audit recommendations classified as material weaknesses or significant deficiencies;**
    b. **Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.**

RESPONSE: The Department will provide responses to this question at its main hearing on January 7, 2013. The Department's outstanding audit recommendations do not pertain to the Department's Medicaid Mental Health Community Programs.