Joint Budget Committee
Briefing for Health Care Policy and Financing and Human Services:
Behavioral Health Services (Mental Health and Substance Abuse)
December 9, 2015
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The majority of publicly funded behavioral health services in Colorado are funded through two departments: the Department of Human Services’ (DHS) Office of Behavioral Health (OBH) and the Department of Health Care Policy Financing’s (HCPF) Behavioral Health Community Programs. The JBC staff for behavioral health services provided a briefing on the two Departments’ budget requests. This document provides a summary of the briefing. The written briefing documents provided by JBC staff are available here and here. The JBC hearing with a presentation from DHS Director Reggie Bicha and HCPF Director Sue Birch is scheduled for December 16, 2015.

Most JBC members attended (Senators Lambert and Steadman, and Representatives Hamner, Young, and Rankin), as well as a few other legislators who attended all or part of the briefing (Senator Aguilar and Representatives Ginal, Kraft-Tharp, Thurlow, Primavera, Everett, Ryden, and Joshi). JBC Member Senator Grantham was ill.

Department of Health Care Policy and Financing

JBC staffer, Carolyn Kampman, provided an overview of the HCPF behavioral health community programs budget, noting the following key points:

- 7.4% of total HCPF funds ($654 M) are appropriated for behavioral health
- The funding split is 67% Federal Funds (FF), 29% General Fund (GF) and 4% Cash Funds (CF), including hospital provider fee and tobacco settlement funds
- Capitation payments to Behavioral Health Organizations (BHOs) represent almost 99% of the total funds appropriated to HCPF for behavioral health
- The FY2016-17 budget requests an average annual capitation per patient of $506, though this varies by BHO and eligibility category. This is less than anticipated, as expansion adults have not been as expensive as expected.
- A table on page 14 shows average annual expenditure per member by BHO. JBC members requested information about the variation across BHOs, as the rates range from $466 to $655 annually.
Medicaid services excluded from behavioral health and paid instead through the Medical Services Premium line item for Medicaid, include:
  o Inpatient medical treatment for clients with acute medical conditions that include an SUD diagnosis ($110M)
  o Inpatient SUD treatment for children and youth under age 21 ($1.9M)
  o Pharmaceuticals for behavioral health services ($51.7M total, of which $37M was spent on antipsychotic drugs

Informational Issue: Overview of FY2016-17 Request (pages 11-17)

Ms. Kampman noted that HCPF behavioral health programs will have a reduction in appropriations in the current FY of $17 M, but the majority of this funding will need to be reinstated for FY2016-17. In the current FY, the per capita expenditures were lower than anticipated.

Several trends were noted, including a significantly higher utilization of SUD services in all regions in the final quarter of FY2014-15. The enhanced SUD benefit was added in January 2014, so ramp up and implementation time was anticipated. The spending is anticipated to remain at/near final quarter of FY2014-15 levels. The expansion population has utilized SUD treatment at a higher rate than other Medicaid populations, and the clients are disproportionately male.

Issue Brief: Integrating Behavioral and Primary Health Care (pages 18-26)

Ms. Kampman provided an overview of the HCPF’s plans and activity regarding integration of care, including the SIM grant, HB12-1281 payment reform pilots, and others. She noted that in her visits around the state to Community Mental Health Centers and BHOs, she found numerous examples of integration occurring in many communities, with primary care brought to clients whose key issue is a mental health diagnosis or substance use disorder, as well as behavioral health brought to primary care settings to meet a variety of needs. Ms. Kampman discussed a number of barriers to integrated care (page 21) identified by HCPF, DHS, and CDPHE (in the “Tri-Agency Regulatory Alignment Initiative to Support Integrated Care” report). In addition, the WICHE Behavioral Health Needs Analysis and CBHC’s interactive online map pinpointing the locations of integrated projects allowing the user to filter by region, level of integration, and type of site were mentioned as resources.

The Western Slope pilot program (RMHP Prime) with risk-based capitation for both medical and behavioral health care was discussed at some length as a program with initial positive results (pages 22-26). After hearing positive news about a full capitation model, Senator Lambert mentioned a letter from Colorado Behavioral Healthcare Council (CBHC) outlining their concerns with the current HCPF proposal to move away from capitation to FFS and asked if HCPF could address those concerns at their hearing. Other JBC members chimed in, and all comments indicated that they agreed with their local mental health providers and CBHC that the capitated model seemed more desirable. HCPF will be asked to address this issue at the hearing.
Rep. Young was impressed with the RMHP Prime project thus far, but asked HCPF to provide information on the delayed timeline of the pilot and the rationale for only implementing one pilot in the state.

**Issue: Accountable Care Collaborative Phase II (pages 27-32)**

Ms. Kampman provided an overview of the ACC and BHO programs and HCPF’s concept paper for ACC Phase II. The document also lists the concerns of behavioral health providers with responses from HCPF, which are listed on pages 30-32. The JBC requested that HCPF provide further information about Phase II at their hearing, including addressing the provider concerns. HCPF was also asked to discuss their further vision, including how Managed Service Organization (MSOs) or Community Centered Boards (CCBs) might be integrated in the future.

**Department of Human Services, Office of Behavioral Health (OBH)**

The Office of Behavioral Health (OBH) is responsible for the public behavioral health system, including community-based mental health and substance use disorder (SUD) services that are not otherwise available, including for clients who are NOT eligible for Medicaid or who need services that are not covered by Medicaid. OBH contracts with 17 community mental health centers (CMHCs) to provide mental health services and with 4 Managed Service Organizations (MSOs) for the provision of SUD treatment and detoxification services through local treatment providers. OBH is also responsible for the operation of the state’s two mental health institutes that provide inpatient hospitalization for individuals with serious mental illness (Pueblo and Ft. Logan).

Carolyn Kampman provided an overview of the CDHS OBH budget, noting the following key points:
- Behavioral health services are 22.6% of CDHS GF and 13.3% of total funds
- The FY 2015-16 request for the Behavioral Health Services section of the Department of Human Services budget consists of 70.9% General Fund, 8.6% cash funds, 7.1% reappropriated funds, and 13.4% federal funds.

**Description of Requested Changes:**

R3 requests almost $4M GF and 7.5 FTE to address continued increases in the number of court-ordered competency evaluations and restorations to competency. This is discussed in more detail in an Issue Brief summarized below.

Significant part of state marijuana revenues are proposed for the 3 following purposes:

R11 proposes use of $4.7M to contract for programs for intensive residential treatment for individuals with severe substance use disorders by paying for beds for pregnant women (32 beds) adult men (32 beds) and young adults ages 18 to 25 (16 beds). The funds would be distributed through a procurement process to community providers.
based on their identification of need in their area and ability to provide the services. Annual costs after the first year would be $6.1M.

R12 proposes use of $300,000 to contract with an organization to establish up to 15 sober living homes for individuals leaving SUD treatment. These homes would provide stable, drug-free housing for approximately 60 people each year.

R13 proposes use of $500,000 to contract with substance abuse treatment providers to provide “Individual Placement and Support (IPS) services to clients with severe SUDs. The funding would support ten contract staff at five sites, providing services to approximately 300 clients per year.

R14 proposes a net zero change for the Behavioral Health Crisis System through less funds to the contractor and more funds to the Department for 2.7 FTE to monitor the program. JBC members wondered why funds allocated to services had not been spent.

R19 reflects the proposed 1% provider reimbursement cut, which would reduce funding by $1M for DHS behavioral health providers. The impact of this cut is larger across other DHS providers and HCPF.

Issue: WICHE Study Concerning State’s Behavioral Health Needs (pages 12-19)

This study is lengthy, but seems to be driving much of the OBH’s vision, including proposed activities and budget items. It includes over 80 recommendations for actions from multiple state agencies. The report identifies four promising practices that can help address some of the identified service gaps and disparities: (1) Telehealth; (2) Integrating primary and behavioral health care; (3) Prevention and early intervention; and (4) Peer support services. The report includes data that clearly demonstrates a reduction in the State’s ability to provide inpatient psychiatric care for civil patients. The report also identifies systemic barriers that inhibit the effective delivery of behavioral health services – several of which involve the allocation of responsibilities between DHS and HCPF.

Appendix E (pages 79-92) reflects the WICHE study recommendations as well as actions and initiatives that DHS has taken in response to the WICHE study findings.

Issue: Competency Evaluation and Restoration Services (pages 20-29)

In 2012, DHS entered into a Settlement Agreement related to a legal challenge concerning the length of time pretrial detainees wait to receive competency evaluations and competency restoration treatment. In order to comply with this Agreement, DHS requested an addition $2.7 million in September 2015 for Mental Health Institutes to address continued increases in the number of competency-related court orders. The JBC approved this interim supplemental request. DHS has submitted an associated request for an additional $4.1 million GF in FY 2016-17. The requested funds are a critical component of DHS’s plan to address the increasing number of court orders and
to avoid further legal action, as their current available resources do not allow them to uphold the Agreement. DHS also outlined several additional actions they are taking to address the situation.

The Department’s FY 2015-16 request includes two components: an increase of $333,917 GF to hire additional psychologists to perform court-ordered competency evaluations and an increase of $2,393,180 GF to increase capacity to house individuals requiring inpatient competency evaluations and restoration.

JBC staff recommended that the Committee ask DHS to provide an update on its progress in implementing the changes for which additional funds were requested in September. In addition, staff recommended that the Committee ask DHS about the next steps that are necessary to improve the efficiency and effectiveness of the system.

*Informational Issue: Impact of Medicaid Expansion on CMHCs (pages 30-33)*

In September 2015, DHS submitted a request to the JBC to reduce GF support for CMHCs by $2.5 million for FY 2015-16 based on the impact of Medicaid eligibility expansion. The JBC denied this request, and instead sent a letter to provide feedback to DHS and request consideration of several issues as DHS finalized its FY 2015-16 contracts with CMHCs. In response, DHS worked with the Centers to finalize FY 2015-16 contracts and made several changes to contract terms, including allowing funds to be used for lower severity clients. DHS now anticipates reverting less than $100,000 GF in FY 2015-16.

DHS’s interim supplemental request for FY 2015-16 also requested an increase in GF appropriation of $200,000 to the Office of State Planning and Budgeting (OSPB) to contract with an outside vendor to examine how funding should be distributed and aligned between DHS and HCPF. The JBC approved this request. DHS’s request for FY 2016-17 does not reflect any further contract-related changes.

*Informational Issue: SUD Services for Adolescents and Pregnant Women (pages 35-42)*

The 2015 Long Bill included a Request for Information to both DHS and HCPF about the $1.5M marijuana funds allocated in 2014 for SUD residential treatment for pregnant women and adolescents. The report was due November 1, 2015 and is summarized by the JBC staff. The summary includes a listing of all of the existing programs for these populations, as well as the remaining need that may require state funding, and the impact of Medicaid’s enhanced SUD services benefit. DHS provides data demonstrating the need for these services for both populations, but especially for pregnant women and uses this data to support their budget request (R11 described above).
Informational Issue: Gambling Addiction Program Audit (pages 43-46)

An August 2015 state audit concerning DHS’s Gambling Addiction Program found that DHS has not awarded grants in compliance with statute or maximized the use of its resources to address problem gambling. The Program is supported by an annual appropriation of $100,000 cash funds from limited gaming revenues (2.0% of the $5M annually transferred to the Local Government Limited Gaming Impact Fund).

The audit found that over the last five fiscal years, DHS has used only 36% of Program funds for grants. The remaining funds were used for administrative and marketing costs or not used at all. The audit also found that the Program has been poorly administered. The audit provided 2014 survey data indicating that an estimated 95,000 Coloradans (2.4% of adult population) have a gambling disorder that included “persistent and recurrent problematic gambling behavior leading to clinically significant mental impairments or distress.” Additionally, the National Problem Gambling Helpline reported that it received about 9,300 calls from Coloradans seeking help in 2014. The audit provided several recommendations for improving the Program’s effectiveness.

Senator Steadman requested that DHS address whether or not part of the problem is the lack of resources, given that only $100,000 has been provided annually. Representative Primavera commented that she is working with stakeholders on developing a legislative solution to this issue for the 2016 legislative session.

Update on Long Bill Footnotes

Long Bill Footnote #36 on Incentive Based Payments for Treatment and Detox Contract (pages 63-67) provides a detailed response from CDHS about the implementation of this footnote. DHS includes information on which line items were impacted, the dollar amounts, and performance measures used. DHS is no longer withholding money up front, but rather pulling money from providers later if performance measures are not met.